

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's Date

What is your blood type?  A-  A+  B-  B+  AB-  AB+  O-  O+  Unsure

Are you dieting?  No  Yes, since \_\_\_\_/\_\_\_\_/\_\_\_\_ What kind of diet? \_\_\_\_\_

How would you rate your current overall health? Place a mark along the line where you feel is most appropriate.

Very Poor \_\_\_\_\_

\_\_\_\_\_ Excellent

For the following statements below that pertain to you, please indicate by either highlighting or circle the point score adjacent to the statement. Please total your score and record it at the end of the section. Please answer truthfully and honestly. If you have any questions, please do not hesitate to ask!

**Section A: History**

**Point Score**

1	Have you ever taken tetracyclines (Sumycin®, Panmycin®, Vibramycin®, Minocin®, etc.) or other antibiotics or acne for 1 month or longer?	50
2	Have you, at any time in your life, taken other "broad spectrum" antibiotics for respiratory, urinary or other infections for 2 months or longer, or for shorter periods 4 or more times in a 1-year span?	50
3	Have you taken a broad spectrum antibiotic drug -- even for one period?	6
4	Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs?	25
5	Have you been pregnant . . . . . 1 time?	3
	2 or more times?	5
6	Have you taken birth control pills for . . . . . 6 months to 2 years?	8
	more than 2 years?	15
7	Have you take prednisone, Decadron®, or any cortisone-type drug by mouth or inhalation for . . . 2 weeks or less?	6
	more than 2 weeks?	15
8	Does exposure to perfumes, insecticides, or other chemicals provoke . . . . . mild symptoms?	5
	moderate to severe symptoms?	20
9	Are your symptoms worse on damp, muggy days or in moldy places?	20
10	Have you had athlete's foot, ringworm, "jock itch" or other chronic fungus infections of the skin or nails? Have such infections been . . . . . mild or moderate?	10
	Severe or persistent?	20
11	Do you crave sugar?	10
12	Do you crave breads?	10
13	Do you crave alcoholic beverages?	10
14	Does tobacco smoke <b>really</b> bother you?	10
<b>Total Score, Section A</b>		

For each symptom that is present, enter the appropriate number in the Point Score column:  
 If a symptom is **occasional or mild** . . . . . score 3 points  
 If a symptom is **frequent and/or moderately severe** . . . . . score 6 points  
 If a symptom is **severe and/or disabling** . . . . . score 9 points  
 Total the score for this section, and record it in the box at the end of this section.

<b>Section B: Major Symptoms</b>	<b>Point Score</b>
1 Fatigue or lethargy	
2 Feeling of being "drained"	
3 Poor memory	
4 Feeling "spacey" or "unreal"	
5 Inability to make decisions	
6 Numbness, burning or tingling	
7 Insomnia	
8 Muscle aches	
9 Muscle weakness or paralysis	
10 Pain and/or swelling in joints	
11 Abdominal pain	
12 Constipation	
13 Diarrhea	
14 Bloating, belching or intestinal gas	
15 Vaginal burning, itching, or discharge	
16 Prostatitis	
17 Impotence	
18 Loss of sexual desire or feeling	
19 Endometriosis or infertility	
20 Cramps and/or other menstrual irregularities	
21 Premenstrual tension	
22 Attacks of anxiety or crying	
23 Cold hands or feet and/or chilliness	
24 Shaking or irritable when hungry	
<b>Total Score, Section B</b>	

<b>Section C: Other Symptoms</b>	<b>Point Score</b>
1 Drowsiness	
2 Irritability or jitteriness	
3 Incoordination	
4 Inability to concentrate	
5 Frequent mood swings	
6 Headaches	
7 Dizziness/loss of balance	
8 Pressure above ears/ Feeling of head swelling	
9 Tendency to bruise easily	
10 Chronic rashes or itching	
11 Psoriasis or recurrent hives	
12 Indigestion or heartburn	
13 Food sensitivity or intolerance	
14 Mucus in stools	
15 Rectal itching	
16 Dry mouth or throat	
17 Rash or blisters in mouth	
18 Bad breath	
19 Foot, hair or body odor not relieved by washing	
20 Nasal congestion or post nasal drip	
21 Nasal itching	
22 Sore throat	
23 Laryngitis, loss of voice	
24 Cough or recurrent bronchitis	
25 Pain or tightness in chest	
26 Wheezing or shortness of breath	
27 Urinary frequency, urgency, or incontinence	
28 Burning on urination	
29 Spots in front of eyes or erratic vision	
30 Burning or tearing of eyes	
31 Recurrent infections or fluid in ears	
32 Ear pain or deafness	
<b>Total Score, Section C</b>	

<b>Total Score, Section C</b>	
<b>Total Score, Section B</b>	
<b>Total Score, Section A</b>	
<b>GRAND TOTAL SCORE</b>	