



A.R.E. HEALTH & REJUVENATION CENTER

MASSAGE AND DAY SPA

215 67th Street, Virginia Beach, VA 23451-2016

Phone 757-437-7202 ✦ Fax 757-457-7138

E-mail: massage@edgarcayce.org ✦ Web site: www.edgarcayce.org/hrc

Dear Friend,

Thank you for your request for a Cayce-based health assessment. We hope to provide you with information that will be helpful to your health for years to come!

To help us personalize your health assessment, please print out and complete the attached forms in the comfort and convenience of your home. Because of federal regulations, we must ask that you use postal mail to return your completed forms to us at:

A.R.E. - H.R.C. Spa
215 67th Street, Virginia Beach, VA 23451-2061

We will need to receive your completed forms at least five business days prior to your scheduled appointment.

Congratulations on your commitment to improving your health; we look forward to assisting you in doing so!

Janice Long
Health Center Manager

The Cayce Comprehensive Symptom Inventory (CCSI)

The *Cayce Comprehensive Symptom Inventory* (CCSI) is a structured assessment instrument intended for use as an adjunct to traditional and alternative assessment procedures. The CCSI consists of a wide variety of signs and symptoms of physical and emotional distress. The items are arranged in scales, each scale representing a pattern of etiology (cause and effect) used by Edgar Cayce in his system of assessment and diagnosis. Some items are retrospective, requiring information preceding the previous twelve-month period.

Information provided in the CCSI report you receive should not be used to diagnose, treat, cure, or mitigate disease, and is not intended to replace appropriate medical care.

General Instructions For Rating Symptoms

Individuals taking the CCSI are asked to rate the presence of the sign or symptom during the past twelve months. For most items, choose the number which best describes your experience of the symptom during the past 12 months. For a few symptoms you will be asked for information prior to the past 12 months.

SYMPTOM RATING

Proceed with the administration by assigning a number for each symptom. Here are some criteria for rating the severity of symptoms:

0 = No or None

If the client has not had any problem with this symptom during the past 12 months, enter “0”.

1 = Mild

If the client is aware of having a problem with this symptom during the past 12 months but has not sought professional treatment it is probably a “mild” rating. The client may be using an “over the counter medication” or some form of self-treatment. Also, a mild level probably does not seriously affect quality of life or cause significant discomfort. Examples of this level would be an occasional mild headache of short duration.

2 = Moderate

The client will probably seek treatment for the moderate level of a symptom because it is likely to adversely affect quality of life or cause notable discomfort. The client may find that he/she avoids certain activities or is required to make adjustments in daily activities because of a moderate symptom. The client probably has discussed the symptom with his/her doctor and received a prescription or some form of professional treatment. An example of this level would be fairly frequent headaches or increasing pain levels that cause the client to miss work or other daily activities from time to time.

3 = Severe

The client is very likely to seek treatment when a symptom is “severe.” Severe levels of symptomatology cause significant discomfort and adversely affect quality of life. An example of this level would be chronic and debilitating headaches (such as migraine) that make it almost impossible to have a normal life.

CAYCE COMPREHENSIVE SYMPTOM INVENTORY (CCSI)

Copyright © 1998 by David McMillin, all rights reserved.

Name: _____

Age: _____

Date: _____

Sex: _____

SCALE 1

- _____ Cold extremities
- _____ Itchy or dry skin
- _____ Skin blemishes (eczema, psoriasis, rash, acne, etc.)
- _____ Hands or feet are numb or fall asleep
- _____ Lumps or tumors under skin

SCALE 2

- 2X _____ Kidney or bladder problems
- _____ Cold, clamminess over body
- 2X _____ Cold area on abdomen
- _____ Tiredness or fatigue
- _____ Constipation
- _____ Stomach or intestinal gas

SCALE 3

- _____ Stomach or intestinal gas
- 2X _____ Indigestion or "sour stomach"
- _____ Nausea
- _____ Headache
- _____ Bad taste in mouth
- _____ Constipation
- 2X _____ Anemia
- _____ General weakness and lack of energy or vitality

SCALE 4

- 2X _____ Heartburn
- 2X _____ Belching
- _____ Indigestion
- 2X _____ Regurgitation of food
- _____ Constipation

SCALE 5

- 2X _____ Catches cold easily
- _____ Prone to severe colds
- 2X _____ Prone to congestion (head, throat or lungs)
- _____ Irregular or fast pulse
- _____ Tiredness or fatigue
- _____ Abnormal appetite (increased, decreased, erratic)
- _____ Skin rash
- 2X _____ Headaches
- 2X _____ Indigestion
- _____ Hemorrhoids
- _____ Stomach or intestinal gas
- _____ Chronic muscle pain or diagnosis of fibromyalgia

CAYCE COMPREHENSIVE SYMPTOM INVENTORY (CCSI)

SCALE 6

- Indigestion
- Constipation
- Dull headaches
- Pain or heaviness along right side of abdomen
- Bad breath or bad taste in mouth not directly due to food or drink
- General dullness or drowsiness
- 2X Gallstones or gallbladder problems
- Burning or irritation to eyes
- 2X Dizziness

SCALE 7

- Impaired or distorted sense of taste
- Impaired or distorted sense of smell
- Impaired or distorted vision
- Impaired or distorted hearing or tinnitus
- Feeling of fullness in throat or face
- Supersensitive reactions to sounds, actions, smells, etc.

Scale 8

- Decreased urination
- Urine has strong odor
- Burning sensation during urination
- Puffy under eyes or burning of eyes or blurred/dimmed vision
- Swelling or heaviness in lower extremities
- Aching muscles and/or joints (rheumatism)

SCALE 9

- 2X High blood pressure or palpitations
- Headaches
- Lower back pain or sciatic pain
- Tiredness or fatigue
- 2X Constipation

SCALE 10

- 2X Dental problems such as weak enamel or cavities
- Dry, faded, or thinning hair
- Finger nails split or break off
- Poor resistance to disease
- Low blood pressure or poor circulation to extremities
- 2X Weak bones, bone loss, or bone deformity
- Underactive thyroid
- Tiredness or fatigue
- Respiratory problems

SCALE 11

- 2X Excessive bleeding (lack of clotting) or wounds heal slowly
- Low resistance to disease or lack of vitality
- 2X Cysts or tumors
- Blotches, spots or bruises on surface of body

SCALE 12

CAYCE COMPREHENSIVE SYMPTOM INVENTORY (CCSI)

- 2X _____ Swelling or heaviness in lower extremities
_____ Lower back pain (lumbago)
_____ Burning or irritation of eyes or dimness of vision
_____ Dizziness
_____ Nausea
_____ Headache

SCALE 13

- _____ Abnormal appetite (increased, decreased, or erratic)
_____ Indigestion or high acidity in stomach, throat, or mouth
_____ Stomach or intestinal gas
_____ Abnormal heart action (low or high) or discomfort around heart
3X _____ Stomach empties too slowly or too quickly after eating
_____ Headaches
_____ Nausea
_____ Constipation

SCALE 14

- 3X _____ Skin blemishes (eczema, psoriasis, rash, acne, etc.)
2X _____ Swollen or painful joints (arthritis or rheumatism)
_____ Indigestion or stomach or intestinal gas
_____ Tender spots or painful areas over the body
_____ Nasal congestion (catarrh) or sinus problems
_____ Headache
_____ Depression
_____ Constipation

SCALE 15

- _____ Dry or thinning hair or ends of hair split
_____ Nails brittle or thin, nails split or break, or peel around cuticle
_____ Chronic dental problems
_____ Dry or rough skin
_____ Depression
_____ Tiredness or fatigue
_____ Lack of interest in sex
_____ Fullness, contraction, or choking sensation in neck or throat
_____ Cold extremities
_____ Poor concentration
_____ Abnormal appetite (increased, decreased, or erratic)

SCALE 16

- _____ Difficulty thinking or remembering; absentminded; slow to react
2X _____ Involuntary or uncoordinated movements (tics, twitches, tremors)
2X _____ Difficulty walking or maintaining balance
_____ Incontinence or drooling
_____ Sensory system impairment (speech, hearing, taste, or smell)
_____ Conscious awareness of involuntary process - digestion, bloodflow, etc

SCALE 17

- 2X _____ History of seizures or convulsions

CAYCE COMPREHENSIVE SYMPTOM INVENTORY (CCSI)

- 2X _____ Cool or cold spot on right side of abdomen
_____ Lapse or loss of consciousness
_____ Injury to tailbone or soreness of tailbone
_____ Constipation
_____ Abnormal mental and physical development
2X _____ Injury, pain or soreness on right side of abdomen below last rib

SCALE 18

- _____ Anger or hate
_____ Resentment, bitterness, or jealousy
_____ Anxiety, worry, or fear
_____ Depression
_____ Hereditary predisposition for illness or prenatal condition

SCALE 19

- _____ Sensory system impairment (speech, hearing, taste, or smell)
_____ Tiredness or fatigue
_____ Depression
_____ Constipation
_____ Thinning of hair or loss of body hair
_____ Underweight
_____ Splotches or blotches (white) on skin
_____ Dark circles under the eyes

SCALE 20

- _____ Headache
_____ Abnormal blood pressure (high, low, or erratic)
_____ Abnormal pulse (quick, slow, or irregular)
_____ Fever or temperature at times without apparent cause
_____ Feeling of fullness in throat or face
_____ Hot and/or cold sensations (flushing)
_____ Abdominal pain or aching across lower portion of hips
_____ Kidney or bladder problems
_____ Constipation

SCALE 21

- _____ Tiredness or fatigue
_____ Heart palpitations or rapid pulse
2X _____ General weakness
_____ Shortness of breath
_____ Fever or temperature at times without apparent cause
2X _____ Underweight
_____ Dizziness
_____ Indigestion

SCALE 22

- 3X _____ History of irritable bowel syndrome or inflammatory bowel disease
2X _____ History of intestinal flu
_____ Mucous in stool

CAYCE COMPREHENSIVE SYMPTOM INVENTORY (CCSI)

_____ Diarrhea
_____ Intestinal gas

SCALE 23

2X _____ Pain along right rib cage, right shoulder or arm, or upper right back
_____ Constipation
_____ Nausea
_____ Headaches, especially after eating
_____ Fever
3X _____ Intolerance to fats or greasy foods
_____ Bad breath or bad taste in mouth not directly due to food or drink
_____ Brown, yellow, or gray colored skin or brown splotches on skin
_____ Dizziness
_____ Abnormal pulse (quick, slow, or irregular)
_____ Shortness of breath

Scale 24

_____ Shortness of breath
2X _____ Cough
_____ Feeling of heaviness, fullness or pain in lungs
_____ Prone to congestion (head, throat or lungs)
2X _____ Wheezing
_____ Hay fever or other respiratory allergy

Scale 25

_____ Over or under-reactive to stimuli, or slow to react
_____ Lack of discernment or insight
_____ Poor concentration
_____ Poor memory
_____ Difficulty doing analysis or calculations
_____ Irrationality or delusional thinking
_____ Incoordination of movements or reflexes, or paralysis due to stroke
_____ Hallucinations
_____ Lack of self control

Scale 26

_____ Slow pulse
_____ Rapid pulse
_____ Palpitation or throbbing of heart
_____ Low blood pressure
_____ High blood pressure
_____ Erratic blood pressure (sometimes high, sometimes low)
_____ Chest pain (angina) or feeling of fullness around heart
_____ Fluttering of heart

Scale 27

3X _____ Indigestion 1 to 3 hours after eating
_____ Intestinal gas
_____ Constipation
_____ Diarrhea

CAYCE COMPREHENSIVE SYMPTOM INVENTORY (CCSI)

Mucous in stools

Scale 28

- 3X _____ Excess sugar in urine (sweet smelling urine or high urine test)
2X _____ Urination is frequent, excessive, or scant

Wounds heal slowly

Kidney or bladder problems

Impaired or distorted vision

Scale 29

- 3X _____ Pain or discomfort on left side of abdomen

Low blood pressure

Rapid pulse

Nausea

Highly suggestible or overly imaginative

Mood swings or emotional upsets

Scale 30

- _____

Infertility

Abnormal sex drive (high, low, or absent)

Menstrual or menopausal problems (female)

Prostate problems or impotence (male)

Pelvic pain or discomfort

HEALTH HISTORY AND LIFESTYLE OVERVIEW

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Street Address: _____ Phone: () _____

City: _____ State: _____ Zip: _____

Occupation (job title): _____

Physicians caring for you: _____

Please tell us what is bothering you. If this involves a specific health condition or illness, please tell us about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factors that you think may have played a role in its onset and progression. (Please attach a sheet if more space is required).

Is your health currently getting better, worse, or staying the same? _____

What would you like to have happen as a result of this consultation? _____

Please list any medical problems you have and all previous surgeries:

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Use additional space to give information as needed about these conditions

List all medications (prescription and non-prescription) that you take now. _____

List any other medications that have been tried in the past to treat your symptoms: _____

Please list any allergies you have: _____

What other treatments, if any, have you tried? Put a star by those that have helped. _____

How would you describe your health in general? _____

During the last year have you had: (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> unexplained fevers | <input type="checkbox"/> night sweats | <input type="checkbox"/> weight loss of 10 lb. or more |
| <input type="checkbox"/> loss of appetite | <input type="checkbox"/> excessive fatigue | <input type="checkbox"/> problems with depression |
| <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> easy bruising | <input type="checkbox"/> unusual stress in home life |
| <input type="checkbox"/> chest pain or tightness | <input type="checkbox"/> easy bleeding | <input type="checkbox"/> unusual stress in work life |
| <input type="checkbox"/> persistent or unusual cough | <input type="checkbox"/> swollen ankles | <input type="checkbox"/> any lumps in neck, armpits, or groin |
| <input type="checkbox"/> coughing up blood | <input type="checkbox"/> stomach pain | <input type="checkbox"/> trouble breathing with exercise |
| <input type="checkbox"/> change in bowel habits | <input type="checkbox"/> persistent diarrhea | <input type="checkbox"/> trouble breathing when lying flat |
| <input type="checkbox"/> dark black stools | <input type="checkbox"/> excessive constipation | <input type="checkbox"/> difficulty starting or stopping urination |
| <input type="checkbox"/> bleeding on stools | <input type="checkbox"/> blood in urine | <input type="checkbox"/> pain or burning when urinating |

What other health practices do you incorporate into your lifestyle at the present time? _____

How familiar are you with Cayce and his work? (circle one):

Not familiar 1 2 3 4 5 6 7 8 9 10 Most familiar

How closely do you follow the recommendations in the Cayce health readings? (circle one):

Not at all 1 2 3 4 5 6 7 8 9 10 Closely

Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

- a.
- b.
- c.
- d.
- e.

Do you think the pain and/or symptoms that you are experiencing could be purposeful? That is, could they be your body's wisdom saying, "I need some help... let's change some things here!" Please explain:

Do you feel your pain and/or illness is a reflection of short-term superficial circumstances or longer term, potentially deeper-seated challenges?

What areas of your lifestyle are likely involved with your condition and you would like to improve:
(Prioritize # 1, 2, 3, etc.)

- _____ My level of anxiety
- _____ My pace of living
- _____ Not enough quiet time and rest
- _____ Diet and nutrition program
- _____ My exercise program
- _____ Not enough time spent in nature
- _____ My creative expression
- _____ My feelings around career
- _____ My social and family life
- _____ My communication skills

Please list any self-destructive lifestyle habits (e.g. smoking, lack of exercise, addictions, etc.)

What might it cost you if you don't significantly improve your lifestyle and any underlying contributors to compromised health? (For example: vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

What is your present level of commitment to change the underlying causes of problem(s) which relate to your lifestyle? (Rate from 1 to 10, with 10 being 100% committed). _____

List your 3 highest priorities in life, which come to mind and speak to your heart. Where does your health and vitality factor in?

a.

b.

c.

What obstacles could prevent you from changing those lifestyle factors that are undermining your health?

What might stop you from following the plan that we may recommend for you?

Who would be willing to support you in your health goals?

Please list your special interests and passion:

<p>Women only:</p> <p>Age at onset of menstruation: _____ No. of miscarriages/c-sections: _____</p> <p>Number of children: _____ Age at onset of menopause: _____</p>
--

How was your health as a child? (circle one): excellent good fair poor

Did you have any serious emotional or mental traumas as a child? _____ Please explain:

What is your blood type? (circle one): A B AB 0 don't know

Do you wake rested? _____

Please rate your current emotional health (please circle): excellent good fair poor unstable crisis

Are you currently in psychotherapy? _____ Do you have a good support network/team? _____

Does your home environment have a supportive effect on your health? _____

How many hours of relaxation (not including sleep) do you give yourself during the work week? _____

During weekends? _____ Favorite recreational activities? _____

Do you have amalgam (silver) fillings? _____ Any other dental problems? _____

Are you considering any elective surgery or medical procedures in the near future? _____

Family Health History

Relation	Age	State Of Health (if living)	Age At Death	Cause of Death	Check if your blood relatives have/had Disease	Relationship
Father					Arthritis, gout	
Mother,					Asthma, hay fever	
Brothers					Cancer	
					Chemical dependency	
					Diabetes	
					Heart disease, stroke	
Sisters					High blood pressure	
					Syphilis, gonorrhea	
					Tuberculosis	
					Other	

CONSENT FORM FOR NUTRITIONAL EVALUATION

Please read the following carefully and sign/date at the bottom. If you have any questions please discuss those with the chiropractor who reviews the results of the evaluation.

This package consists of:

- 1) Instructions for Nutritional Assessment Forms
- 2) Nutritional History
- 3) Personalized Nutritional Analysis through Computer Evaluation

The information provided by you (person seeking nutritional advice) is not used to diagnose, treat, cure or prevent any disease. The sole purpose of this nutritional evaluation is to assess for possible nutritional deficiencies based on the submitted information. It is not to be used as a substitute for care by a licensed health care provider in your area/state.

The suggested nutritional supplementation and dietary changes are not intended to diagnose, treat, cure, or prevent any disease. Instead, these are utilized to support the best possible normal homeostasis, physiology, body function, health, and well-being. Every person has individual inherent physiological and biochemical processes and functions and therefore no specific results of the nutritional regimen with respect to time, effectiveness or otherwise can be guaranteed.

Please consult with your primary care physician or a pharmacist regarding potential interactions/contraindications between your current medications/over-the-counter medications and the suggested herbs or other supplements.

The dietary changes and nutritional supplementation suggested are, whenever possible, based on most recent scientific research, understanding and to the best of our knowledge.

My signature indicates I understand the information above. It is my own choice to follow the nutritional suggestions. I understand that outcomes vary and cannot be guaranteed. I am not holding my chiropractor or the A.R.E. responsible for any result or outcome pertaining to the above.

Name of treating chiropractor: _____

Full Patient Name (please print)

Signature

Date

INSTRUCTIONS FOR THE NUTRITIONAL ASSESSMENT FORMS

Please fill out the attached forms carefully and according to the instructions below. They will provide necessary and essential information to evaluate your nutritional status.

Please be thorough and do not leave any blanks:

a) **Nutritional History** Please Answer all questions carefully. Please write N/A if a question does not apply to you.

b) **Personal Diet Record**

For seven consecutive days, itemize and write down everything you eat and drink:

- Include all meals, snacks, beverages, and water
- State the kind of each food, i.e. which specific vegetable, fruit, meat, other sources of protein; if you consume milk, state, if it is 4%, 2%, 1%, or fat-free, apply the same for all other dairy products you consume.
- Carefully note the amounts, weight, and number of servings of each food or individual parts of a meal you consume.
- Describe whether you consume whole grain or white flour foods or products.
- Mention the kind of oils and fats you use for cooking, baking, salad dressings, etc. (f.i. butter, olive oil) as well as the amounts (f.i. 1 tablespoon or 1 teaspoon).
- Note the brand of ready made/prepared meals or snacks you consume.
- Put down a checkmark each time you have a bowel movement. Note the consistency of your bowel movement if it was unusual (loose or hard stool).
- Record diligently any reactions to food, such as: Bloating, gas, cramps, intestinal pains, headaches, dizziness, diminished concentration, irritability, etc.

c) **Personalized Nutritional Analysis Through Computer Evaluation**

Page 1: Please complete the personal information section. Write down all complaints you have. List all medications(s) you are presently taking as well as all nutritional supplements (vitamins, minerals, herbs, etc), even if you do not take them on a regular basis. Then put a check mark next to the conditions you have or have had as well as the year of occurrence. If you have a condition that is not on the list, please add that condition under “other”.

Page 2: Fill out the family history section.

Pages 2 to 4: Section “Information Survey”: put a check mark next to each statement that applies to you.

Please return all completed forms including the signed release form to the health care provider from whom you have received these forms.

Thank you!

Nutritional History

Name: _____ Today's Date: _____
Address: _____ Age: _____

Sex: _____

Phone: _____
Date of last medical checkup: _____ Height: _____
Reason for coming in: _____ Weight: _____

Usual Weight: _____

Personal Data

1. Last grade of school completed _____ Still in school? _____
2. Are you employed? _____ Occupation _____
3. Does someone else live on your home _____ Who? _____
4. Do you smoke in any way? _____ How much? _____
5. Have you recently lost or gained more than 10 lb? _____ If yes, please explain how _____
6. Are you pregnant? _____ How many months? _____
7. How many pregnancies have you carried to term? _____
8. Are your menstrual periods normal? _____ If not, please explain _____

9. Have you been told that you have (check any that apply):
Diabetes _____ High Blood Pressure _____ Hardening of the arteries _____
Lung Disease _____ Kidney Disease _____ Liver Disease _____ Ulcers _____
Cancer _____ Other _____
10. Do you eat at regular times each day? _____ How many times per day? _____
11. Do you usually eat snacks? _____ When? _____
12. Where do you usually eat your meal?
Morning _____ Noon _____ Night _____
With Whom?
Morning _____ Noon _____ Night _____
13. Would you say your appetite is good? _____ Fair? _____ Poor? _____
If poor, please explain: _____
14. What foods do you particularly dislike? _____
15. Are there foods you don't eat for other reasons? _____
16. Do you have any difficulty eating? _____
17. How would you describe your feelings about food? _____

18. Who prepares your meals? _____
19. Are you, or is any member of your family, on a special diet? _____
If yes, who and what kind? _____
20. Do you drink alcohol? _____ How many drinks per day? _____
Do you ever drink alcohol excessively? _____ How often? _____
21. Do you take any kind of medication, either prescribed by a doctor or over the counter, for any
Condition? _____
22. How would you describe your exercise habits?
Kind of exercise _____ How intense? _____
How long at a time? _____ How often? _____
23. Are there any other facts about your lifestyle that you think might be related to your nutritional
Health? _____ Please Explain: _____

Personalized Nutritional Analysis

Patient's name:				Today's Date:	
Age:	Sex:	Weight:	Height:	BP:	
Are you pregnant?		lactating?		# of times pregnant?	# of children?

List all vitamins/minerals being used:

(use brand name and number used per day)

	Potency/Amt	#/day	Brands
Vitamin A	_____	_____	_____
Vitamin B Complex	_____	_____	_____
Vitamin C	_____	_____	_____
Bioflavonoids	_____	_____	_____
Vitamin E	_____	_____	_____
Calcium	_____	_____	_____
Copper	_____	_____	_____
Chromium	_____	_____	_____
Iodine	_____	_____	_____
Iron	_____	_____	_____
Magnesium	_____	_____	_____
Manganese	_____	_____	_____
Phosphorus	_____	_____	_____
Potassium	_____	_____	_____
Silica	_____	_____	_____
Zinc	_____	_____	_____
Glandular Extracts	_____	_____	_____
Digestive Enzymes	_____	_____	_____
Algin	_____	_____	_____
Bone Meal	_____	_____	_____
Kelp	_____	_____	_____
Lecithin	_____	_____	_____
Pectin	_____	_____	_____
Protein Power	_____	_____	_____
Yeast	_____	_____	_____
Other	_____	_____	_____
Multiple Vitamins	_____	_____	_____

List any other supplements you are taking:

Family History

	Yourself	Mother	Father	Brothers/Sisters
DIABETES	1	10	19	28
ANEMIC	2	11	20	29
GLAUCOMA	3	12	21	30
HEART PROBLEMS	4	13	22	31
ALLERGY	5	14	23	32
KIDNEY TROUBLE	6	15	24	33
GOUT	7	16	25	34
CANCER	8	17	26	35
ARTHRITIS	9	18	27	36

Information Survey

In the space provided on the left side of each question, please enter a digit 1 indicating these symptoms, signs, or statements apply to you.

- | | |
|--------------------------|---|
| <input type="checkbox"/> | 1. Inability of the eyes to adjust to darkness (night blindness.) |
| <input type="checkbox"/> | 2. Eyeballs have lost luster; vision impaired; eyes dry and inflamed. |
| <input type="checkbox"/> | 3. Skin is rough and dry, especially the elbows, knees, and buttocks. |
| <input type="checkbox"/> | 4. Unable to distinguish yellow and blue. |
| <input type="checkbox"/> | 5. Eyelids "glued" together, especially in the morning. |
| <input type="checkbox"/> | 6. Loss of sense of smell. |
| <input type="checkbox"/> | 7. Loss of appetite. |
| <input type="checkbox"/> | 8. Skin blemishes including "liver spots" and skin rashes. |
| <input type="checkbox"/> | 9. Repeated attacks of upper respiratory infections. |
| <input type="checkbox"/> | 10. Dryness of the nose and throat. |
| <input type="checkbox"/> | 11. Dryness of scalp (flakiness or dandruff.) |
| <input type="checkbox"/> | 12. Brittle nails (finger or toes.) |
| <input type="checkbox"/> | 13. Ridges in nails (finger or toes.) |
| <input type="checkbox"/> | 14. Frequent spells of fatigue. |
| <input type="checkbox"/> | 15. Frequent spells of diarrhea. |
| <input type="checkbox"/> | 16. Loss of hearing. |
| <input type="checkbox"/> | 17. Known to have or had gall stones. |
| <input type="checkbox"/> | 18. Known to have or had kidney stones. |
| <input type="checkbox"/> | 19. Recurrent sties in the eye. |
| <input type="checkbox"/> | 20. Work in bright light area. |
| <input type="checkbox"/> | 21. Work in dim light area. |
| <input type="checkbox"/> | 22. Known to have or had ulcers (stomach, duodenal, colon.) |
| <input type="checkbox"/> | 23. Frequent allergies (any and all varieties.) |
| <input type="checkbox"/> | 24. Frequent canker sores. |
| <input type="checkbox"/> | 25. Subject to "stress" (under pressure.) |

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- | | |
|--------------------------|--|
| <input type="checkbox"/> | 26. Twitching of eye muscles. |
| <input type="checkbox"/> | 27. Swelling around the eyes. |
| <input type="checkbox"/> | 28. Frequent "blood shot" eyes. |
| <input type="checkbox"/> | 29. Fatigue easily. |
| <input type="checkbox"/> | 30. Loss of appetite. |
| <input type="checkbox"/> | 31. Easily upset and irritable. |
| <input type="checkbox"/> | 32. Loss of strength in the lower arms and lower legs. |
| <input type="checkbox"/> | 33. Tenderness of calf muscles. |
| <input type="checkbox"/> | 34. Confusion and loss of memory. |
| <input type="checkbox"/> | 35. Gastric distress (abdominal pains; indigestion.) |
| <input type="checkbox"/> | 36. Constipation. |
| <input type="checkbox"/> | 37. Irregularities of the heart beat. |
| <input type="checkbox"/> | 38. Delayed or slowed reflexes. |
| <input type="checkbox"/> | 39. Prickling sensation in lower extremities. |

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- | | |
|--------------------------|--|
| <input type="checkbox"/> | 40. Cracks and sores in the corner of the mouth. |
| <input type="checkbox"/> | 41. Red, sore tongue. |
| <input type="checkbox"/> | 42. Feeling of grit or sand in the eyes. |
| <input type="checkbox"/> | 43. Burning of the eyes. |
| <input type="checkbox"/> | 44. Sensitivity to light. |
| <input type="checkbox"/> | 45. Frequent sores on the lips. |

- 46. Women - itching of the vaginal area.
- 47. Men - Itching of the scrotum.
- 48. Swelling or feeling of swelling of the tongue.
- 49. Muscle cramps in lower legs and feet.
- 50. Scaling around the nose, mouth, forehead, and ears.
- 51. "whiteheads" especially on bridge of nose and under eyelids.
- 52. Spells of dizziness.
- 53. Oily skin and/oily hair.
- 54. Excessive watering of eyes.
- 55. lack of stamina and vigor.
- 56. Unexplained loss of weight.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 57. Ringing sounds in the ears.
- 58. Sore lips, mouth, and tongue.
- 59. Loss of hair (thinning.)
- 60. Numbness and cramps in the arms and/or legs.
- 61. Muscular weakness.
- 62. Nervousness, irritability, depression.
- 63. Painful joints of fingers and hands.
- 64. Increase in urination.
- 65. Known to have low blood sugar (low glucose tolerance.)
- 66. Convulsions (black-out spells.)
- 67. Fainting spells.
- 68. Use oral contraceptives (presently or in the past.)
- 69. Skin conditions known as eczema.
- 70. Skin condition known as juvenile acne.
- 71. Required frequent dental visits for tooth decay.
- 72. Known to have high cholesterol level.
- 73. Frequent attacks of diarrhea.
- 74. Burning sensation of the feet.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 75. Known to be anemic.
- 76. Known to have (or had) Pernicious Anemia.
- 77. Soreness or weakness in the arms and legs.
- 78. Arm and shoulder pain.
- 79. Shooting pains in any part of the body.
- 80. Loss of appetite or desire to eat.
- 81. General muscle weakness.
- 82. Inability to concentrate.
- 83. Painful facial muscles.
- 84. Hot and cold sensations.
- 85. Difficulty in walking (stumbling, shuffling, irregular gait.)
- 86. Jerking sensation of the limbs.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 87. Muscle pains.
- 88. Poor appetite.
- 89. Dry and/or peeling skin.
- 90. Lack of energy.
- 91. Sleeplessness.
- 92. Redness or inflammation of skin.
- 93. Mental depression.
- 94. Have used heavy sulfa drugs or antibiotics.

- 95. Bloatingness.
- 96. Constipation.
- 97. Flatulence (gas.)
- 98. Loss of desire for meat.
- 99. Hungry at start of the meal, but can eat very little.
- 100. Known to have blood in the urine (dark urine.)
- 101. Overweight.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 102. Early graying of hair.
- 103. Inflammation of the tongue.
- 104. Changes in bowel structure (alternating loose and hard stool(s).)
- 105. Easily fatigued.
- 106. Shortness of breath.
- 107. Spells of dizziness.
- 108. Use oral contraceptives (presently or in the past.)
- 109. Grayish-brown pigmentation of skin, especially on the face.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 110. Muscular weakness.
- 111. Generally fatigued.
- 112. Loss of appetite.
- 113. Frequent indigestion.
- 114. Red skin across nose, under eyes.
- 115. Bad breath.
- 116. Frequent canker sores.
- 117. Suffer from insomnia (cannot get to sleep; stay asleep.)
- 118. Irritable, easily upset.
- 119. Recurring headaches.
- 120. Under stress, strain tension.
- 121. Deep depressed feeling.
- 122. Loss of memory.
- 123. Dry, scaly patches where skin is exposed to sunlight.
- 124. Burning sensation of the tongue.
- 125. Tongue is dark red and mouth is sore.
- 126. Have desire for alcohol.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 127. Have had sulfa therapy.
- 128. Extreme fatigue.
- 129. Known to be anemic.
- 130. Irritable.
- 131. Depression.
- 132. Nervous.
- 133. Headaches.
- 134. Constipation.
- 135. Early graying of hair.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 136. Under stress, pressure, tension.
- 137. Physically feel weak.
- 138. Frequent colds or upper respiratory infections.
- 139. Physically and/or mentally overworked or overactive.
- 140. Loss of feeling in hands and feet.

- 141. Frequent gastric distress.
- 142. Abdominal cramps or pains.
- 143. Known to have low blood sugar.
- 144. Attacks of vomiting.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 145. Known to have anemia.
- 146. Bleeding gums.
- 147. Easy bruising.
- 148. Slow healing of cuts and wounds.
- 149. Small red spots just under the skin.
- 150. Susceptible to infections, including colds.
- 151. Shortness of breath.
- 152. Swollen painful joints.
- 153. Frequent nosebleeds.
- 154. Smoker (cigarette, pipe, cigar.)
- 155. Known to have had metal poisoning.
- 156. History of severe burns (including sunburns.)
- 157. Unusual heart beat (varies fast to slow.)

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 158. Muscular numbness, tingling, or spasms.
- 159. Tissues are flabby.
- 160. Dull pains in lower back and thighs.
- 161. Deep pains in the legs (bone aches.)
- 162. Vague aches and pains.
- 163. Feeling of soreness or tenderness in ribs or breast bone.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 164. Stomach or gastric ulcers.
- 165. Have now or had disc problems (slipped disc in spine.)
- 166. Changes in heart rate (fast to slow.)
- 167. Cardiac (heart) weakness.
- 168. Women - One or more miscarriages.
- 169. Use mineral oil for laxative purposes.
- 170. Have seen "fat" in your stool.
- 171. Gall bladder trouble.
- 172. Colon trouble (colitis.)
- 173. Impaired circulation (cold spots or patchy skin.)
- 174. Men - Known sterility (unable to reproduce.)
- 175. Women - Menstrual disorders or hot flashes.
- 176. Swollen veins (varicose veins.)
- 177. Chest pains and/or pain in the left arm.
- 178. History of blood clot.
- 179. History of phlebitis (inflamed veins.)

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 180. Brittle or lusterless hair.
- 181. Nails of fingers or toes break, peel, crack, brittle.
- 182. Have had allergies (any type.)
- 183. Underweight and cannot gain weight.
- 184. Have or had skin disorders (eczema, acne, or dry skin.)
- 185. Frequent attacks of diarrhea.
- 186. Dandruff.
- 187. Known to have kidney trouble.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 188. Known to have intestinal malabsorption problems.
- 189. Colitis (colon irritation or inflammation.)
- 190. Cuts bleed a long time.
- 191. Have had need of antibiotic therapy (large or frequent doses.)
- 192. Gall bladder problems or disease.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 193. Muscle cramps and numbness and tingling in arms and legs.
- 194. Frequent muscle cramps.
- 195. Vague pains in joints.
- 196. Heart palpitations (irregular beats.)
- 197. Slow pulse rate.
- 198. Insomnia.
- 199. Women - Menstrual cramps (past or present.)
- 200. Trembling fingers.
- 201. Dull backache.
- 202. Tooth decay.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 203. Feeling of coldness even in warm weather.
- 204. Known to have low blood pressure.
- 205. Tendency to gain weight.
- 206. Dull pain under the shoulder blades.
- 207. Sluggish metabolism.
- 208. Dry hair.
- 209. Decreased sexual interest.
- 210. Dull headaches.
- 211. Edema of the eyes, hands, and feet (swelling.)
- 212. Goiter (have or had in past.)
- 213. Alternating fast and slow pulse.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 214. Known to be anemic.
- 215. Dizzy spells.
- 216. Difficult breathing.
- 217. Cry easily without reason.
- 218. Finger nails appear flat and brittle.
- 219. Pain in the heels.
- 220. Pain in the finger tips.
- 221. Shoulder joints are painful.
- 222. Sleepy in daytime; sleepless at night.
- 223. Constipation.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 224. Feeling of apprehension.
- 225. Feel irritable.
- 226. Twitching muscles.
- 227. Tremors of the hands.
- 228. Irregular pulse.
- 229. Muscular weakness.
- 230. Foot and leg cramps.
- 231. Easily confused.
- 232. Feeling disoriented.
- 233. Feel depressed frequently.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 234. Failure of muscle coordination.
- 235. As a child, had partial paralysis of unknown cause.
- 236. As a child, had poor and/or failing eyesight.
- 237. As a child, had poor and/or failing hearing.
- 238. Attacks of dizziness.
- 239. Noises in the ears.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 240. Indigestion occurs 2 or 3 hours after meals.
- 241. Indigestion occurs 15 to 30 minutes after meals.
- 242. Long history of constipation.
- 243. History of constipation alternating with diarrhea.
- 244. Excessive lower bowel gas.
- 245. Excessive belching after meals.
- 246. Heavy, full feeling after heavy protein (meat) meal.
- 247. Stomach cramps after meals.
- 248. Belching "sour taste" after meals.
- 249. Frequent use of antacids (Tums, Rolaids, etc.)

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 250. Headache, shakiness, trembleness relieved by eating sweets.
- 251. Irritable if meal is skipped or before breakfast.
- 252. Strong craving for sweets.
- 253. Hungry shortly after eating.
- 254. Wake up during the night feeling hungry.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

- 255. Night sweats.
- 256. Increased thirst.
- 257. Chronic fatigue.
- 258. Lowered resistance.
- 259. Member of family has diabetes.
- 260. Sores take a long time healing.
- 261. Definitely overweight.
- 262. Weight loss without dieting.
- 263. Feel better after exercising.

Indicate which of the above you have noticed for the longest period of time:

Question number: _____ years: _____

Clinical nutritional information developed by:
Dr. Lawrence J. Hutti

Software program developed by:
Nelson Marquina, PhD

Project direction:
Dr. Peter Schoeb

Please list everything you eat and drink for the next 7 days.

Time	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						
Day 4						
Day 5						
Day 6						
Day 7						

Is there anything else you would like us to know about you?