



# A.R.E. HEALTH & REJUVENATION CENTER

## MASSAGE AND DAY SPA

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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. Individuals taking the CCSI are asked to rate the presence of the sign or symptom during the past twelve months. Some items are retrospective, requiring information preceding the previous twelve-month period.

## General Instructions For Rating Symptoms

Here are some general criteria for rating the severity of symptoms on the CCSI. 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)

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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:

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

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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.)

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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.)

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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?

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

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

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Please list your special interests and passion:

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**Women only:**

Age at onset of menstruation: \_\_\_\_\_ No. of miscarriages/c-sections:

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Number of children: \_\_\_\_\_ Age at onset of menopause: \_\_\_\_\_

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:

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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 by 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 three 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.

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

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

Question number:                      years:

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

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

Question number:                      years:

- |  |  |
|--|--|
|  | 40. Cracks and sores in the corner of the mouth. |
|  | 41. Red, sore tongue.                            |
|  | 42. Feeling of grit or sand in the eyes.         |
|  | 43. Burning of the eyes.                         |
|  | 44. Sensitivity to light.                        |
|  | 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 breadth.
- 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 were 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, Roloids, 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 3 days:

Time	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

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