Please check the following if they apply to you in the past six months:

__ Bloating __Hypertension __ Indigestion __ Heartburn

__ Gas __ Nausea __ Diarrhea __ Constipation

__ Stiffness __ Swelling __ Pain __ Belching

Ears: _____ Ringing _____ Itching _____ Crackling _____ Popping

Cravings for: _____ Sugar _____ Coffee _____ Cigarettes _____ Alcohol

_____ Major Addictions _____Specific foods – please list: _____

Sleep: _____ Trouble falling asleep/staying asleep – Explain: _____

Do you wake? _____ How Often?_____ Why? _____

Is your sleep refreshing? _____ Explain: _____

Do you exercise? _____ Yes _____ No – If not, why not? _____

What type of exercise do you do? _____

Do you cook? _____ Yes _____ No What % of food is home cooked? _____

Where does the rest come from? _____

Typical Diet ~ What did you eat yesterday?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Liquids: _____