KARA FITZGERALD, ND
Individualized EVIDENCE-BASED INTEGRATIVE MEDICINE
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Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____
month day year

Cell Phone: (_____) _____-_____

Place of Birth:_____
City or town & country if not US

Occupation: _____

Height: ___' ____ " Weight: _____ Sex: _____

Today's Date _____ Email_____

Would you like to receive our eNewsletter? Yes No

Referred by ☐ Physician/Clinician (name, contact)_____
☐ Book ☐ Website ☐ Media ☐ Friend or Family Member ☐ Other _____

Physician:
Name *Phone Number*
_____
Fax _____

Please list all food or drug allergies:_____

_____

Please list what kind of reaction you have to these allergies:_____

_____

What do you hope to achieve with your visit to Dr. Fitzgerald?_____

When was the last time you felt well?_____

What caused the change in your health?_____

What makes you feel worse?_____

What makes you feel better?_____

If you could erase three problems, what would they be?_____

_____

1. Please check appropriate box(es):

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European ☐ Other

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister
   _____

   _____

4. Do you have any pets or farm animals? Yes____ No____ Types_____
   If yes, where do they live? 1. _____ indoors 2. _____ outdoors 3. _____ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes____ No____
   If so, when and where? _____
   _____
   What city and state did you grow up in? _____rural or industrial?_____

6. Have you or your family recently experienced any major life changes? Yes____ No____
   If yes, please comment: _____
   _____

7. Have you experienced any major losses in life? Yes____ No____
   If so, please comment: _____
   _____

8. How important is religion (or spirituality) for you and your family's life?
   a. _____ not at all important
   b. _____ somewhat important
   c. _____ extremely important

9. How much time have you lost from work or school in the past year?
   a. _____ 0-2 days
   b. _____ 3 –14 days
   c. _____ > 15 days

10. Previous jobs: _____

    _____

11. Past Medical and Surgical History:

	ILLNESSES	WHEN	COMMENTS
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn's Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		

	ILLNESSES	WHEN	COMMENTS
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		
	INJURIES	**WHEN**	**COMMENTS**
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Other (describe)		

	OPERATIONS	WHEN	COMMENTS
au.	Appendectomy		
av.	Dental Surgery		

aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

12. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Children
Ages (if living)	_____	_____	_____	_____	_____
Health	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____
Check those applicable:					
Anemia	_	_	_	_	_
Arthritis	_	_	_	_	_
Asthma/Hayfever/Hives	_	_	_	_	_
Cancer	_	_	_	_	_
Type of Cancer_____					
Diabetes	_	_	_	_	_
Glaucoma	_	_	_	_	_
Gout	_	_	_	_	_
Heart Disease	_	_	_	_	_
High Blood Pressure	_	_	_	_	_
Kidney Disease	_	_	_	_	_
Mental Illness	_	_	_	_	_
Seizures/Epilepsy	_	_	_	_	_
Stroke	_	_	_	_	_
Thyroid problems	_	_	_	_	_

13. How often have you have taken antibiotics?

	< 5 times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

14. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

< 5 times **> 5 times**

Infancy/ Childhood		
Teen		
Adulthood		

15. What medications are you taking now? Include non-prescription drugs.

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

16. Are you allergic to any medications? Yes____ No____
    If yes, please list them and what kind of reaction you have to them:
    _____
    _____

17. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

18. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

19. As a child, were there any foods that you had to avoid because they gave you symptoms?
    Yes____ No____
    If yes, please: name the food and symptom (Example: milk – gas and diarrhea) _____
    _____
    _____

20. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	Usual Breakfast	**√**		**Usual Lunch**	**√**		**Usual Dinner**	**√**
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
	Usual Breakfast	**√**		**Usual Lunch**	**√**		**Usual Dinner**	**√**
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

21. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

22. Are you on a special diet? Yes____ No____

_____ ovo-lacto	_____ vegetarian	_____ other (describe):
_____ diabetic	_____ vegan	_____
_____ dairy restricted	_____ blood type diet	_____

23. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain: _____

24. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.? Yes____ No____

b. If yes, are these symptoms associated with any particular food or supplement(s)? Yes____ No____

c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

_____
_____

25. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

26. Do you feel much **worse** when you eat a lot of :

_____high fat foods	_____refined sugar (junk food)
_____high protein foods	_____fried foods
_____high carbohydrate foods (breads, pastas, potatoes)	_____1 or 2 alcoholic drinks
	_____other _____

27. Do you feel much **better** when you eat a lot of :

_____high fat foods	_____refined sugar (junk food)
_____high protein foods	_____fried foods
_____high carbohydrate foods (breads, pastas, potatoes)	_____1 or 2 alcoholic drinks
	_____other _____

28. Does skipping a meal greatly affect your symptoms? Yes____ No____

29. Have you ever had a food that you craved or really "binged" on over a period of time?
Food craving may be an indicator that you may be allergic to that food. Yes____ No____
If yes, what food(s)? _____
_____

30. Do you have an aversion to certain foods? Yes____ No____
If yes, what foods? _____

31. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			

Thin, long or narrow	
Small and hard	
Loose but not watery	
Alternating between hard and loose/watery	

32. Intestinal gas:
_____Daily _____Present with pain
_____Occasionally _____Foul smelling
_____Excessive _____Little odor

33. a. Have you ever used alcohol? Yes____ No____
b. If yes, how often do you now drink alcohol?
___ No longer drinking alcohol
___ Average 1-3 drinks per week
___ Average 4-6 drinks per week
___ Average 7-10 drinks per week
___ Average >10 drinks per week
c. Have you ever had a problem with alcohol? Yes____ No____
If yes, please indicate time period (month/year): from _____ to _____.

34. Have you ever used recreational drugs? Yes____ No____

35. Have you ever used tobacco? Yes____ No____
If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
If yes, what type of nicotine have you used? _____Cigarette _____ Smokeless
_____Cigar _____Pipe _____Patch/Gum

36. Are you exposed to second hand smoke regularly? Yes____ No____

37. Do you have mercury amalgam fillings? Yes____ No____

38. Do you have any artificial joints or implants? Yes____ No____

39. Do you feel worse at certain times of the year? Yes____ No____
If yes, when? _____spring _____fall
_____summer _____winter

40. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
If yes, which one(s)? _____lead _____cadmium
_____arsenic _____mercury
_____aluminum

41. Do odors affect you? Yes____ No____

42. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					

g.	With your boyfriend/girlfriend					
h.	With your children					
i.	With your parents					
j.	With your spouse					

43. Have you ever had psychotherapy or counseling? Yes____ No____
Currently? _____ Previously? _____ If previously, from _____ to _____.
What kind? _____
Comments: _____

44. Are you currently, or have you ever been, married? Yes____ No____
If so, when were you married? _____ Spouse's occupation _____
When were you separated? _____ Never _____
When were you divorced? _____ Never _____
When were you remarried? _____ Never _____ Spouse's occupation _____
Comments: _____

45. Hobbies and leisure activities: _____
_____

46. Do you exercise regularly? Yes__ No___ If yes, can you work up a good sweat? Yes____ No____
47. If no, how motivated are you to start?_____
If so, how many times a week?
1._____1x
2._____2x
3._____3x
4._____4x or more

When you exercise, how long is each session?
1._____ ≤15 min
2._____ 16-30 min
3._____ 31-45 min
4._____ > 45 min

What type of exercise is it?
_____jogging/walking
_____basketball
_____home aerobics
_____tennis
_____water sports
_____other _____

48. Any other family history we should know about? Yes____ No____
If so, please comment: _____

49. What is the attitude of those close to you about your illness?
_____Supportive
_____Non-supportive

FOR WOMEN ONLY (questions 50-58):

50. Have you ever been pregnant? (If no, skip to question 53.) Yes____ No____

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? Yes____ No____

Have you had other problems with pregnancy? Yes____ No____

If so, please comment: _____
_____

51. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram_____
Pap Smear: ___ Normal ___Abnormal
Mammogram: ___ Normal ___ Abnormal

52. Have you ever used birth control pills? Yes____ No____ If yes, when _____

53. Are you taking the pill now? Yes____ No____

54. Did taking the pill agree with you? Yes____ No____ Not applicable _____

55. Do you currently use contraception? Yes____ No____
If yes, what type of contraception do you use? _____

56. Are you in menopause? No _____ Yes _____ If yes, age at last period_____
Do you take: Estrogen?___ Ogen?___ Estrace?___ Premarin?___ Other (specify)_____
Progesterone?___ Provera? ___ Other (specify) _____

57. How long have you been on hormone replacement therapy (if applicable)? _____

58. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?
Yes____ No____ Not applicable _____

59. Please check if these symptoms occur presently **or** have occurred in the past 6 months.

GENERAL:	**Mild**	**Mod-erate**	**Severe**
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	**Mild**	**Mod-erate**	**Severe**
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			

Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			
MOOD/NERVES, Cont'd:	**Mild**	**Mod-erate**	**Severe**
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			

Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
DIGESTION:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			
DIGESTION, Cont'd:	**Mild**	**Mod-erate**	**Severe**
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			

All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
SKIN PROBLEMS:			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			

Eczema			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			

Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

SKIN, DRYNESS OF:	**Mild**	**Mod-erate**	**Severe**
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			

LYMPH NODES:			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
NAILS:			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			
Toenails			
White spots/lines			

RESPIRATORY:	Mild	Mod-erate	Severe
Bad breath			
Bad odor in nose			
Cough - dry			
Cough - productive			
Hay fever : Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

URINARY:	Mild	Mod-erate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
FEMALE REPRODUCTIVE:			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			

FEMALE REPRODUCTIVE, Cont'd:	Mild	Mod-erate	Severe
Premenstrual: Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Medical Symptom/Toxicity Questionnaire

NAME: _____ DATE: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching, or passing gas
___ Heartburn
___ Intestinal/Stomach pain
Total _____

EARS

___ Itchy ears Total
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss
Total _____

EMOTIONS

___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability, or aggressiveness
___ Depression
Total _____

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
Total _____

EYES

___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near-or far-sightedness)
Total _____

HEAD

___ Headaches

___ Faintness
___ Dizziness
___ Insomnia
Total _____

HEART
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
Total _____

JOINTS/MUSCLES
___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
Total _____

LUNGS
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing
Total _____

MIND
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities
Total _____

MOUTH/THROAT
___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores
Total _____

NOSE
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation
Total _____

SKIN
___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating
Total _____

WEIGHT
___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight

___ Compulsive eating
___ Water retention
___ Underweight
Total _____

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge
Total _____

GRAND TOTAL _____

Key to Questionnaire

Add individual scores and total each group. Add each group scores and give a grand total.
• Optimal is less than 10-- Mild Toxicity: 10-50 -- Moderate Toxicity: 50-100 -- Severe Toxicity: over 100

TIME LINE of MEDICAL COMPLAINTS and MAJOR LIFE EVENTS

In this space, go back as far as you can remember- or even earlier if you have that information- and document any medical issues or major life events that may have impacted your health-both favorably or negatively.

Prenatal period:

Birth:

Early childhood:

Middle childhood:

Teens:

Young adulthood:

Adulthood:

GOOD HEALTH

KARA FITZGERALD, ND
Individualized EVIDENCE-BASED INTEGRATIVE MEDICINE

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3 Day Diet Diary

Instructions for Completing the Diet Diary

It is important to keep an accurate record of your usual food and beverage intake as a part of this study. Please complete this 3 Day Diet Diary for three consecutive days with one day being a weekend day.

- Record information as soon as possible after the food has been consumed.
- Do not change your eating behavior at this time unless your doctor advises you to. The purpose of this food record is to analyze your present eating habits.
- Describe the food or beverage consumed. e.g., milk - what kind? (whole, 2%, or nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
- Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon sugar, potato with 2 teaspoons butter, etc.
- Please record all beverages, including water. List them in the "Beverage" category.
- Please record all bowel movements and their consistency (regular, loose, firm, etc.).

Diet Diary

Name _____ **Date** _____

Time	Food	Amount

Time	Beverage	Amount

Bowel Movements:

Time	Consistency