FILE # _____
DATE: _____

NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
HOME PHONE: _____
CELL PHONE: _____
EMPLOYER: _____
CO. ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

SEX: (circle one) MALE FEMALE
AGE: _____
DATE OF BIRTH: _____
SOCIAL SECURITY: _____
E-MAIL ADDRESS: _____
BUSINESS PHONE: _____
OCCUPATION: _____
STUDENT STATUS: (circle one) HS COLLEGE FT/PT
MARITAL STATUS: _____

HOW WERE YOU REFERRED TO THIS OFFICE?

FRIEND: _____
PHYSICIAN: _____
OTHER: _____

TV RADIO PHONE BOOK MAILER
ATTY: _____
NEWSPAPER: _____

HEALTH INSURANCE

INS. CO: _____
INSURED'S NAME: _____
RELATIONSHIP TO INSURED: _____
POLICY #: _____
GROUP #: _____

SPOUSE'S INSURANCE

INS. CO: _____
INSURED'S NAME: _____
POLICY #: _____
SPOUSE'S SS#: _____
D.O.B. _____

Is your injury due to an accident? _____

Are you eligible for Medicare? _____

Did it occur at work? _____
If yes have you reported it to your employer?
_____

AUTHORIZATION TO RELEASE INFORMATIONS:
I herby authorize this clinic to release any information acquired in the courses of my examination or treatment

AUTHORIZATION OF BENEFITS:
I herby assign and grant the benefits that I am eligible to receive for professional services rendered in this office to this office. I understand that I am financially responsible for these charges not paid by my insurance.

PATIENTS SIGNATURE: _____ (PARENT IF MINOR)

**** PLEASE PRESENT YOU INSURANCE CARD WHEN RETURNING THIS FORM**
**** PAYMENT IS EXPECTED IN FULL UPON FIRST VISIT**

Ratio Wellness & Chiropractic
FINANCIAL POLICY REGARDING FEES

PLEASE NOTE THAT REGARDLESS OF INSURANCE BENEFITS AVAILABLE TO YOU, ANY FEES THAT ARE DENIED WILL BE YOUR RESPONSIBILTY TO PAY.

PLEASE CHECK ONE AND SIGN BELOW

_____ **I will pay for services as they are rendered.**

Treatment may be paid by cash, personal check or credit card. An insurance receipt will be issued upon request when the balance is paid in full

_____ **Group Health/Medical Insurance. Please bill my group health insurance directly.**

Please present you insurance ID card to the front desk personnel. Specific information is required for us to bill your insurance directly. Please sign our Office Policy form.

ALSO: If it is determined that we cannot bill your insurance directly, you will be advised that payment is required at time of service.

_____ **Workmen's Compensation Claim. Please bill my employer directly.**

Please advise the front desk personnel that your services are work-related. Specific information is required in order for us to bill this type of claim. Please complete the Workmen's Compensation Information Sheets.

_____ **Automatic Accident Injury Claim. Please bill my auto insurance directly.**

Please advise the front des personnel that your services are related to an auto accident. Specific information is required in order for us to bell this type of claim. Please complete the Auto Accident Information sheets.

_____ **Medicare Patient**

Our office will file your claim with Medicare for you. Your 20% co-pay will be due at the end of each visit after your $150 deductible has been met.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services tendered to me will be immediately due and payable.

Patient Signature _____

PAST HISTORY:

MARK "**X**" IF YOU EVER HAD OR NOW HAVE THE FOLLOWING CONDITIONS.

CIRCLE ALL CURRENT PROBLEMS.

_____ ALLERGIES
_____ ANEMIA
_____ ARTHRITIS
_____COLITIS
_____ DIABETES
_____ HYPOGLYCEMIA
_____ EPILEPSY
_____ POLIO
_____ ULCERS
_____ INJURIES
_____ DIZZINESS
_____ FAINTING
_____ HEADACHES
_____ TREMORS
_____ WEAKNESS/ FATIGUE
_____ GALLBLADDER TROUBLE
_____ LIVER TROUBLE
_____ THYROID TROUBLE
_____ VENEREAL DISEASE
_____ PNEUMONIA
_____ NERVOUSNESS
_____ SKIN PROBLEMS
_____ SMOKING
_____ HOSPITALIZAION
_____ OTHER

_____ WEIGHT GAIN OR LOSS
_____ HEARING DIFFICULT
_____ EYE TROUBLE/ GLASSES
_____ PERSISTENT COUGH
_____ CHEST PAIN
_____ BREATHING DIFFICULTY
_____ HEART TROUBLE
_____ RAPID HEARTBEAT
_____ HYPERTENSION
_____ CHOLESTEROL
_____ ABDOMINAL PAIN
_____ SWOLLEN JOINTS
_____ POOR APPETITE
_____ CONSTIPATION/ DIARRHEA
_____ NAUSEA/ VOMITING
_____ DIFFICULTY URINATING
_____ PARALYSIS
_____ TUMOR OR LUMPS
_____ CANCER
_____ JOINT PAINS
_____RHEUMATIC FEVER
_____ BREAST SORENESS
_____ VAGINAL PROBLEMS
_____ OPERATIONS (**LIST THEM**)

Please describe your current problem

_____

_____

How long have you had this condition? _____

HAVE YOU EVER HAD CHIRPORACTIC CARE? _____ DOCTOR'S NAME_____

NAME OF YOUR MEDICAL PHYSICIAN: _____

DATE OF LAST PHYSICAL EXAM: _____

DATE OF LAST LABORATORY TESTS: _____ LIST THEM: _____

LIST MEDICATIONS: -

_____

_____

Please answer the following questions:

1) Why did you choose to come to this clinic?

_____

_____

_____

2) For you to feel your treatment successful, what do you want to take place over the course of your care here?

_____

_____

_____

3) How long do you feel this will take?

_____

_____

4) What are the areas of your lifestyle that you would like to improve: (Circle, than prioritize #1, 2, 3 etc.)

My level of anxiety	My pace of living
Not enough quiet time and rest	My diet and nutrition program
My exercise program	My energy level

5) What is you present level of commitment to address any underlying causes of your signs and symptoms that related to your lifestyle? (Rate from 1 to 10 being with 10 being 100% committed)

_____

_____

6) How confident are you that you will follow through on the healthy lifestyle changes (e.g. nutrition and exercise) that it will take to achieve your wellness goals? (Rate 1 to 10, where 1 is “not at all” and 10 is “100%” certainty”).

_____

_____

_____

Name

1. Please state your ***primary*** reason for attending this clinic. If it involves a specific health condition, please describe ***in detail***. In your own words, list the very first time that you noticed the condition and describe carefully any factors that you suspect may have played a role in its onset and perpetuation. (Please attach a sheet if more space is required). _____

2. Is your health currently getting better, worse, or staying the same? How do you know?

3. What are the most significant measures that you have taken to date to improve your state of health?

4. 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?

5. Are you currently working with a professional counselor, psychologist, social worker, pastor or therapist? (Y/N) Select One

6. Have you consulted a medical doctor regarding the aforementioned condition? Please explain his/her diagnosis, therapy and the result.

FAMILY HISTORY:

7. Please indicate whether there is any history of the following conditions in your immediate family (grandparents, parents, siblings) and give details below:

Heart Disease, Cancer, Diabetes, Osteoarthritis, Ankylosing Spondylitis, Rheumatoid Arthritis, Multiple Sclerosis, Muscular Dystrophy, Mental Illness, Autoimmune disorders, Asthma, Allergies, Psoriasis, Eczema, Alcoholism, Drug Abuse or any other conditions which may be pertinent to your present state of health (please attach sheet if additional space is required).

PERSONAL HISTORY:

8. Were you considered a "difficult child", with history of colic or GI distress?

9. Were you breastfed as child? If so, what was your mother's health at the time? When was the previous pregnancy? (Please look into it if possible).

_____

_____

10. Did you require any medical attention, hospitalization, or medication as an infant (before age 2)? Y/N ____. If yes, please explain in detail. _____

_____

_____

11. Briefly describe your childhood diet: (i.e. favorite foods, intake of fruits and vegetables, intake of fast or packaged foods, etc.)

_____

_____

12. Do any smells, aromas, or volatile chemicals adversely affect you?

_____

13. What is your level of physical activity? _____

14. What do you feel is your weakest organ system, and why? (i.e. heart, kidney, lungs, etc.)_____

_____

15. How many times each year do you have a cold, sinusitis, the flu, sore throat, or bronchitis? How long do they usually last, and are they severe?_____

_____

16. Have you ever fainted, blacked out or had a convulsion? (Y/N) _____. Please describe.

_____

_____

MEDICAL SYMPTOMS QUESTIONNAIRE

Patient Name _____ Date _____ Week _____

Rate each of the following symptoms based upon your typical health profile for:

☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale

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

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	Total 0
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 0
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	Total 0
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	Total 0
MOUTH/THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	Total 0
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	Total 0
HEART	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	
	_____	Chest pain	Total 0

OVER

LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	Total 0 _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	Total 0 _____
JOINTS/ MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	Total 0 _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Compulsive eating	
	_____	Water retention	
	_____	Underweight	Total 0 _____
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	Total 0 _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Poor concentration	
	_____	Poor physical coordination	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	Total 0 _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	Total 0 _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	Total 0 _____
GRAND TOTAL			**TOTAL** 0 _____

OVER

Functional Nutrition Assessment Questionnaire

Name _____ **Sex** Select **Age** _____ **Date** ____/____/____

Medications currently using

_____

Supplements currently taking

_____

Five Most Significant Health Problems

_____

_____

Circle any of the following item you consume:

- ☐ Alcohol
- ☐ Candy or other sweets
- ☐ Chewing tobacco
- ☐ Cigarettes
- ☐ Cigars
- ☐ Coffee
- ☐ Dairy products
- ☐ Deep fried foods
- ☐ Distilled water
- ☐ Fast food
- ☐ Fluoridated/chlorinated water
- ☐ Luncheon meats
- ☐ Margarine
- ☐ Non-herbal tea
- ☐ Refined (white) flour products
- ☐ Refined sugar
- ☐ Soft drinks

Instructions: Read the following symptoms and fill in the number that applies:

0 = Do not have the symptom, the symptom does not apply
1 = It is a minor symptom or it rarely occurs
2 = It is a moderate symptom or it occasionally occurs
3 = It is a significant symptom or it frequently occurs
4 = It is a severe symptom or you are aware of it almost constantly

Rate the severity or frequency of the symptom from 0 to 4. How significant is the symptom? How true is the statement—0 means not at all, 4 means extremely true. Where the question is answered by yes or no, circle Y or N.

1. _____ Fingernails chip, peel or break easily
2. _____ Belching or gas within 1 hr. of a meal
3. _____ Distaste for meat (not a vegetarian for moral other or other reasons)
4. _____ Fewer than one bowel movement per day
5. _____ Stools hard or difficult to pass
6. _____ Bloating after eating
7. _____ Only specific foods cause bloating
8. _____ Sleepy after eating
9. _____ Sensitive to smoke
10. _____ Feeling "wired" or jittery if drinking coffee
11. _____ Pain between the shoulder blades
12. _____ Bizarre, vivid or nightmarish dreams
13. _____ Metallic taste in the mouth
14. _____ Bitter taste in mouth, especially after meals
15. _____ Become sick after drinking wine (as opposed to other alcoholic beverages)
16. _____ Wake up without remembering dreams
17. _____ Bothered if eating food with monosodium glutamate (MSG)
18. _____ Become intoxicated easily if drinking alcohol
19. _____ Severe hangovers after drinking alcohol
20. _____ Trouble tolerating greasy foods
21. _____ Trouble tolerating aspartame (Nutrasweet)
22. _____ Frequent fevers
23. _____ Trouble tolerating garlic or onions
24. _____ Gallbladder attacks (past or present)
25. _____ Urine has a strong odor
26. _____ Dry flaky skin or dandruff
27. _____ Sensitive to chemicals (perfume, insecticides, exhaust fumes)
28. _____ Hemorrhoids or varicose veins
29. _____ Take over the counter pain medication
30. Select Aspirin is an effective pain reliever
31. _____ Sweat a lot
32. _____ Sweat at night
33. _____ Feet have a strong odor or sweat easily
34. _____ Lower bowel gas
35. _____ Alternating constipation/diarrhea
36. _____ Nausea
37. _____ Epigastric (top of stomach) burning or gastric reflux
38. _____ Patches of dry skin, eczema or psoriasis
39. _____ Hair breaks or falls out easily
40. _____ Anus itches
41. _____ Coated tongue

42. _____ Lactose intolerant

43. _____ Colitis, irritable bowel or Crohn's disease

44. _____ Crave sugar

45. _____ Eat a dessert with sugar, donut, soft drink, ice cream etc. (1 = 1x/week; 2 = 2-3x/week; 3 = daily or almost daily; 4 = more than 1x/day)

46. _____ Crave bread or noodles

47. _____ Eat refined white flour products (French, Italian or other white bread, bagels, pasta etc.) [1= 1x/week; 2 = 2-3x/week; 3 = daily or almost daily; 4 = more than 1x/day]

48. _____ Are there any foods that you feel that you would not want to give up? (Think of foods that you eat every day like bread, cheese etc.)

49. _____ Have you taken tetracyclines (Sumycin, Panmycin Vibramycin, Minocin) for acne? [1 = 1 mo.; 2 = 2 mo.; 3 = 3 mo.; 4 = 4 mo. or longer]

50. _____ Have you taken broad-spectrum antibiotics for urinary, respiratory or other infection? (1 = 1 course < 2 mo.; 2 = 1 course 2 mo. or longer; 3 = 2x in a single year; 4 = more than 2x in a single year)

51. _____ Hay fever or seasonal allergies

52. _____ Feel worse when in a moldy or musty place

53. _____ Sinusitis (nose stuffy, sinus headaches or sinus infections)

54. _____ Runny or drippy nose

55. _____ Catch colds at the beginning of winter

56. _____ Migraine headaches

57. _____ Binge eating or uncontrolled eating

58. _____ Asthma, wheezing or difficulty breathing

59. _____ Crave coffee or sugar in the afternoon

60. _____ Afternoon headaches

61. _____ Fatigue that is relieved by eating

62. _____ Shaky, headachy, or tired when meals are delayed

63. _____ Family history of diabetes (1 = distant relative; 2 = 1 or 2 direct relatives; 3 = 3 or 4 direct relatives; 4 = more than 4 direct relatives)

64. _____ Frequent thirst

65. _____ Cuts take a long time to heal

66. _____ Frequent urination

67. _____ Frequent infections

68. _____ Numbness or tingling in the extremities

69. _____ Fatigue

70. _____ Cry, become teary or sad for no reason

71. _____ Ankles swell

72. _____ Become cold easily or when others are not

73. _____ Depression

74. _____ If #73 is a symptom of yours, can you characterize your depression as feeling "low" with a strong desire to sleep, sleeping a lot and having trouble getting out of bed

75. _____ If #73 is a symptom, can you characterize your depression as feeling agitated, anxious or having difficulty falling and staying asleep

76. _____ Lack of motivation (function from day to day but lacking initiative)

77. _____ Brittle, coarse hair

78. _____ Difficulty losing weight

79. _____ Frequent colds or the flu

80. _____ Frequent diets (reducing food intake) (1=1 or 2; 2=3 or 4; 3 = 5 or 6; 4 = 7 or more)

81. _____ Crave salt or salty foods

82. _____ Crave greasy or fatty foods

83. _____ Pain on the inside (medial) knee or on one side of the low back

84. _____ Become dizzy when standing up suddenly

85. _____ Trouble getting out of bed in the morning

86. _____ Tend to be a "night" person

87. _____ Tendency to worry

88. _____ Tend to be calm on the outside, troubled inside

89. _____ Changed marital status (1=w/in 2 years; 2= w/in 1 year; 3= w/in 6 mos.; 4 = w/in 3 mos.)

90. _____ Death of a loved one. (1=w/in 2 years; 2= w/in 1 year; 3= w/in 6 mos.; 4 = w/in 3 mos.)

91. _____ Changed jobs, lost a job or started a new job. (1=w/in 2 years; 2= w/in 1 year; 3= w/in 6 mos.; 4 = w/in 3 mos.)

92. _____ How many hours do your work each week? (1= 45 or less; 2= 45-50; 3= 50-55; 4=more than 55)

93. _____ Keyed up, trouble calming down.

94. _____ Fall asleep only to wake up after a few hours and have trouble falling back to sleep

95. _____ Difficulty falling asleep

96. _____ Feelings of insecurity

97. _____ Heart races or palpitates

98. _____ Clench or grind teeth

99. _____ Jaw clicks, pops, locks or makes noise

100. _____ Tension headaches (base of skull)

101. _____ Headaches when hot or out in the sun

102. _____ Get up at night to urinate

103. _____ Decreased ability to taste or smell

104. _____ Get hives

105. _____ Acne

106. _____ Undigested food in stool

107. _____ Taken birth control pills (1= 6 mos. or less ; 2= 1 yr. or less; 3= 1-2 yrs.; 4= more than 2 yrs.)

108. _____ Feel spacey or unreal

109. _____ Rehabilitated or done construction in a house built before 1970 (1= yes, but didn't live there during work; 2= lived there when the work was done; 3= rehabbed more than 1; 4= lived in more than 1 house that's been rehabbed)

Functional Nutrition Assessment Questionnaire

110. _____ Fungus or yeast infections

111. _____ Exposure to diesel fumes

112. _____ Do you smoke , how many pack-years (number of years times the number of packs per day)? [1=2 or less; 2=3-5; 3=7-10 and 4= more than 10 pack-years]

113. _____ Did you quit smoking (1= more than 10 yrs ago; 2= 5-10 yrs.; 3=1-5 yrs.; 4= less than 1yr)

114. _____ How many alcoholic beverages each week? (1= 1-7; 2= 8-14; 3= 14-21; 4= more than 21 alcoholic beverages per week)

115. Select Are you a recovering alcoholic?

116. Select History of anorexia or bulimia

117. _____ How many mercury (silver) fillings (1= 1-2; 2= 3-5; 3= 6-7; 4= more than 7 fillings)

118. _____ Have you taken shark cartilage? (mark 1 point for every 3 months on the supplement)

119. Select Diagnosed with chronic fatigue syndrome or fibromyalgia

120. _____ Pain or swelling in the joints

121. _____ Muscles become easily fatigued

122. _____ Anemia that is unresponsive to iron

123. _____ Greasy or shiny stools

124. _____ Clay-colored stools

125. _____ Stomach upset by taking vitamins

126. _____ Hands tremble

127. _____ Calves cramp at night

128. _____ Legs cramp after walking, better after rest

129. _____ Undigested fat in stool

130. _____ (Women) Anxiety, irritability, emotional instability related to menstrual cycle

131. _____ (Women) Depression during period

132. _____ (Women) Weight gain greater than 3 pounds and/or abdominal bloating associated with cycle

133. _____ (Women) Breast tenderness, soreness or swelling associated with cycle

134. _____ (Women) Excess menstrual flow

135. _____ (Women) Sugar, chocolate, or carbohydrate craving associated with cycle

136. _____ Dark circles under the eyes

137. _____ Sense of fullness after meals

138. _____ Do not feel like eating breakfast

139. _____ Feel better if you don't eat

140. _____ Black or tarry stools

141. _____ Pain under right side of ribcage

142. _____ Itchy skin (maybe worse at night)

143. _____ Cold sores, fever blisters or Herpes lesions

144. _____ Sunburn easily or get "sun poisoning"

145. _____ Cough that produces mucus

146. _____ Bruise easily

147. _____ Frequent infections (ear, bladder, lung etc.)

148. _____ Eyes sensitive to bright light

149. _____ Exercise makes you feel worse

150. _____ Blush or face turns red for no reason

151. _____ Pain in chest, left arm or left side of neck

152. _____ Sigh frequently, air hunger or trouble catching breath

153. _____ Fluid retention

154. _____ (Men) Dribble after voiding urine

155. _____ (Men) Frequent urination or urgency to urinate

156. _____ (Men) Interruption of the stream during urination

157. _____ Pain or burning when urinating

158. _____ Bloody, cloudy and/or darkened urine

159. _____ Decreased libido

160. _____ Decreased scalp hair (not pattern baldness)

161. _____ Increased body hair

162. Select Under 4' 10" tall

163. Select Over 6' 6" tall

164. Select Early sexual development

165. _____ Brittle hair that breaks easily

166. _____ Exercise (1= daily; 2= 4x/week or more; 3= 1-3x/week; 4= 1x/week or less)

167. Select (Women) Irregular (non-cancerous) cells found on a PAP smear

168. Select Have you ever had polyps?

169. Select Use of antidepressant medication?

170. Select Have the drugs (in #169) helped?

171. _____ Anxiety

172. Select Use of anti-anxiety medication

173. Select Has anti-anxiety medication helped?

174. _____ Tightness across the shoulder

175. _____ Stiff in the morning

176. _____ Joints are stiff and swollen

177. _____ Bursitis or tendonitis

178. Select Have you ever had a herniated disc

179. _____ Flexible joints or "double jointed"

180. _____ Joints click or pop

181. Select History of stress fractures

182. _____ Bone loss (reduced density on bone scan, loss of height, etc.)

183. Select Are you shorter than you used to be?

184. Select History of kidney stones (or family tendency for kidney stones)

185. Select Yellow in the whites of the eyes

186. _____ (Women) Occasionally skip periods

187. _____ (Women) Excess facial hair

188. _____ (Women) Painful to have sexual intercourse

189. _____ (Women) Bleeding between periods
190. _____ (Women over 35) Irregular menstrual cycle
191. _____ (Women over 35) Hot flashes
192. _____ (Women over 35) Decrease in libido as getting older
193. _____ (Women) Vaginal discharge
194. _____ (Women) Poor concentration associated with certain times of menstrual cycle
195. _____ (Women) Vaginal itching or dryness
196. Select (Women) Are you taking hormone replacement
197. Select Women) Have you had a partial hysterectomy
198. Select (Women) Have you had a total hysterectomy
199. _____ (Women) Cysts in breasts
200. _____ (Women) Ovarian cysts
201. _____ (Women) Scanty blood flow during period
202. Select Take synthroid or other thyroid hormone
203. Select Are you a vegan (no dairy, meat, or fish)
204. _____ Nutrasweet (aspartame) consumption (1= 1x/wk or less; 2= 2-3x/week; 3= 4-7x/week; 4= more than 1x daily)
205. _____ Sweat has strong odor
206. Select Do you have tinnitus (ringing in your ears)
207. _____ Do you consume margarine? (1= 1x/wk or less; 2= 2-3x/week; 3= 4-7x/week; 4= more than 1x daily)
208. _____ Small bumps on the back of the arm
209. _____ Trouble seeing at night
210. Select Lateral 1/3 of eyebrows doesn't grow hair
211. _____ Eyes itch during hay fever season
212. _____ Rapid heart beat
213. _____ Anxious, nervous or jittery
214. _____ Bad breath

*****

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