

To Your Health!

NUTRITION AND HERBALS

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Client Information

Name _____ Date _____

Telephone (H) _____ (W) _____ (C) _____

Email address _____

Mailing address _____

Gender _____ Age _____ DOB _____ Ethnicity _____

Height _____ Weight _____ Frame size Sml Med Lrg

Occupation _____ Marital status _____

Reason for your visit _____

Hours in regular work week _____

Activity level and work conditions (check all that apply):

- Sitting Mixture sitting/walking Computer Lifting/carrying
 Driving Fluorescent lights Construction Outside
 Other _____

When is your usual bedtime? _____ Rising time? _____

Do you use an alarm to wake up? _____ How well do you sleep? _____

List regular physical activities _____

How often performed and duration _____

List hobbies/other recreation _____

How often performed _____

On a scale of 1 to 10 (10 being the highest), how stressed are you? _____

List your stressors _____

General Medical:

How would you describe your health in general? _____

What is your chief complaint? _____

Symptoms _____

What initiates/aggravates them (environment, diet) _____

Severity: Mild Moderate Severe Interferes with my life

Do you:

Smoke tobacco? _____ How much? _____

Drink alcohol? _____ How often? _____

Use recreational drugs? _____ What kind and how often? _____

Health History: (Please note condition for yourself and/or family members and describe)

Condition	Self	Mother	Father	Grand Parent	Condition	Self	Mother	Father	Grand Parent
Heart or blood vessels					Abdominal or intestinal				
Bones or skeletal					Emotional				
Kidneys or bladder					Weight loss or gain				
Genital or reproductive					Allergies				
Lungs or chest					Cancer				
Head, sinus, ears					Diabetes				
Bowel changes, blood in stool					Chronic colds or infections				
Brain or neurological					Arthritis				
Eyes					Hepatitis				
Skin					HIV/AIDS				
Autoimmune					Alcoholism				
Drug abuse					Thyroid/Adrenal				

Dental work done within the past 2 years _____

Do you have amalgam (silver) fillings? _____ How many? _____

When was the last time you were on a course of antibiotics? _____

What were they prescribed for? _____

Symptom Questionnaire: (Scoring: 0 = least/never 1 = light/rarely 2 = moderate/occasionally 3 = severe/always)

Colon Health	0	1	2	3
<i>Feeling that bowels do not empty completely</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Lower abdominal pain relief by passing gas or stool</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Alternating constipation and diarrhea</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Diarrhea</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Constipation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Hard dry or small stool</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Large amounts of foul smelling gas</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Laxative use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Frequent/recurrent infections or colds</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Yeast infections or fungal infections</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>History of antibiotic use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Meat eater (meat is large part of meals, meat 3x per day)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Recurrent stomach pain</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total				

Hypoacidity in Stomach	0	1	2	3
<i>Excessive belching, burping, or bloating</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Gas immediately following a meal</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Offensive breath</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Sense of over-fullness after meals</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Difficulty digesting fruits and vegetables (undigested food in stool)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Poor appetite</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Stomach upsets easily</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>History of constipation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Known food allergies</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total				

Hyperacidity of the Stomach	0	1	2	3
<i>Stomach pain, burning, or aching 1-4 hours after meal</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Stomach pain before meals</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Antacid use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Feeling hungry an hour or two after eating</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Heartburn when lying down or bending forward</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Temporary relief from antacids, food, milk, carbonated beverages</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Digestive problems subside with rest and relaxation; increase with stress</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, caffeine</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Burping or bloating</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Sudden acute indigestion</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Aspirin or NSAID(ibuprophen, Tylenol, etc) use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Family history of ulcer or gastritis</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Current ulcer</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total				

Blood Sugar Balance	0	1	2	3
<i>Crave sweets during the day</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Heart palpitates if meals are missed</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Irritable if meals are missed</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Depend on coffee or sodas to keep yourself going in the afternoon or get started in morning</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Get lightheaded, dizzy, and/or shaky if meals are missed</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Eating relieves fatigue</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Feel shaky, jittery, tremors</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Agitated, easily upset, nervous, anxious</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Poor memory, forgetful</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Blurred vision</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Wake at night, hard to get back to sleep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Often have to eat in the middle of the night</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Frequent unrealistic fears or worries</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Fatigue after meals</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Eating sweets does not relieve cravings for sugar</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Must have sweets after meals</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Waist girth is equal or larger than hip girth</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Frequent urination</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Increased thirst and appetite, always hungry</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Difficulty losing weight</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Excessively weak for no apparent reason</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Moody or depressed</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Get sleepy or drowsy after lunch</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total				

Adrenal Function	0	1	2	3
<i>Cannot stay asleep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Crave salt</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Slow starter in the morning</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Afternoon fatigue</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Dizziness when standing up quickly</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Afternoon headaches</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Headaches with exertion or stress</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Weak and/or ridged nails</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Low blood pressure</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Weakness after colds or slow recovery</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Poor circulation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Susceptible to colds, asthma, or bronchitis</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Difficulty holding chiropractic adjustments</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Cannot fall asleep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Perspire easily</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Under high amounts of stress</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Weight gain when under stress</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Wake up tired even after six or more hours of sleep</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Excessive perspiration or perspiration with little or no activity</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Increased blood pressure</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Headaches</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Hot flashes</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total				

Thyroid Function	0	1	2	3
<i>Tired, sluggish, reduced initiative</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Feel cold – hands, feet, all over</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Require excessive amounts of sleep to function properly</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Increase in weight gain even with low-calorie diet</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Difficulty losing weight</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Difficult, infrequent bowel movements, constipation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Depression, lack of motivation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Morning headaches that wear off as day progresses</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Outer third of eyebrow thins</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Thinning of hair on scalp, face or genitals, or excessive falling hair</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Dryness of skin and/or scalp</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Mental sluggishness</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i> ringing in ears or noises in head</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Hearing impaired</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Heart palpitations</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Inward trembling</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Increased pulse even at rest</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Nervous and emotional</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Insomnia</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Night sweats</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Difficulty gaining weight</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Fast pulse at rest</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Intolerant of high temperatures</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Easily flushed</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total				

List any medications or supplements that you take:

Medications/Supplements	Dosage	How often	Comments

Nutrition and Eating habits:

On average, how many times a week do you:

Cook full meals at home? _____

Eat alone? _____

Shop for food? _____

Eat and work simultaneously? _____

Eat at a restaurant? _____

Eat breakfast? _____

Eat in the car? _____

Eat meat? _____

How often do you have a bowel movement? _____

Any problems with your bowel movements? _____

Do you drink coffee? _____

How much per day? _____

Do you drink sodas? _____

How many per day? _____

How much water do you drink per day? _____

List ten of your favorite foods _____

List foods that you absolutely will not eat _____

Describe an average breakfast (Please be as realistic as possible) _____

Describe an average lunch _____

Describe an average dinner _____

Do you eat snacks? _____ What time(s) of the day? _____

Describe an average snack _____

Eating Patterns: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Emotional eater | <input type="checkbox"/> Eat out of necessity |
| <input type="checkbox"/> Forget to eat | <input type="checkbox"/> Don't know when to stop |
| <input type="checkbox"/> Hungry all of the time | <input type="checkbox"/> Love well prepared food |
| <input type="checkbox"/> Eat out of boredom | <input type="checkbox"/> Healthy eating habits |
| <input type="checkbox"/> No joy in eating | |

I eat: too much just enough not enough

Do you have any food allergies? What are they? _____

How do they affect you? _____

Do you have seasonal allergies? _____ Describe them _____

What popular diets have you tried and what reactions did you have to them?

Where do you usually shop for food? _____

What is your weekly budget for food? _____ How many members in your family? _____

Heath Goals:

What are your health care goals? _____

What is your most important health goal? _____

On a scale of 1 to 10 (10 being the most important) how important is that health goal to your lifestyle? _____

On a scale of 1 to 10 how willing are you to change diet/eating habits? _____

What is your time frame for achieving these goals? _____

How do you see me helping you to achieve these goals? _____

What type of support system do you have to change your diet/nutrition/habits? _____

What are impediments to a change in your diet/nutrition/habits? _____

Body Typing

There are several body typing techniques that have been developed. I have found that by combining blood typing, enzyme/endocrine typing, and metabolic typing I get a good overall picture of how your body processes food and what types of foods work best for your constitution.

What is your blood type? _____ (Don't worry if you don't know it)

Section 1: Enzyme/Endocrine Typing

1. Which of the following best describes your body, especially when weight is gained?
 - a. Gain weight evenly (may then stay in stomach area)
 - b. Carry weight in hips and thighs, upper body stays thinner
 - c. Carry weight in upper body, especially the stomach, legs stay thin with weight gain
 - d. Remained similar since teens (slim & trim, heavy)
2. In which category is your favorite food?
 - a. Carbohydrates (Vegetables/breads/pies/sweets)
 - b. Rich foods, fatty foods, spicy foods
 - c. Proteins (meat)
 - d. Dairy
3. Which foods give you problems? Do not circle if no foods bother you.
 - a. Carbohydrates (Vegetables/breads/pies/sweets)
 - b. Rich foods, fatty foods, spicy foods
 - c. Proteins (meat)
 - d. Dairy
4. Please circle any issues you have had from all four sections. (Present or past)
 - a. Allergies / cold hands and feet / depression / fatigue / headaches / hemorrhoids / low blood pressure / neck and shoulder aches / PMS / pancreatitis / skin eruptions / wheat intolerance (sprue) / upset stomach / ulcer
 - b. Aching feet / arthritis / bladder infection / breast lumps / breast tumors / bypass surgery / cataracts / cirrhosis / cystitis / eczema / gallbladder problems / gallstones / hay fever / hepatitis / hives / jaundice / prostate problems / psoriasis / urinary problems
 - c. Alcohol addiction / arteriosclerosis / back problems / Candidiasis / constipation / ear infections / heart disease / herniated disc / high blood pressure / insomnia / kidney disease / lower back ache / loss of hearing / osteoporosis or osteopenia / sciatica
 - d. Aching knees / chronic allergies / colds / colitis / Crohn's disease / diarrhea to constipation / diverticulosis / irritable bowel/ milk intolerance

Section 2: Oxidative Typing

- Circle the FALSE or TRUE answer that best describes you.
- If neither choice fits you exactly, try to choose the one that comes closest to your tendencies
- Try to answer the questions from your direct experience rather than from any preconceived ideas that you may have about the issue at hand: for example, you may believe that you should be eating low-fat foods but, in practice, fat-rich foods may actually agree with you; or you may think you are hungry between meals when, in fact, you may be eating out of habit or boredom – not because you are physically hungry.
- When responding to a statement phrased in the negative (e.g., “Vegetarian meals are not satisfactory to me”) a TRUE answer would mean that you agree with the statement.

1. My appetite at breakfast is strong	FALSE	TRUE
2. My appetite at lunch is strong	FALSE	TRUE
3. My appetite at dinner is strong	FALSE	TRUE
4. Going without food for four or more hours is uncomfortable	FALSE	TRUE
5. I often get hungry and need to snack between meals	FALSE	TRUE
6. I live to eat, rather than eat to live	FALSE	TRUE
7. My cravings lean more toward meat and fat than carbohydrates (Don't think about sugar...more like fruits/vegetables/grain products)	FALSE	TRUE
8. Vegetarian meals are not satisfactory to me	FALSE	TRUE
9. Eating meat or fatty food restores my energy	FALSE	TRUE
10. I prefer salty and/or fatty foods to sweet foods	FALSE	TRUE
11. Fruits alone generally do not satisfy me	FALSE	TRUE
12. Fasting is very difficult for me	FALSE	TRUE
13. Eating before bedtime improves the quality of my sleep	FALSE	TRUE
14. Orange juice in the morning does not agree with me	FALSE	TRUE
15. Coffee tends to make me feel wired or jittery	FALSE	TRUE
16. My eyes and/or nose tend to be moist	FALSE	TRUE
17. I need to urinate often during the day	FALSE	TRUE
18. I tend to cough or clear my throat fairly frequently	FALSE	TRUE
19. I prefer to sleep in, in the morning	FALSE	TRUE
20. If I cut myself, the wound heals quickly	FALSE	TRUE

Please circle the best descriptor in each group for your makeup even if neither describes you perfectly:

Tall & lean

Short & stocky

Pale ears

Red ears

Large pupils

Small to medium pupils

Sleeps poorly

Sleeps well

Poor digestion

Good digestion

Constipation

Diarrhea

High body temp

Low body temp

Long breath hold (over 50 seconds)

Short breath hold (under 50 seconds)

Migraines

Asthma

Goal oriented

Procrastinates/*laissez faire*

Solitary

Social

Hyper

Calm