

Krispin Sullivan, MS CN
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Dear Prospective Client,:

Should you decide to proceed I look forward to working with you. Read the enclosed Information for New Clients carefully before making your decision to work with me. After reading please call if you have questions. All appointments are by phone with follow-up by phone, mail, email and fax when appropriate. If you are uncomfortable with this please call and discuss it with me. Charges and payments are explained on the Information for New Clients sheet. There is no difference in the quality of consultation whether long distance or local.

The most important component allowing me to provide you with the information, education, and support you need is your full and detailed reporting of lifestyle, symptoms, conditions and past treatment outcomes, including a complete medical/health history, current food diary, and current medications and supplements lists. Following up, asking questions, and providing detailed updates of outcomes is key to your success in discovering and utilizing what works for you. Understand that your initial program is unlikely to be your final maintenance program. Be ready to commit to working until you get the answers you need.

RETURN BY MAIL/EMAIL:

1. The enclosed Client Profile form, both sides and four page questionnaire.
2. A list of all supplements and medications, include copies of labels. List how many you take. Form is enclosed.
3. A complete health history. Include all of your current concerns, questions, etc. Ask questions. Detail complaints. The more information you provide the better I can serve you. Even if others have told you 'it doesn't mean anything' or 'it's not important' I want to know.
4. A diet diary with 4 typical days of food and drink intake. Include water consumption as well as foods and other liquids, approximate amounts and include the time of consumption. This will allow us to design a program that is comfortable for you. If you have different patterns of food intake, such as weekdays and weekends or home and traveling, give several days of each.
5. The three forms, Under-Methylation; Over-Methylation and Pyroluria. For most scores will be within normal range but for some these forms will uncover hidden causes of ill health.

Required tests:

- | | |
|--------------------|--|
| 1. A1C | 6. Vitamin D 25(OH)D |
| 2. Fasting glucose | 7. Optional - 23andme.com gene testing |
| 3. Fasting Insulin | 8. Optional – ubiome microbiome testing, email to learn how to order tests 7, 8 and 9. |
| 4. Ferritin | 9. Optional - histamine |
| 5. Homocysteine | |

Please have your physician order the tests and send/fax to me or order your own at <http://lef.org> Their phone order number is 1-800-544-4440 (not available to residents of New York State) You may request the requisition and results be emailed to you to save time.

Optional tests: SEND or have your physician fax recent blood work or bone scans (within the last 90 days): Chem 27, CBC and platelets. Any tests relating to your concerns/goals should be included. **Blood tests, other than those listed are not required unless you currently have a diagnosed medical condition.**

REGARDING INSURANCE PLEASE READ: I am not a physician. Insurance rarely reimburses for nutritional programs. Do not expect it. I do not bill insurance companies. Services are to be paid when invoiced. You will need to work out any reimbursement with your physician and insurance company.

After sending your information if you do not hear from me within 10 days please call. Your file may have been misplaced (researchers' buried desk syndrome) or may have gotten lost in the mail or cyberspace.

Sincerely,

Krispin Sullivan, MS CN

Information for New Clients

Please read carefully. It explains what to expect and what you need to send.

WHAT TO EXPECT-- During your first phone appointment we will review your forms, medical information, personal history and special goals. You will be sent a food and supplement plan that will be explained to you during a follow-up phone consult. You will receive a written program, a Practical Nutrition Workbook, and other written information. I am a nutrition educator. You are making an investment in your future. Ask questions. If you do, you will find long-term answers. This information will enable you to take the best possible care of your health.

WHAT TO SEND -- your forms; a four day food diary; a list of your questions; medical information including blood tests if available; a complete **list of supplements** with dose information, those you use *and those you do not use*; a complete **list of medications** with dose information; any other information you think may be important.

WHAT ABOUT CHARGES? -- Phone/Mail/E-mail Consultations and follow-up support are billed at \$90 per hour for actual time used. All consultation and program support billing will include charges for the time it takes to research and write your program in addition to online or phone time. Clients will be invoiced following the consult. **Invoices are due when received. There is no grace period. Please keep your account current.** Phone follow-up time is recorded and an invoice/statement sent at the end of each month due on receipt.

WHAT ABOUT TOTAL COSTS? -- Your first consultation will take about one or two hours, on the phone plus program prep and send. You will be charged for 'actual time', your interview plus program preparation. Program support is provided as needed.

Chronic conditions will need more extended support time and will increase the total cost. Suggested supplements or special foods will add to your costs. Supplement costs average \$25-\$75 a month but may be higher if acute or chronic illness is present.

I DON'T SELL VITAMIN OR MINERAL SUPPLEMENTS.

TESTING--I use minimal testing as needed determined by your initial interview and questionnaire. Fees are paid to the labs. Tests worth the cost if deemed necessary may include:

Blood tests required of all clients: Recent (less than 6 months old) or request from your physician or order your own from <http://lef.org>. **Vitamin D 25-hydroxyvitamin-D; Ferritin; Fasting Insulin; Fasting Glucose; HgA1c; Homocysteine.**

Optional but always good to keep in your file- A **standard blood panel** with a **Chemistry 25/27, CBC, Platelet Count and Differential**- This test is similar to your yearly blood test. Cost: Varies with lab, paid by your insurance or by you to the lab. If you have believe you have an issue with thyroid add Free T3; Free T4; TSH and Reverse T3. You may opt for 23andme gene testing, especially if your condition is long standing. Get your raw data to me for analysis. <http://refer.23andme.com/v2/share/6037539286874301729>

Needed if basic program does not fully address any gut issues: Genova's Diagnostics Comprehensive Digestive Stool Analysis.

Stool and salivary samples give information on the condition of digestion and the intestinal tract that can not be determined by other testing methods. This test is suggested for clients with chronic digestive disturbances. The cost is approximately \$300-\$400 paid directly to the lab.

Rarely used or needed: Salivary Hormone Testing- Various panels such as Male; Female; Postmenopausal; Adrenal Stress Index; DHEA; IGF-1 and/or Melatonin. Depending on panel/s \$45-\$250.

On a separate sheet write all the "Questions I would like to ask about nutrition":

Krispin Sullivan CN
Voice 1.775-831-0292
Fax 1.775-996-0204

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Incline Village, NV 89451
www.krispin.com krispin@krispin.com

DATE: / /

CLIENT PROFILE

PLEASE FILL OUT COMPLETELY, BOTH SIDES AND
SIGN STATEMENT AT BOTTOM OF OTHER SIDE

NAME		MARITAL STATUS (CIRCLE ONE) S / M / D / W	
ADDRESS			
CITY		STATE	ZIP
HOME PHONE:		EMAIL	
FAX / CELL PHONE (circle one):		BIRTHDATE:	AGE:
OCCUPATION:		CHILDREN #	AGES:

CHILDHOOD DISEASES/INJURIES/SURGURIES:

Were you abused or neglected?

CHILDHOOD MEDICATIONS:

ADULT DISEASES / ACCIDENTS / SURGERIES: (Women include detailed reproductive history including any pregnancy, miscarriage, abortion or menstrual cycle issues. Men include any sexual, urinary and prostate

ALLERGIES (include age of first occurrence):

ADULT MEDICATIONS PAST with doses and dates (all current medications should be listed on the sheet provided):

CURRENT HEIGHT AND WEIGHT:

HGT:

WGT:

IDEAL WEIGHT:

WEIGHT HISTORY (if applicable) If long and detailed continue explanation under Major Concerns:

FAVORITE FOODS / CRAVINGS (to give me an idea of foods you like and re cravings to show what your body seeks out. Put all cravings, even for 'bad' things):

CURRENT MAJOR CONCERNS- These are your goals, the things you want to change. Use extra sheets if needed:

SUBSTANCE ABUSE-FOOD / DRUG / ALCOHOL HISTORY (if applicable):

FAMILIAL MEDICAL DISEASES (blood relatives only, parents, grandparents, aunts, uncles, and the like):

I understand that I am the primary person responsible for my health care. In all cases I must make the final decision about what is right for me. It is possible that Ms. Sullivan may deem it necessary for me to see a physician, my own or a referral, because of conditions I may report. I agree to follow-up with that advice. I understand that Krispin Sullivan is not a physician and does not diagnose disease nor does she treat disease with diet and supplements. Any program she may suggest for me is not in lieu of competent medical care. Nutrition supports health. It may also enhance the positive effects and/or help reduce the negative side-effects of medically necessary treatment as prescribed by a physician. I understand that my refusal to seek medical care, if and when deemed necessary, would make it impossible for Ms Sullivan to work with me.

SIGNATURE

DATE

NAME: _____ DATE: _____

SUPPLEMENT AND MEDICATION LIST

Make sure to include a copy of the label of any multiple supplements. Include the dose per tablet and number of tablets taken at each time. Example- B-6 50 mg 1 tablet or thyroid 0.125 1 tablet or Inhaler 1 spray or My Favorite Multiple 2 tablets with breakfast and 2 tablets with dinner (include label on this). If medications are taken occasionally put them at the bottom or on the back. If you often miss a daily dose of medications or supplements please note that.

On arising:

With first meal:

With lunch:

With dinner:

Before bed:

Any other times and doses:

Health Appraisal Questionnaire

Name: _____

Date: _____

Part I

Circle any of the following medications you are taking:

- | | | | | | | |
|-----------------------------|--------------------------|---------------------------------|----------------------------------|--------------------|-----------------------|------------------------------|
| • Antacids | • Antidiabetic / Insulin | • Cortisone / Anti-inflammatory | • High Blood Pressure Medication | • Laxatives | • Radiation | • Relaxants / Sleeping Pills |
| • Antibiotics / Antifungals | • Aspirin / Tylenol | • Heart Medications | • Hormones | • Lithium | • Chemotherapy | • Thyroid Medication |
| • Antidepressants | • Recreational Drugs | | | • Ulcer Medication | • Oral Contraceptives | |
- Other _____

Circle if you eat, drink or use:

- | | | | | |
|------------------------|-------------------|--|------------------------------|--|
| • Alcohol | • Coffee | • Luncheon meats | • Refined sugars | • Vitamins and / or minerals (Please List) |
| • Candy | • Distilled water | • Margarine | • Saccharine (Sweet and Low) | _____ |
| • Carbonated beverages | • Fried foods | • Eat at fast food restaurants regularly | | _____ |
| • Cigarettes | • Chew tobacco | | | _____ |

Circle if you:

- | | | |
|-----------------------------|------------------------------|------------------------------------|
| • Diet often | • Salt food without tasting | • Are exposed to chemicals at work |
| • Do not exercise regularly | • Are under excessive stress | • Are exposed to cigarette smoke |

INSTRUCTIONS: Circle the number which best describes the intensity of your symptoms. If you do not know the answer to a question, leave it blank.

0 = Symptom is not present 1 = Mild 2 = Moderate 3 = Severe

Part II

SECTION C:

SECTION A:

- | | | | | |
|---|---|---|---|---|
| 1. Burping | 0 | 1 | 2 | 3 |
| 2. Fullness for extended time after meals | 0 | 1 | 2 | 3 |
| 3. Bloating | 0 | 1 | 2 | 3 |
| 4. Poor appetite | 0 | 1 | 2 | 3 |
| 5. Stomach upsets easily | 0 | 1 | 2 | 3 |
| 6. History of constipation | 0 | 1 | 2 | 3 |
| 7. Known food allergies | 0 | 1 | 2 | 3 |

SECTION B:

- | | | | | |
|---|---|---|---|---|
| 1. Abdominal cramps | 0 | 1 | 2 | 3 |
| 2. Indigestion 1-3 hours after eating | 0 | 1 | 2 | 3 |
| 3. Fatigue after eating | 0 | 1 | 2 | 3 |
| 4. Lower bowel gas (flatulence) | 0 | 1 | 2 | 3 |
| 5. Alternating constipation and diarrhea | 0 | 1 | 2 | 3 |
| 6. Diarrhea | 0 | 1 | 2 | 3 |
| 7. Roughage and fiber causes constipation | 0 | 1 | 2 | 3 |
| 8. Mucous in stools | 0 | 1 | 2 | 3 |
| 9. Stool poorly formed | 0 | 1 | 2 | 3 |
| 10. Shiny stool | 0 | 1 | 2 | 3 |
| 11. Three or more large bowel movements daily | 0 | 1 | 2 | 3 |
| 12. Foul smelling stool | 0 | 1 | 2 | 3 |
| 13. Dry, flaky skin and / or dry brittle hair | 0 | 1 | 2 | 3 |
| 14. Pain in left side under rib cage | 0 | 1 | 2 | 3 |
| 15. Acne | 0 | 1 | 2 | 3 |
| 16. Food allergies | 0 | 1 | 2 | 3 |
| 17. Difficulty gaining weight | 0 | 1 | 2 | 3 |

- | | | | | |
|---|----|---|---|---------------------|
| 1. Stomach pains | 0 | 1 | 2 | 3 |
| 2. Stomach pains just before and / or after meals | 0 | 1 | 2 | 3 |
| 3. Dependency on antacids | 0 | 1 | 2 | 3 |
| 4. Chronic abdominal pain | 0 | 1 | 2 | 3 |
| 5. Butterfly sensations in stomach | 0 | 1 | 2 | 3 |
| 6. Difficulty belching | 0 | 1 | 2 | 3 |
| 7. Stomach pain when emotionally upset | 0 | 1 | 2 | 3 |
| 8. Sudden, acute indigestion | NO | | | YES |
| 9. Relief of symptoms by carbonated beverages | NO | | | YES |
| 10. Relief of stomach pain by drinking cream / milk | NO | | | YES |
| 11. History of ulcer or gastritis | NO | | | YES |
| 12. Current ulcer | NO | | | YES ⁽¹⁰⁾ |
| 13. Black stool when not taking iron supplements | NO | | | YES ⁽¹⁰⁾ |

SECTION D:

- | | | | | |
|--|----|---|---|-----|
| 1. Seasonal diarrhea | 0 | 1 | 2 | 3 |
| 2. Frequent and recurrent infections (colds) | 0 | 1 | 2 | 3 |
| 3. Bladder and kidney infections | 0 | 1 | 2 | 3 |
| 4. Vaginal yeast infection | 0 | 1 | 2 | 3 |
| 5. Abdominal cramps | 0 | 1 | 2 | 3 |
| 6. Toe and fingernail fungus | 0 | 1 | 2 | 3 |
| 7. Alternating diarrhea / constipation | 0 | 1 | 2 | 3 |
| 8. Constipation | 0 | 1 | 2 | 3 |
| 9. History of antibiotic use | NO | | | YES |
| 10. Meat eater | NO | | | YES |
| 11. Rapidly failing vision | NO | | | YES |

Part III

SECTION A:

- | | | | | |
|---|---|---|---|---|
| 1. Intolerance to greasy foods | 0 | 1 | 2 | 3 |
| 2. Headaches after eating | 0 | 1 | 2 | 3 |
| 3. Light coloured stool | 0 | 1 | 2 | 3 |
| 4. Foul smelling stool | 0 | 1 | 2 | 3 |
| 5. Less than one bowel movement daily | 0 | 1 | 2 | 3 |
| 6. Constipation | 0 | 1 | 2 | 3 |
| 7. Hard stool | 0 | 1 | 2 | 3 |
| 8. Sour taste in mouth | 0 | 1 | 2 | 3 |
| 9. Grey coloured skin | 0 | 1 | 2 | 3 |

- | | | | | |
|---|----|---|---|--------------------|
| 10. Yellow in whites of eyes | 0 | 1 | 2 | 3 |
| 11. Bad breath | 0 | 1 | 2 | 3 |
| 12. Body odor | 0 | 1 | 2 | 3 |
| 13. Fatigue and sleepiness after eating | 0 | 1 | 2 | 3 |
| 14. Pain in right side under rib cage | 0 | 1 | 2 | 3 |
| 15. Painful to pass stool | 0 | 1 | 2 | 3 |
| 16. Retain water | 0 | 1 | 2 | 3 |
| 17. Big toe painful | 0 | 1 | 2 | 3 |
| 18. Pain radiates along outside of leg | 0 | 1 | 2 | 3 |
| 19. Dry skin / hair | 0 | 1 | 2 | 3 |
| 20. Red blood in stool | NO | | | YES ⁽⁶⁾ |

Part III Section A (Continued)

21. Have had jaundice or hepatitis	NO	UNKNOWN	YES	8. Chronic fatigue	0	1	2	3
22. High blood cholesterol and low HDL cholesterol ...	NO	UNKNOWN	YES ⁽¹⁰⁾	9. Trouble waking up in the morning	0	1	2	3
23. Is your cholesterol level above 200?.....	NO	UNKNOWN	YES	10. Depressed, apathetic	0	1	2	3
24. Is your triglyceride level above 115 ?.....	NO	UNKNOWN	YES	11. Low sex drive	0	1	2	3

SECTION B:

1. Swollen eyes (bulging)	0	1	2	3	12. Puffy, wrinkly skin	0	1	2	3
2. Strong smelling urine	0	1	2	3	13. Sugar causes irritability and mood swings	0	1	2	3
3. Thick skin and finger nails	0	1	2	3	14. Premenstrual tension	0	1	2	3
4. Dry skin	0	1	2	3	15. Constipation	0	1	2	3
5. Sensitive to the cold	0	1	2	3	16. Thinning or loss of outside portion of eyebrow	0	1	2	3
6. Cold hands and feet	0	1	2	3	17. Gain weight easily	0	1	2	3
7. Excessive menstrual bleeding	0	1	2	3	18. Anemia unaffected by iron	NO			YES
					19. Axillary (armpit) temperature below 36.4°C (97.6°F) ..	NO			YES
					20. Slow reflexes	NO			YES
					21. Infertility	NO			YES

Part IV

SECTION A:

1. Sensitive to exhaust fumes, smoke, smog and / or petrochemicals	0	1	2	3
2. Periodic constipation	0	1	2	3
3. Cannot tolerate much exercise	0	1	2	3
4. Depression or rapid mood swings	0	1	2	3
5. Dark circles under the eyes	0	1	2	3
6. Dizziness upon standing	0	1	2	3
7. Lack of mental alertness	0	1	2	3
8. Catch colds easily when weather changes	0	1	2	3
9. Headaches	0	1	2	3
10. Difficulty breathing	0	1	2	3
11. Water retention	0	1	2	3
12. Eyes sensitive to bright light	0	1	2	3
13. Feel weak and shaky	0	1	2	3

SECTION B:

1. Inflamed or bleeding gums	0	1	2	3
2. Running nose	0	1	2	3
3. Get boils or styes	0	1	2	3
4. Nose bleeds	0	1	2	3
5. Loss of smell	0	1	2	3
6. Throat infections	0	1	2	3
7. Cold sores, fever blisters	0	1	2	3
8. Loss of taste	0	1	2	3
9. Poor wound healing	0	1	2	3
10. Hair falls out	0	1	2	3
11. Swollen lymph glands	0	1	2	3
12. Ear infections	0	1	2	3
13. Hair grows slowly	0	1	2	3
14. Slow to recover from cold or flu	0	1	2	3
15. Catch colds or flu easily	0	1	2	3
16. Bumpy skin on back of arms	0	1	2	3

SECTION C:

1. Itching of nose or eyes	0	1	2	3
2. Itching of roof of mouth or throat	0	1	2	3
3. Migraine headaches	0	1	2	3
4. Entire body aches, painful to touch	0	1	2	3
5. Swollen joints	0	1	2	3
6. Food sensitivity or allergy	0	1	2	3
7. Certain foods make you sick, depressed, jittery	0	1	2	3
8. Chronic pain	0	1	2	3
9. Painful stomach and / or intestine	0	1	2	3
10. Alternating constipation and diarrhea	0	1	2	3
11. Mucous in throat	0	1	2	3
12. Post nasal drip	0	1	2	3
13. Discharge from eyes	0	1	2	3
14. Watery eyes	0	1	2	3
15. Puffiness or dark circles under eyes	0	1	2	3
16. Ear discharge or ears stuffed up	0	1	2	3
17. Nasal congestion	0	1	2	3
18. Running nose	0	1	2	3
19. Breathe through mouth	0	1	2	3
20. Swollen tongue	0	1	2	3
21. Difficulty swallowing	0	1	2	3
22. Bedwetting	0	1	2	3
23. Hyperactivity	0	1	2	3
24. Chronic lung congestion	0	1	2	3
25. Use aspirin or Tylenol regularly	0	1	2	3
26. Wheezing	0	1	2	3
27. Skin rashes	0	1	2	3
28. Sneezing	0	1	2	3

Part V

SECTION A:

1. Difficulty breathing at night	0	1	2	3
2. Chest pain while waking	0	1	2	3
3. Heaviness in legs	0	1	2	3
4. Calf muscles cramp while walking	0	1	2	3
5. Heart pounds easily	0	1	2	3
6. Feel jittery	0	1	2	3
7. Heart misses beats or has extra beats	0	1	2	3
8. Swelling of feet and ankles	0	1	2	3
9. Rapid beating heart	0	1	2	3
10. Heartburn after eating	0	1	2	3
11. Pain in left arm	0	1	2	3
12. Exhaust with minor exertion	0	1	2	3
13. Do you do aerobic exercise?	YES			NO
14. Have you ever exercised regularly?	YES			NO
15. Drink 5 or more cups of coffee daily	NO			YES
16. Severe cough	NO			YES
17. Has a doctor ever told you that you have heart trouble?	NO			YES ⁽⁶⁾

SECTION B:

1. Cold hands and feet	0	1	2	3
2. Slurred speech	0	1	2	3
3. Calf muscles cramps while walking	0	1	2	3
4. Headaches	0	1	2	3
5. Numbness	0	1	2	3
6. Poor concentration	0	1	2	3
7. Ringing in ears	0	1	2	3
8. Ear canal hair	NO			YES
9. Tingling and / or burning in hands or feet	NO			YES
10. Spider veins on nose and / or face	NO			YES

SECTION C:

1. Pain when getting up in morning in back of head and neck	0	1	2	3
2. Dizziness	0	1	2	3
3. Vertigo	0	1	2	3
4. Blushing with no apparent cause	0	1	2	3
5. Is your blood pressure high?	NO			YES ⁽¹⁰⁾

Part VI

SECTION A:

1. Dizziness when standing suddenly	0	1	2	3
2. Loss of vision when standing suddenly	0	1	2	3
3. Crave sweets	0	1	2	3
4. Headaches relieved by eating sweets or alcohol ..	0	1	2	3
5. Feel shaky or jittery	0	1	2	3
6. Irritable if a meal is missed	0	1	2	3
7. Wake up in middle of night craving sweets	0	1	2	3
8. Feel tired or weak if a meal is missed	0	1	2	3
9. Heart palpitations after eating sweets	0	1	2	3
10. Need to drink coffee to get started	0	1	2	3
11. Impatient, moody, nervous	0	1	2	3
12. Feel tired 1 to 3 hours after eating	0	1	2	3
13. Poor memory	0	1	2	3
14. Feel faint	0	1	2	3
15. Poor concentration	0	1	2	3
16. Forgetful	0	1	2	3
17. Calmer after eating	NO			YES

SECTION B:

1. Night sweats	0	1	2	3
2. Increased thirst	0	1	2	3
3. Lowered resistance to infection	0	1	2	3
4. Fatigue	0	1	2	3
5. Boils and leg sores	0	1	2	3
6. Lesions, cuts take a long time to heal	0	1	2	3
7. Overweight	0	1	2	3
8. Feel pick up from exercise	0	1	2	3
9. Failing eyesight	0	1	2	3
10. Crave sweets, but eating sweets does not relieve symptoms	0	1	2	3
11. Family history of diabetes	NO			YES
12. Sugar in urine	NO			YES

Part VII

1. Chest pain	0	1	2	3
2. Chronic cough	0	1	2	3
3. Difficulty breathing	0	1	2	3
4. Coughing up blood	0	1	2	3
5. Coughing up phlegm	0	1	2	3
6. Pain around ribs	0	1	2	3
7. Shortness of breath	0	1	2	3

8. Rattling mucous when you breathe	0	1	2	3
9. Sensitive to smog	0	1	2	3
10. Infections settle in lungs	0	1	2	3
11. Live or work around people who smoke	0	1	2	3
12. Bronchitis	NO			YES ⁽¹⁰⁾
13. Exposed to chemicals and / or radiation	NO			YES ⁽⁶⁾
14. Smoker	NO			YES ⁽⁶⁾

Part VIII

1. Frequent urination	0	1	2	3
2. Frequent bladder infections	0	1	2	3
3. Rarely need to urinate	0	1	2	3
4. Urination when you cough or sneeze	0	1	2	3
5. Painful / burning when passing urine	0	1	2	3
6. Difficulty passing urine	0	1	2	3
7. Dripping after urination	0	1	2	3
8. Can't hold urine	0	1	2	3
9. Rose coloured (bloody) urine	0	1	2	3

10. Cloudy urine	0	1	2	3
11. Strong smelling urine	0	1	2	3
12. Back or leg pains associated with dripping after urination	0	1	2	3
13. History of kidney or bladder infections	NO			YES
14. Have used antibiotics to control urinary tract infections	NO			YES
IF YES, when did you last use them? _____				
TREATMENT DURATION _____				
15. Back pain in the kidney area	0	1	2	3
16. General water retention	0	1	2	3

MALES ONLY

Part IX

SECTION A:

1. Difficulty urinating	0	1	2	3
2. A sense of bladder fullness	0	1	2	3
3. Increased straining with smaller and smaller amounts of urine passed	0	1	2	3
4. Rose coloured (bloody) urine	0	1	2	3
5. Pain or burning while urinating	0	1	2	3
6. Wake up to urinate at night	0	1	2	3
7. Dripping after urination	0	1	2	3
8. Pain or fatigue in the legs or back	0	1	2	3
9. Lack of sex drive	0	1	2	3
10. Ejaculation causes pain	0	1	2	3

2. Low sexual drive	0	1	2	3
3. Premature ejaculation	0	1	2	3
4. Pain / coldness in genital area	0	1	2	3
5. Infertile	NO			YES ⁽⁵⁾
6. Varicose veins on scrotum	NO			YES
7. Low sperm count	NO			YES ⁽⁵⁾

SECTION C:

1. Discharge from penis	0	1	2	3
2. Past or present rash on penis	0	1	2	3
3. Swollen genitals	0	1	2	3
4. Swelling in groin	0	1	2	3
5. Venereal disease (gonorrhea, syphilis, herpes, other)	NO			YES ⁽⁹⁾

SECTION B:

1. Difficulty attaining and / or maintaining an erection	0	1	2	3
---	---	---	---	---

Have V.D. now? _____ Had in past? _____

FEMALES ONLY

Part X

SECTION A: Circle if you experience any of these symptoms within approximately 2 weeks (ovulation) prior to menstruation. (Section A ONLY)

1. Monthly weight gain	0	1	2	3
2. Depression	0	1	2	3
3. Moodiness / irritability	0	1	2	3
4. Bloating and swelling	0	1	2	3
5. Nausea and / or vomiting	0	1	2	3
6. Suicidal feeling	NO			YES ⁽¹⁰⁾
7. Anxiety	0	1	2	3
8. Leg cramps and tenderness	0	1	2	3
9. Asthma attacks	NO			YES ⁽¹⁰⁾
10. Headaches	0	1	2	3

11. Easily distracted	0	1	2	3
12. Angry	0	1	2	3
13. Tender breasts	0	1	2	3
14. Low backache	0	1	2	3
15. Other _____				

SECTION B:

1. Vaginal itching	0	1	2	3
2. Vaginal discharge	0	1	2	3
3. Low or no desire for sex	0	1	2	3
4. Dislike for intercourse	0	1	2	3
5. Missed periods	NO			YES
6. Over 15 years of age and have not begun menstruation	NO			YES

Part X Section B (Continued) Females Only

7. Unable to get pregnant NO YES
 8. Miscarriages NO YES How many ____
 9. Abortion NO YES How many ____

SECTION C:

Check if you experience any of these symptoms during menstruation (Section C ONLY)

1. Low abdominal pain 0 1 2 3
 2. Dull ache radiating to low back or legs 0 1 2 3
 3. Increased urinary frequency 0 1 2 3
 4. Pelvic soreness 0 1 2 3
 5. Diarrhea 0 1 2 3
 6. Headaches 0 1 2 3
 7. Abdominal bloating 0 1 2 3
 8. Menstrual pain 0 1 2 3
 9. Nausea and / or vomiting 0 1 2 3
 10. Have to lie down on first 1 or 2 days 0 1 2 3
 11. Craving for sweets 0 1 2 3
 12. Insomnia 0 1 2 3
 13. Light scanty blood flow 0 1 2 3
 14. Pain and cramps without blood flow 0 1 2 3
 15. Heavy menstrual bleeding 0 1 2 3
 16. Anxiety about menstrual cycle 0 1 2 3
 17. Pain during period is progressively getting worse with time 0 1 2 3

SECTION D:

1. Vaginal bumps and sores 0 1 2 3
 2. Pubic area sore 0 1 2 3

3. Ovarian cysts NO YES₍₁₀₎
 4. Uterine cysts NO YES₍₁₀₎
 5. Pain in ovaries 0 1 2 3
 6. Breast lumps NO YES₍₁₀₎
 7. Breasts sore to touch 0 1 2 3
 8. Breasts painful 0 1 2 3
 9. Water retention 0 1 2 3
 10. Swollen feeling 0 1 2 3
 11. Premenstrual breast pain or discomfort 0 1 2 3
 12. Mother used D.E.S. (hormones) while pregnant NO YES
 13. Recent pap smear positive NO YES₍₁₅₎
 14. Family history of breast cancer NO YES
 15. Form of birth control: ____ None ____ Pill ____ IUD ____ Sponge
 ____ Diaphragm ____ Foam O her: _____

SECTION E:

1. Hot flashes 0 1 2 3
 2. Night sweats 0 1 2 3
 3. Hysterectomy NO YES
 4. Depression / Mood swings 0 1 2 3
 5. Insomnia 0 1 2 3
 6. Craving for sweets 0 1 2 3
 7. Heavy bleeding two weeks / months 0 1 2 3
 8. Sweating throughout day 0 1 2 3
 9. Dryness of skin, hair and vagina 0 1 2 3
 10. Painful intercourse 0 1 2 3
 11. Vaginal pain 0 1 2 3
 12. Vaginal itching 0 1 2 3
 13. Osteoporosis (bone loss) NO YES

Part XI

SECTION A:

1. Pain in fingers 0 1 2 3
 2. Bones sore / painful 0 1 2 3
 3. Eat meat 0 1 2 3
 4. Cavities 0 1 2 3
 5. Arthritis 0 1 2 3
 6. Drink carbonated beverages / soda NO YES ____ oz./week
 7. Gum disease NO YES
 8. Bone loss NO YES
 9. Calcium deposits NO YES
 10. Use antacids NO YES ____ #/week
 11. Dentures NO YES
 12. Bone deformities NO YES
 13. Told you have osteoporosis / osteomalacia NO YES₍₅₎
 14. Recent bone fracture NO YES
 15. Are you post menopausal NO YES

SECTION B:

1. Muscle spasms 0 1 2 3
 2. Tightness in shoulder muscles 0 1 2 3

3. Muscle cramps 0 1 2 3
 4. Pain in arms and / or hands 0 1 2 3
 5. Leg cramps at night 0 1 2 3
 6. Stiff all over 0 1 2 3
 7. Stiff in morning 0 1 2 3
 8. Unable to sit straight 0 1 2 3
 9. Pain in neck and / or shoulders 0 1 2 3
 10. Back pain 0 1 2 3

SECTION C:

1. Over flexible joints (double-jointed) 0 1 2 3
 2. Back pain 0 1 2 3
 3. Swollen knees / elbows 0 1 2 3
 4. Athletic injury 0 1 2 3
 5. Bursitis 0 1 2 3
 6. Tendonitis 0 1 2 3
 7. Joint pain 0 1 2 3
 8. Slipped disc NO YES₍₅₎
 9. Herniated disc NO YES₍₁₀₎
 10. Loss in height NO YES
 11. Injure easily NO YES

Part XII

1. Head feels heavy 0 1 2 3
 2. Light headedness / fainting 0 1 2 3
 3. Loss of balance 0 1 2 3
 4. Dizziness 0 1 2 3
 5. Ringing / buzzing in ears 0 1 2 3
 6. Trembling hands 0 1 2 3
 7. Loss of feeling in hands and / or feet (toes) 0 1 2 3
 8. Exhaustion on slightest effort 0 1 2 3

9. Limbs feel to heavy to hold up 0 1 2 3
 10. Loss of grip strength 0 1 2 3
 11. Tingling pain sensation 0 1 2 3
 12. Convulsions NO YES₍₁₀₎
 13. Incoordination 0 1 2 3
 14. Nervousness 0 1 2 3
 15. Accident prone NO YES
 16. Loss of muscle tone NO YES
 17. Need for 10-12 hours sleep NO YES
 18. Have had shingles NO YES

Part XIII

1. Nightmares 0 1 2 3
 2. Can't fall asleep 0 1 2 3
 3. Intense dreams 0 1 2 3
 4. Leg cramps / restless leg at night 0 1 2 3

5. Restless, uneasy sleeper 0 1 2 3
 6. Awake frequently throughout night NO YES
 7. Wake up in the middle of night, can't fall back to sleep NO YES
 8. Sleep walk NO YES

Do you have any other symptoms that have not been covered in the questionnaire?

Creating a Food Diary

- It is best to record what you eat as soon as you can and record all foods that are eaten.
- Remember to include the beverages you drink as part of what you consume for meals and snacks.
- If you eat a "mixed food" such as a sandwich, include the mayo or butter that you might add to the bread. Include butter that you might put on cooked veggies or dressing that might top off a salad.

Portion Size Guidelines

Here are some portion size guidelines to help you in determining how much you might be eating. Keep in mind, a portion of food is fairly small. The amounts you normally eat probably constitute more than one serving. For example, a typical portion of cooked spaghetti noodles, cereal, or cooked rice equals about 2.5 cups. That's how much we would normally eat! Yet, the correct portion is one half cup. This means that under typical circumstances, we're eating five servings but count it as ONE!

Portions of food: Food Size of one serving easy way to assess

Breads 1 slice store cut slices of loaf bread	Canned fruit 1/2 cup half a fist
Hot dog bun 1/2 of bun whole bun = 2 servings	Fruit juice 3/4 cup size of a medium potato
Hamburger bun 1/2 of bun whole bun = 2 servings	Dried fruits or nuts 1/4 cup sprinkle over the palm
Sub roll 1/2 of a 4" roll whole sub roll = 4+ servings	Milk or yogurt 1 cup size of tennis ball
Cereal 3/4 cup amount to fill a cupcake liner	Cheese 1 1/2-2 ounces size of small bar of soap
Rice, pasta, beans 1/2 cup cooked size of a tangerine	Turkey or chicken 3 ounces size of a small cell phone
Cooked veggies 1/2 cup size of a tangerine	Beef, pork, fish 3 ounces same as above
Raw veggies 1 cup size of a tennis ball	Butter, margarine, oil 1 tablespoon top of your thumb with nail
Fruit 1 small 4" banana or half a fist	

Following is an example of a page from a food diary and a blank form for you to start your own.

Diet Diary for John Hancock Date June 5, 2005

Food Item Eaten/Beverage Consumed Portion Size

Breakfast: 8AM blueberry yogurt—1 serving (6 oz); whole wheat toast—1 piece with butter—1 pat

Snack: 10:30 AM cranberries—1 cup; coffee—1 cup with 2 creams added

Lunch: 1:00 PM turkey sandwich (2 slices wheat bread, 1 tbsp mayonnaise, 1 leaf of lettuce, 1 slice Swiss cheese, about 1 serving of sliced turkey); 1 bag potato chips; 1 medium apple; 1 soda Coke (12-ounce can); and 1 chocolate chip cookie

Snack: 3:30 PM microwave popcorn—1 bag; 1 soda (12-ounce can),

Dinner: 8:00 PM homemade turkey pot pie—2 servings (mixed vegetables—corn, peas, carrots, potatoes; pastry crust; gravy); 1 glass of milk (8 ounces); 1 white dinner roll with butter—1 pat

Snack: 9:30 PM ice cream---3 scoops; 1 soda (12-ounce can),

Water- total daily intake in ounces: 64 ounces

Note: To create a food diary, use the enclosed pages or make multiple copies of the form on the reverse side or make your own equivalent. Please make sure it is readable and that your name and the date are on each page. Please provide a minimum of 3 days. If possible providing 7 days is better.

Record your mood, energy, and cravings for each day and how you slept the night before. Use the back or extra sheets if needed.

Food Diary for _____ Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces: _____

Cravings:

Energy:

Mood:

Sleep:

Make as many copies as you need for each day or use plain paper but use the same format.

Food Diary for _____ Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces: _____

Cravings:

Energy:

Mood:

Sleep:

Make as many copies as you need for each day or use plain paper but use the same format.

Food Diary for _____ Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces: _____

Cravings:

Energy:

Mood:

Sleep:

Make as many copies as you need for each day or use plain paper but use the same format.

Food Diary for _____ Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces: _____

Cravings:

Energy:

Mood:

Sleep:

Over-Methylation Questionnaire

Methylation is an intracellular, metabolic process that supports thousands of body functions including turning stress on and off, turning genes on and off that express diseases, and other health regulatory functions. An overactive methylation processes is an imbalance that results in symptoms and can be improved with nutrition and supplements.

Please write your name here: _____ Check all that apply:

1. ___ Elevated neurotransmitters Serotonin, Dopamine? Norepinephrine?
2. ___ Highly artistic, highly musical? Can have grandiose thoughts?
3. ___ Multiple chemical sensitivities?
4. ___ Often obsessive, but not compulsive? Somewhat paranoid?
5. ___ Many food sensitivities?
6. ___ Depression? Despair?
7. ___ Fidgety? Restless legs?
8. ___ Anxiety? Wound up? Anxiousness observable by other people? Panic Attacks? Nervous?
9. ___ Difficult to break a sweat? Low perspiration?
10. ___ Poor reactions to taking SAM-e, inositol, methionine, tri-methyl-glycine supplements?
11. ___ Low libido, low sex drive?
12. ___ Depression? Thoughts of suicide?
13. ___ Insomnia? Not need much sleep? Light sleeper?
14. ___ Highly religious?
15. ___ Dry eyes and mouth? Low tears. Impeded lacrimation? Dry mouth? Low salivation?
16. ___ Underachiever as a child?
17. ___ Hyperactive? Learning disabilities?
18. ___ Apathy? Low Motivation?
19. ___ Low libido (low sex drive?)
20. ___ Hairy body? Hirsute?
21. ___ Hear things that did not occur? Auditory hallucinations?
22. ___ Spacey? Often distracted and unaware of ambient surroundings?
23. ___ High tolerance to pain?
24. ___ Can injure self? Self mutilation?

_____ Total number of statements checked.

Scoring: More than 4—supplementation indicated.

Designed by Dr. Jack Tips (Ph.D., C.C.N.) "The WellnessWiz" for clinical use. © 2014 by Apple-A-Day Press
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Disclaimer: This questionnaire is not intended to be used to diagnose any disease or as a basis for prescribing for any disease. It is solely for clinician insight and patient self-knowledge.

Pyroluria Questionnaire:

Poor stress control, nervousness, anxiety, mood swings, inner tension, anger, depression, aggressiveness, learning problems? Pyroluria runs in families, so if you are pyroluric, chances are the same anxiety and poor stress responses will occur in other family members. Take the self-test below. CHECK YES TO ANY OF THE FOLLOWING QUESTIONS:

- 1. When you were young, did you sunburn easily? Do you have fair or pale skin?
- 2. Do you have a reduced amount of head hair, eyebrows, or eyelashes, or do you have prematurely gray hair?
- 3. Do you have poor dream recall or nightmares?
- 4. Are you becoming more of a loner as you age? Do you avoid outside stress because it upsets your emotional balance?
- 5. Have you been anxious, fearful, or felt a lot of inner tension since childhood but mostly hide these inner feelings from others?
- 6. Is it hard to clearly recall past events and people in your life? 7. Do you have bouts of depression and/or nervous exhaustion? 8. Do you have cluster headaches?
- 9. Are your eyes sensitive to sunlight?
- 10. Do you belong to an all-girl family, or have look-alike sisters?
- 11. Do you get frequent colds or infections, or unexplained chills or fevers?
- 12. Do you dislike eating protein? Have you ever been a vegetarian?
- 13. Did you reach puberty later than normal?
- 14. Are there white spots/flecks on your fingernails, or do you have opaquely or paper- thin nails?
- 15. Are you prone to acne, eczema, or psoriasis?
- 16. Do you prefer the company of one or two close friends rather than a gathering of friends?
- 17. Do you have stretch marks on your skin?
- 18. Have you noticed a sweet smell (fruity odor) to your breath or sweat when ill or stressed?
- 19. Do you have or did you have, before braces crowded upper front teeth?
- 20. Do you prefer not to eat breakfast, or even experience light nausea in the morning?
- 21. Does your face sometimes look swollen while under a lot of stress?
- 22. Do you have a poor appetite, or a poor sense of smell or taste?
- 23. Do you have any upper abdominal, splenic pain? As a child, did you get a "stitch" in your side when you ran?
- 24. Do you tend to focus internally (on yourself) rather than on the external world?
- 25. Do you frequently experience fatigue?
- 26. Do you feel uncomfortable with strangers?
- 27. Do your knees crack or ache?
- 28. Do you overreact to tranquilizers, barbiturates, alcohol, or other drugs-(does a little produce a powerful response)?
- 29. Does it bother you to be seated in a restaurant in the middle of the room?
- 30. Are you anemic?
- 31. Do you have cold hands and/or feet?
- 32. Are you easily upset (internally) by criticism?
- 33. Do you have a tendency toward morning constipation?
- 34. Do you have tingling sensations or muscle spasms in your legs or arms?
- 35. Do changes in your routine (traveling, new situations) provoke stress?
- 36. Do you tend to become dependent on one person whom you build your life around?

Score _____ If you scored 15 or more, it would be worth your while to get needed biochemical repair.

Write your name here: _____

Under-Methylation Questionnaire

Methylation is an intracellular, metabolic process that supports thousands of body functions via chemical reactions including turning stress on and off, neutralizing genes that express diseases, and detoxification. Methyl donors (vitamins and compounds such as SAME, homocysteine, methylcobalamine, and folate) help regulate methylation processes that control neurotransmitters, immunological responses, nerve function, and detoxification. A lack of methyl molecules (CH₃) in the body is an underlying cause of hundreds of symptoms and directly relates to the aging processes.

Please write your name here : _____ Check All That Apply:

1. ____ Type A personality, perfectionistic, driven, obsessive, compulsive?
2. ____ Impulsive? Do you have impulses to do things that you know you shouldn't?
3. ____ If more than three brothers/sisters, are most of your siblings males?
4. ____ Large ears?
5. ____ Second toe as long or longer than your big toe?
6. ____ Do you need large doses of supplements or medications to get an impact?
7. ____ Do you struggle with excessive sugar, alcohol or drug use?
8. ____ Does your mind race? Hyperactive?
9. ____ Inwardly tense? Oppositional Defiance?
10. ____ Respiratory allergies? Asthma? Histamine reactions? Hives? Histadelia? Inhalant allergies?
11. ____ High sex drive, excessive libido? Easy to reach orgasm?
12. ____ Depression? Thoughts of suicide?
13. ____ Insomnia? Not need much sleep? Light sleeper?
14. ____ Headaches, chronic?
15. ____ Easily become aggressive?
16. ____ Need to eat frequently?
17. ____ Dry, cracked fingers, fingertips, heels?
18. ____ Chicken skin, areas of fatty bumps, lipomas?
19. ____ Dandruff?
20. ____ Neurological, brain, or nerve concerns?
21. ____ High libido (Ihigh sex drive?)
22. ____ High salivary flow? High tear flow.
23. ____ Anxiety? Depression? Panic disorder? Phobias? Gambling/shopping disorder?
24. ____ Smoke tobacco?

_____ Total number of statements checked. *Scoring: More than 4—supplementation indicated.*