APOL CHIROPRACTIC
500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE NUTRITIONAL HEALTH FORM

Name _____ Age _____ Today's date M/D/Y _____

Birth Date M/D/Y _____ Weight _____ Height _____ Occupation _____

Address City, State, Zip _____

Phone(s) _____ Email Address _____

1. What are your health goals? Please rank them in order of priority.

A) _____

B) _____

C) _____

2. What is the reason for this visit? _____

3. At the completion of our first visit together, how will we know if we were successful? What is the single most important thing we must accomplish?

_____

LIFESTYLE INDICATORS

1. Do you consume any of the following? Check the appropriate answer. < meaning "less than" > meaning "greater than"

Alcohol:	○ None	○ < 2 drinks/day	○ > 2 drinks/day	○ or Stopped recently M/D/Y _____
Coffee:	○ None	○ < 2 cups/day	○ > 2 cups/day	○ or Stopped recently M/D/Y _____
Soda:	○ None	○ < 2 drinks/day	○ > 2 drinks/day	○ or Stopped recently M/D/Y _____
Sweets/Refined Carbs:		○ < twice/day	○ > twice/day	○ or Stopped recently M/D/Y _____
White Flour:	○ None	○ < twice/day	○ > twice/day	
Milk/Dairy Products:		○ None	○ < twice/day	○ > twice/day
Juice:	○ None	○ < twice/day	○ > twice/day	
Meat/Fish:	○ None	○ Rarely	○ > once a week	○ Everyday

2. Do you smoke cigarettes/cigars or use nicotine gum or other stimulants? ○ No ○ Yes, amount _____

3. What do you do for stress relief? _____

4. How many times a week do you exercise? _____

5. Are there any other health habits that you could share with us? _____

6. Sleep Circle one.	No stress	1	2	3	4	5	6	7	8	9	10	Extreme stress
7. Mindset Circle one.	No stress	1	2	3	4	5	6	7	8	9	10	Extreme stress
8. Personal relationships Circle one.	No stress	1	2	3	4	5	6	7	8	9	10	Extreme stress
9. Occupational Circle one.	No stress	1	2	3	4	5	6	7	8	9	10	Extreme stress
10. Finances Circle one.	No stress	1	2	3	4	5	6	7	8	9	10	Extreme stress

11. List medications you are currently taking: _____

_____

12. Any known drug allergies? _____

13. List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking _____

_____

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2/11

SIGNS & SYMPTOMS	When (check one or both)		Severity (check one)			Comment
Mood swings	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Anxiety/Nervousness/Irritable (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Overly Reactive/Short fuse/Anger (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Low Mood/Depression (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Low Blood Sugar/High Blood Sugar	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Lowered self-esteem/self-image (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Care for others before yourself	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Sadness/Crying (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Trouble Concentrating	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Memory difficulties	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Fatigue/Anemia (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Increased Appetite/Constant hunger (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Sweet cravings/Carbs/Chocolate (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Caffeine/Stimulant cravings (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Salt cravings	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Headaches/Migraines (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Muscle Pain/Joint Aches/Backache (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Weight gain/Trouble Losing Weight (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Weight loss	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Water Retention	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Bloating/Belching/Gas (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Stomach Burning/Nausea/Indigestion (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Constipation	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Light colored stool	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Loose stool/Diarrhea/IBS (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Acne/Rashes/Brown Spots (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Excessive facial hair/body hair (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Body/Head hair loss (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Infertility	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Lowered libido/Heightened libido (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Hot flashes/Night Sweats (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Palpitations	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Breast tenderness/Breast cysts (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Nipple discharge	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Vaginal infections/Yeast infections (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Urinary Frequency/Incontinence/Infections (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Dry eyes/Dry skin/Overall dryness (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Changes to Labia/Clitoral tissue (atrophy, thinning, itching, discoloration, burning) (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Vaginal changes (dryness, tearing, decreasing size) (circle)	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	
Other	○ Ongoing	○ Worse w/Period	○ Mild	○ Moderate	○ Severe	

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SYMPTOM SURVEY

Only check symptoms that apply. MILD = occurs rarely, MODERATE = occurs several times a month, SEVERE = constant

A	Acid foods upset	○ Mild	○ Moderate	○ Severe	Strong light irritates	○ Mild	○ Moderate	○ Severe
	Get chilled, often	○ Mild	○ Moderate	○ Severe	Urine amount reduced	○ Mild	○ Moderate	○ Severe
	"Lump" in throat	○ Mild	○ Moderate	○ Severe	Heart pounds after retiring	○ Mild	○ Moderate	○ Severe
	Dry mouth-eyes-nose	○ Mild	○ Moderate	○ Severe	"Nervous" stomach	○ Mild	○ Moderate	○ Severe
	Pulse speeds after meals	○ Mild	○ Moderate	○ Severe	Appetite reduced	○ Mild	○ Moderate	○ Severe
	Keyed up - fail to calm	○ Mild	○ Moderate	○ Severe	Cold sweats often	○ Mild	○ Moderate	○ Severe
	Cuts heal slowly	○ Mild	○ Moderate	○ Severe	Fever easily raised	○ Mild	○ Moderate	○ Severe
	Gag Easily	○ Mild	○ Moderate	○ Severe	Neuralgia-like pains	○ Mild	○ Moderate	○ Severe
	Unable to relax, startles easily	○ Mild	○ Moderate	○ Severe	Staring, blinks little	○ Mild	○ Moderate	○ Severe
	Extremities cold, clammy	○ Mild	○ Moderate	○ Severe	Sour stomach frequent	○ Mild	○ Moderate	○ Severe
B	Joint stiffness after arising	○ Mild	○ Moderate	○ Severe	Breathing irregular	○ Mild	○ Moderate	○ Severe
	Muscle-leg-toe cramps at night	○ Mild	○ Moderate	○ Severe	Pulse slow; feels "irregular"	○ Mild	○ Moderate	○ Severe
	"Butterfly" stomach, cramps	○ Mild	○ Moderate	○ Severe	Gagging reflex slow	○ Mild	○ Moderate	○ Severe
	Eyes or nose watery	○ Mild	○ Moderate	○ Severe	Difficulty swallowing	○ Mild	○ Moderate	○ Severe
	Eyes blink often	○ Mild	○ Moderate	○ Severe	Constipation/diarrhea alternating	○ Mild	○ Moderate	○ Severe
	Eyelids swollen, puffy	○ Mild	○ Moderate	○ Severe	"Slow starter"	○ Mild	○ Moderate	○ Severe
	Indigestion soon after meals	○ Mild	○ Moderate	○ Severe	Gets "chilled" infrequently	○ Mild	○ Moderate	○ Severe
	Always hungry; "lightheaded" often	○ Mild	○ Moderate	○ Severe	Perspire easily	○ Mild	○ Moderate	○ Severe
	Digestion rapid	○ Mild	○ Moderate	○ Severe	Circulation poor, sensitive to cold	○ Mild	○ Moderate	○ Severe
	Vomiting frequent	○ Mild	○ Moderate	○ Severe	Subject to colds, asthma, bronchitis	○ Mild	○ Moderate	○ Severe
	Hoarseness frequent	○ Mild	○ Moderate	○ Severe				
C	Eat when nervous	○ Mild	○ Moderate	○ Severe	Heart palpitates if meals delayed	○ Mild	○ Moderate	○ Severe
	Excessive appetite	○ Mild	○ Moderate	○ Severe	Afternoon headaches	○ Mild	○ Moderate	○ Severe
	Hungry between meals	○ Mild	○ Moderate	○ Severe	Overeating sweets upsets	○ Mild	○ Moderate	○ Severe
	Irritable before meals	○ Mild	○ Moderate	○ Severe	Sleeping few hrs; difficulty falling asleep	○ Mild	○ Moderate	○ Severe
	Get "shaky" if hungry	○ Mild	○ Moderate	○ Severe	Crave candy or coffee in afternoons	○ Mild	○ Moderate	○ Severe
	Fatigue, eating relieves	○ Mild	○ Moderate	○ Severe	Depression moods: "blues"/melancholy	○ Mild	○ Moderate	○ Severe
	"Lightheaded" if meals delayed	○ Mild	○ Moderate	○ Severe	Abnormal craving for sweets/snacks	○ Mild	○ Moderate	○ Severe
D	Hands/feet go to sleep, numbness	○ Mild	○ Moderate	○ Severe	Muscle cramps worse in exercise/"charley horses"	○ Mild	○ Moderate	○ Severe
	Sigh frequently, "air hunger"	○ Mild	○ Moderate	○ Severe	Shortness of breath worse on exertion	○ Mild	○ Moderate	○ Severe
	Aware of "breathing heavily"	○ Mild	○ Moderate	○ Severe	Dull pain in chest/left arm, worse on exertion	○ Mild	○ Moderate	○ Severe
	High altitude discomfort	○ Mild	○ Moderate	○ Severe	Bruise easily, "black and blue" spots	○ Mild	○ Moderate	○ Severe
	Opens windows in closed room	○ Mild	○ Moderate	○ Severe	Tendency to anemia	○ Mild	○ Moderate	○ Severe
	Susceptible to colds and fevers	○ Mild	○ Moderate	○ Severe	"Nose bleeds" frequent	○ Mild	○ Moderate	○ Severe
	Afternoon "yawner"	○ Mild	○ Moderate	○ Severe	Noises in head or "ringing in ears"	○ Mild	○ Moderate	○ Severe
	Get "drowsy" often	○ Mild	○ Moderate	○ Severe	Breastbone "tightness" on exertion	○ Mild	○ Moderate	○ Severe
	Swollen ankles worse at night	○ Mild	○ Moderate	○ Severe				

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E	Dizziness	○ Mild	○ Moderate	○ Severe	Skin peels on foot soles	○ Mild	○ Moderate	○ Severe
	Dry skin	○ Mild	○ Moderate	○ Severe	Pain between shoulder blades	○ Mild	○ Moderate	○ Severe
	Burning feet	○ Mild	○ Moderate	○ Severe	Use laxatives	○ Mild	○ Moderate	○ Severe
	Blurred vision	○ Mild	○ Moderate	○ Severe	Stools alternate from soft to watery	○ Mild	○ Moderate	○ Severe
	Itching skin and feet	○ Mild	○ Moderate	○ Severe	History of gallbladder attacks or gallstones	○ Mild	○ Moderate	○ Severe
	Excessive falling hair	○ Mild	○ Moderate	○ Severe	Sneezing attacks	○ Mild	○ Moderate	○ Severe
	Frequent skin rashes	○ Mild	○ Moderate	○ Severe	Dreaming, nightmare type bad dreams	○ Mild	○ Moderate	○ Severe
	Bitter/metallic taste in mouth in mornings	○ Mild	○ Moderate	○ Severe	Bad breath (halitosis)	○ Mild	○ Moderate	○ Severe
	Bowel movements painful or difficult	○ Mild	○ Moderate	○ Severe	Milk products cause distress	○ Mild	○ Moderate	○ Severe
	Worrier, feels insecure	○ Mild	○ Moderate	○ Severe	Sensitive to hot weather	○ Mild	○ Moderate	○ Severe
	Feeling queasy; headache over eyes	○ Mild	○ Moderate	○ Severe	Burning or itching anus	○ Mild	○ Moderate	○ Severe
	Greasy foods upset	○ Mild	○ Moderate	○ Severe	Crave sweets	○ Mild	○ Moderate	○ Severe
	Stools light-colored	○ Mild	○ Moderate	○ Severe				
F	Loss of taste for meat	○ Mild	○ Moderate	○ Severe	Indigestion 1/2-1 hr after eating; up to 3-4 hrs	○ Mild	○ Moderate	○ Severe
	Lower bowel gas several hrs after eating	○ Mild	○ Moderate	○ Severe	Mucous colitis or "irritable bowel"	○ Mild	○ Moderate	○ Severe
	Burning stomach sensations, eating relieves	○ Mild	○ Moderate	○ Severe	Gas shortly after eating	○ Mild	○ Moderate	○ Severe
	Coated tongue	○ Mild	○ Moderate	○ Severe	Stomach "bloating" after eating	○ Mild	○ Moderate	○ Severe
	Pass large amounts of foul-smelling gas	○ Mild	○ Moderate	○ Severe				
G 1	Insomnia	○ Mild	○ Moderate	○ Severe	Inward trembling	○ Mild	○ Moderate	○ Severe
	Nervousness	○ Mild	○ Moderate	○ Severe	Heart palpitates	○ Mild	○ Moderate	○ Severe
	Can't gain weight	○ Mild	○ Moderate	○ Severe	Increased appetite without weight gain	○ Mild	○ Moderate	○ Severe
	Intolerance to heat	○ Mild	○ Moderate	○ Severe	Pulse fast at rest	○ Mild	○ Moderate	○ Severe
	Highly emotional	○ Mild	○ Moderate	○ Severe	Eyelids and face twitch	○ Mild	○ Moderate	○ Severe
	Flush easily	○ Mild	○ Moderate	○ Severe	Irritable and restless	○ Mild	○ Moderate	○ Severe
	Night sweats	○ Mild	○ Moderate	○ Severe	Can't work under pressure	○ Mild	○ Moderate	○ Severe
	Thin, moist skin	○ Mild	○ Moderate	○ Severe				
2	Increase in weight	○ Mild	○ Moderate	○ Severe	Mental sluggishness	○ Mild	○ Moderate	○ Severe
	Decrease in appetite	○ Mild	○ Moderate	○ Severe	Hair coarse, falls out	○ Mild	○ Moderate	○ Severe
	Fatigue easily	○ Mild	○ Moderate	○ Severe	Headaches upon arising wear off during day	○ Mild	○ Moderate	○ Severe
	Ringing in ears	○ Mild	○ Moderate	○ Severe	Slow pulse, below 65	○ Mild	○ Moderate	○ Severe
	Sleepy during day	○ Mild	○ Moderate	○ Severe	Frequency of urination	○ Mild	○ Moderate	○ Severe
	Sensitive to cold	○ Mild	○ Moderate	○ Severe	Impaired hearing	○ Mild	○ Moderate	○ Severe
	Dry or scaly skin	○ Mild	○ Moderate	○ Severe	Reduced initiative	○ Mild	○ Moderate	○ Severe
	Constipation	○ Mild	○ Moderate	○ Severe				
3	Failing memory	○ Mild	○ Moderate	○ Severe	Headaches, "splitting or rendering" type	○ Mild	○ Moderate	○ Severe
	Low blood pressure	○ Mild	○ Moderate	○ Severe	Decreased sugar tolerance	○ Mild	○ Moderate	○ Severe
	Increased sex drive	○ Mild	○ Moderate	○ Severe				
4	Abnormal thirst	○ Mild	○ Moderate	○ Severe	Tendency to ulcers,colitis	○ Mild	○ Moderate	○ Severe
	Bloating of abdomen	○ Mild	○ Moderate	○ Severe	Increased sugar tolerance	○ Mild	○ Moderate	○ Severe
	Weight gain around hips or waist	○ Mild	○ Moderate	○ Severe	Women: menstrual disorders	○ Mild	○ Moderate	○ Severe
	Sex drive reduced or lacking	○ Mild	○ Moderate	○ Severe	Young girls: lack of menstrual function	○ Mild	○ Moderate	○ Severe

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G 5	Dizziness	○ Mild	○ Moderate	○ Severe	Hair growth on face or body	○ Mild	○ Moderate	○ Severe
	Headaches	○ Mild	○ Moderate	○ Severe	Sugar in urine (not diabetes)	○ Mild	○ Moderate	○ Severe
	Hot flashes	○ Mild	○ Moderate	○ Severe	Masculine tendencies	○ Mild	○ Moderate	○ Severe
	Increased blood pressure	○ Mild	○ Moderate	○ Severe		○ Mild	○ Moderate	○ Severe
6	Weakness, dizziness	○ Mild	○ Moderate	○ Severe	Poor circulation	○ Mild	○ Moderate	○ Severe
	Chronic fatigue	○ Mild	○ Moderate	○ Severe	Swollen ankles	○ Mild	○ Moderate	○ Severe
	Low blood pressure	○ Mild	○ Moderate	○ Severe	Crave salt	○ Mild	○ Moderate	○ Severe
	Nails, weak, ridged	○ Mild	○ Moderate	○ Severe	Brown spots or bronzing of skin	○ Mild	○ Moderate	○ Severe
	Tendency to hives	○ Mild	○ Moderate	○ Severe	Allergies - tendency to asthma	○ Mild	○ Moderate	○ Severe
	Arthritic tendencies	○ Mild	○ Moderate	○ Severe	Weakness after colds, influenza	○ Mild	○ Moderate	○ Severe
	Perspiration increase	○ Mild	○ Moderate	○ Severe	Exhaustion - muscular and nervous	○ Mild	○ Moderate	○ Severe
	Bowel disorders	○ Mild	○ Moderate	○ Severe	Respiratory disorders	○ Mild	○ Moderate	○ Severe
H	Apprehension	○ Mild	○ Moderate	○ Severe	Weakness	○ Mild	○ Moderate	○ Severe
	Irritability	○ Mild	○ Moderate	○ Severe	Fatigue	○ Mild	○ Moderate	○ Severe
	Morbid fears	○ Mild	○ Moderate	○ Severe	Skin sensitive to touch	○ Mild	○ Moderate	○ Severe
	Never seems to get well	○ Mild	○ Moderate	○ Severe	Tendency toward hives	○ Mild	○ Moderate	○ Severe
	Forgetfulness	○ Mild	○ Moderate	○ Severe	Nervousness	○ Mild	○ Moderate	○ Severe
	Indigestion	○ Mild	○ Moderate	○ Severe	Headache	○ Mild	○ Moderate	○ Severe
	Poor appetite	○ Mild	○ Moderate	○ Severe	Insomnia	○ Mild	○ Moderate	○ Severe
	Craving for sweets	○ Mild	○ Moderate	○ Severe	Anxiety	○ Mild	○ Moderate	○ Severe
	Muscular soreness	○ Mild	○ Moderate	○ Severe	Anorexia	○ Mild	○ Moderate	○ Severe
	Depression; feelings of dread	○ Mild	○ Moderate	○ Severe	Inability to concentrate; confusion	○ Mild	○ Moderate	○ Severe
	Noise sensitivity	○ Mild	○ Moderate	○ Severe	Frequent stuffy nose; sinus infections	○ Mild	○ Moderate	○ Severe
	Acoustic hallucinations	○ Mild	○ Moderate	○ Severe	Allergy to some foods	○ Mild	○ Moderate	○ Severe
	Tendency to cry without reason	○ Mild	○ Moderate	○ Severe	Loose joints	○ Mild	○ Moderate	○ Severe
	Hair is coarse and/or thinning	○ Mild	○ Moderate	○ Severe				
I	Very easily fatigued	○ Mild	○ Moderate	○ Severe	Vaginal discharge	○ Mild	○ Moderate	○ Severe
	Premenstrual tension	○ Mild	○ Moderate	○ Severe	Hysterectomy/ovaries removed	○ Mild	○ Moderate	○ Severe
	Painful menses	○ Mild	○ Moderate	○ Severe	Menopausal hot flashes	○ Mild	○ Moderate	○ Severe
	Depressed feelings before menstruation	○ Mild	○ Moderate	○ Severe	Menses scanty or missed	○ Mild	○ Moderate	○ Severe
	Menstruation excessive and prolonged	○ Mild	○ Moderate	○ Severe	Acne, worse at menses	○ Mild	○ Moderate	○ Severe
	Painful breasts	○ Mild	○ Moderate	○ Severe	Depression of long standing	○ Mild	○ Moderate	○ Severe
	Menstruate too frequently	○ Mild	○ Moderate	○ Severe				

SYMPTOM SURVEY GRADING

A Sympathetic Dominance _____

B Parasympathetic Dominance _____

C Sugar Handling _____

D Cardiovascular _____

E Liver _____

F Digestion _____

G Endocrine 1 Hyperthyroid _____ 2 Hypothyroid _____

3 Hyperpituitary _____ 4 Hypopituitary _____

5 Hyperadrenal _____ 6 Hypoadrenal _____

H B complex _____

I Female _____

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SLEEP HABITS Please fill in or check the appropriate answer.

1. How do you sleep? Check one. ○ Well ○ Trouble falling asleep ○ Trouble staying asleep ○ Insomnia
   How long has this been happening? _____
2. How many hours do you sleep a night on average? _____
3. Do night sweats wake you up? ○ No ○ Yes, how often? _____
4. Do you wake up tired? ○ No ○ Yes, how long has this been happening? _____
5. Is your room completely dark when you sleep at night? (no night light, street lamp, TV, etc.) ○ No ○ Yes
6. Do you get at least 30 minutes of outside daylight time, several days each week? ○ No ○ Yes

REPRODUCTIVE Please fill in or check the appropriate answer.

1. Age of onset of menarche (first period) _____ Approximate date of onset _____
2. Are you currently using a method of birth control? ○ No ○ Yes; what method? _____
3. I have used: ○ Oral ○ Pill ○ Injected ○ Patch ○ Ring ○ Emergency "the day after" pills For how long? _____
4. I have used an IUD: ○ Copper ○ Hormone ○ Other _____ For how long? _____
5. Have you used, or are you currently using fertility or treatment? ○ No ○ Yes, explain _____
6. Please describe problems that you may have experienced associated with the use of any and all birth control methods (such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.) _____
7. Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? ○ No ○ Yes
   What hormone(s), dosage, & for how long? (Specify dates of use) _____
8. Have you been pregnant before? ○ No ○ Yes; age(s) of children: _____

	Number/Amount	Details/Complications
Pregnancies		
Live births		
Miscarriages		
Premature births		
Cesarean births		
Stillbirths		
Abortions		
Ectopic pregnancies		

9. If you have had a miscarriage, how many weeks pregnant were you? _____
10. Have you had an abnormal Pap Test? ○ No ○ Yes; Diagnosis/Reason: _____
    Treatment and/or Medication: _____
11. Have you had a vaginal infection? ○ No ○ Yes; if yes, what? _____
    Treatment and/or Medication: _____
12. Any history of... ○ Ovarian cysts ○ Uterine fibroids ○ Fibrocystic Breasts ○ Endometriosis
    ○ Lichen Sclerosis ○ Vulvodynia ○ Polycystic Ovarian Syndrome (PCOS)

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FEMALE NUTRITIONAL HEALTH FORM 7/11

13. Date of last pelvic/gynecological exam M/D/Y _____ Last Pap Test M/D/Y _____ Last mammogram M/D/Y _____
14. Date of last thermography M/D/Y _____ Unusual results? _____

FOR CYCLING-AGE WOMEN Please fill in or check the appropriate answer.

1. First day of last menstrual period (LMP) _____ Have you had a tubal ligation? ○ No ○ Yes; method? _____
2. Any recent change in your cycle or symptoms associated with your cycle? ○ No ○ Yes; details? _____

3. How many days does menstruation typically last? _____ How many days is your current cycle? Counted from the first day of your period to the first day of your next period ○ < 20 days ○ 20-30 days ○ 30-40 days ○ 40-50 days ○ > 50 days
4. Is your cycle regular? ○ Yes ○ Not always ○ No ; details? _____
5. Typical menstrual flow: ○ Light ○ Medium ○ Heavy; details: _____
6. Do you use: ○ Pads ○ Tampons How many on heavy days? _____
7. Do you pass clots? ○ No ○ Yes; how often? _____
8. Do you spot? ○ No ○ Yes; at what point in your cycle? _____
9. Do you experience cramping? ○ None ○ Mild ○ Moderate ○ Severe; at what point in your cycle? _____
10. Do you experience abnormal vaginal discharge? ○ No ○ Yes; when? _____
11. Do you experience vaginal itching and/or odor? ○ No ○ Yes; when? _____
12. Do you experience breast tenderness? ○ None ○ Mild ○ Moderate ○ Severe
At what point in your cycle? _____ Change in breast size? ○ No ○ Yes
13. Do experience nipple discharge? ○ No ○ Yes; when? _____ Color? _____

FOR MENOPAUSAL WOMEN Please fill in or check the appropriate answer.

1. Your age at the onset of menopause _____ Year of onset _____
2. Have you had a hysterectomy? ○ Complete (ovaries AND uterus) ○ Partial (uterus only) Date _____
Reason _____
3. List any other GYN related surgeries _____

4. Describe your experience transitioning into menopause (symptoms, strong emotions, thoughts, unusual stressors, etc.) _____

5. Have you used, or are you currently using, conventional hormone replacement therapy (HRT)? ○ No ○ Yes; for how long? _____
What? _____ Dosage? _____
6. Have you used, or are you currently using bioidentical hormone creams/gels/sublingual, troche, oral? ○ No ○ Yes; for how long? _____
What? _____ Dosage? _____
7. Have you utilized any alternative, complementary, or natural remedies in your management of menopause? ○ No ○ Yes; for how long? _____

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What? _____ Dosage? _____

8. Have you had, or do you have any vaginal spotting or bleeding since menopause? ○ No ○ Yes; when? _____
Were you evaluated and/or treated by a GYN? ○ No ○ Yes; treatment? _____

9. Did you experience cramping? ○ None ○ Mild ○ Moderate ○ Severe; at what point in your cycle? _____

PLEASE DESCRIBE YOUR CYCLE HISTORY

10. How would you have described your menstruation? ○ Easy ○ Uncomfortable ○ Difficult ○ Debilitating

11. What was your typical menstrual flow? ○ Light ○ Medium ○ Heavy

12. When you were cycling would you consider your cycle regular? ○ Yes ○ No; if no, explain? _____

13. Please describe any 'treatment' ever received for cycle issues _____

NUTRITIONAL ID QUESTIONNAIRE

Circle one answer per question. When complete, count the number of **A**, **B**, and **C** answers to discover your Base Nutritional Plan.

1. **If you had a full schedule for your morning and had to be at your peak until lunch, knowing that you would have no opportunity to snack or reach for a stimulant such as caffeine to keep you going; which of these breakfast choices would give you the highest sustained energy?**
   - **A)** Eggs, with bacon or sausage, and a small amount of hash browns
   - **B)** Almost any meal will give me the energy I need
   - **C)** Something light such as fruit, toast, yogurt or a protein shake would allow me to enjoy peak energy, without any need or desire for a snack
2. **What are your thoughts about salt?**
   - **A)** Love it, would add it often if I thought it was good for me and love vehicles for salt such as chips, pretzels, etc.
   - **B)** I could take it or leave it
   - **C)** I don't like it — I often find foods too salty
3. **If you have ever been on a juice or water fast for any length of time how did you react?**
   - **A)** I reacted terribly; low energy, anxious, and starving
   - **B)** I could fast if necessary
   - **C)** I thrived when fasting and could do this regularly
4. **At Thanksgiving dinner, when the turkey plate is being passed around, which would you prefer?**
   - **A)** I would reach for a thigh or a leg- I prefer the taste
   - **B)** Either light or dark meat would be pleasurable
   - **C)** I prefer white meat and am sometimes repulsed by fattier dark meat
5. **If you had a full schedule for your afternoon and had to be at your peak until after dinner, knowing that you would have no opportunity to snack or reach for a stimulant such as caffeine to keep you going; which of these lunch choices would give you the highest sustained energy?**
   - **A)** I would prefer a burger with cheese and maybe a small spinach salad with dressing to provide the energy needed for my afternoon
   - **B)** Almost any meal will give me the energy I need
   - **C)** My energy would excel if I consumed a large salad with either some cheese or a small chicken breast as a protein
6. **You are given the choice of a lighter fish such as tilapia or a heavier fish such as salmon at your local seafood.**

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A) I would generally chose salmon over a lighter fish
B) Either would work for me depending on the day
C) I would prefer the lighter tilapia over heavier seafood such as salmon

7. If you are out for a celebratory dinner and you are going to eat desert with no guilt attached; which would you choose?

A) I would prefer a piece of cheesecake
B) Either cheesecake or a dish or mixed berries would work for me
C) I would prefer something lighter such as a dish of mixed berries

8. How do you feel about eating dessert?

A) I love it and would eat it often if I could get away with it
B) I can take it or leave it
C) I really do not like desert except on rare occasions

9. If I would consume sweets on their own such as candies, cookies or cakes I would feel....

A) That this would create some negative feeling and possibly cravings for more sweets
B) That this would not create significant challenges for me but I may not be at my best
C) That it would not have any negative effects and may actually satisfy my appetite

10. If you had a full schedule for your evening and had to be at your peak until bedtime, knowing that you would have no opportunity to snack or reach for a stimulant such as caffeine to keep you going; which of these dinner choices would give you the highest sustained energy?

A) A small filet or broiled salmon with green beans or asparagus covered in butter or olive oil
B) Almost any meal will give me the energy I need
C) It would be best if I ate a light protein such as orange roughy or chicken breast with a large salad or vegetables such as broccoli or zucchini, with a small amount of butter or olive oil

11. I experience the most significant weight gain when....

A) I over consume grains, breads and pastas
B) I typically gain weight whenever I eat too much food of any kind- I see no noticeable difference based on fat or grain products
C) I over consume fat

12. If you consumed a cup of caffeinated coffee on an empty stomach; how would you feel?

A) This would make me feel anxious, jittery and / or hungry
B) I could take it or leave it
C) I do well on coffee as long as I do not drink too much

13. If I skip a meal I will feel.....

A) Anxious, jittery, and weak, depressed or have other negative symptoms
B) I would simply have normal hunger pangs
C) That this would not bother me and I may often forget to eat

Scoring:

For every **A** chosen **add 1 point** — Number of **A** answers = _____
For every **B** chosen **add 0 points** — Number of **B** answers = 0
For every **C** chosen **subtract 1 point** — Number of **C** answers = –_____
Your Score = _____

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If your score is between 6 thru 14, you would begin your Base Nutritional Plan as a **Protein Type**
If your score is between -5 thru 5, you would begin your Base Nutritional Plan as a **Mixed Type**
If your score is between -14 thru -6, you would begin your Base Nutritional Plan as a **Veggie Type**

GLUTEN QUESTIONNAIRE

Gluten intolerance has been found to be most common among people of Irish, English, Scottish and Scandinavian, and Eastern European. Often times it is assumed that gluten intolerance is a food allergy, but it is not. It is actually an autoimmune process, which affects an alarming percentage of the population. The most significant symptoms are weight gain, fatigue and depression. The following test is a diagnostic tool to help you to understand the symptoms and signs that are likely to go along with gluten intolerance.

1. Do any of the following apply to you? Check what applies to you.

- ○ Overly sensitive to physical & emotional pain, cry easily
- ○ Muscle or joint pain or stiffness of unknown cause
- ○ Difficulty relaxing, feel tense frequently
- ○ Tendency to over consume alcohol
- ○ Tendency to overeat sweets, bread, carbs
- ○ Cravings for sweets, bread, carbohydrates
- ○ Female hormone imbalance (PMS, menopausal symptoms)
- ○ Weight gain
- ○ Difficulty gaining weight
- ○ Unexplained fatigue
- ○ Eat when upset, eat to relax
- ○ Migraine like headache
- ○ Abdominal pain / cramping
- ○ "Love" specific foods
- ○ Food allergies / sensitivities
- ○ Difficulty digesting dairy products
- ○ Unexplained digestive problems
- ○ Intestinal gas
- ○ Constipation / diarrhea of no known cause
- ○ Abdominal bloating or distention
- ○ Unexplained skin problems/rashes

2. Have you suffered from any of the following conditions?

- ○ Allergies
- ○ Irritable bowel syndrome
- ○ Bulimia
- ○ Iron deficiency / anemia
- ○ Osteoporosis / bone loss
- ○ Chronic fatigue
- ○ Anorexia
- ○ Ulcerative colitis
- ○ Candida
- ○ Lactose intolerance
- ○ Depression
- ○ Crohn's disease
- ○ Rosacea
- ○ Diabetes
- ○ Hypoglycemia

Scoring:

Count the number of **checked** ("yes") responses = _____

If your score is **4 or Less**, your potential for gluten intolerance is: **Not likely**
If your score is between **5 thru 8**, your potential for gluten intolerance is: **Suspected**
If your score is **9 or more**, your potential for gluten intolerance is: **Very likely**

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FEMALE NUTRITIONAL HEALTH FORM 11/11

RELEASE AND WAIVER

We require a 24 hour notice to cancel a nutrition appointment.

Please note that we schedule patients every 10 minutes for nutritional appointments therefore Arriving 5-10 minutes before your scheduled appointment time will allow you to be in the room and ready for testing at your appointment time.

Please note that, your appointment time is the time you should be in the room ready and waiting for the doctor, not the time you arrive at the office.

I understand that Dermatome Compression Analysis and or Nutritional Acoustic Myography is a health assessment system and it is used to assist the practitioner help the patient improve his/her physical state through nutritional and life style recommendations. I also, understand that it is to assist the practitioner in establishing and monitoring patient nutritional programs and progress. I understand that Dermatome Compression Analysis and or Nutritional Acoustic Myography procedures do not diagnose or treat any disease or physical illness. I understand that Dermatome Compression Analysis evaluation and or Nutritional Acoustic Myography does not replace standard laboratory or other clinical diagnostic tools or procedures, and in themselves do not treat anything.

I specifically authorize Dr. Bob Apol to create health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease. I understand that this is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of this testing or any natural health, nutritional or dietary programs recommended, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health. I understand that I am to adhere to the program guidelines. These guidelines have been fully laid out before me and discussed in detail. If I do not fully comply, I understand that this will greatly impact my results and success. I have read and understand the foregoing. This permission form applies to subsequent visits and consultations.

I understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I terminate, any fees for professional services rendered to me will be immediately due and payable. To agree to arbitration for any disputes. Understand that the office may choose the arbitrator and both parties agree to abide by the arbitrator's decision. To wave the right of notice or exemption within the state of Alabama or any other state in regard to personal property, allows one and one half (1.5 %) per month to any balance owed. In the event of default to also pay reasonable collection charges, attorney fees and court cost.

Patient name Please print _____ **Patient signature** _____ **Date** M/D/Y _____

Witness name Please print _____ **Witness signature** _____ **Date** M/D/Y _____