APOL CHIROPRACTIC

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

YOUTH NUTRITIONAL HEALTH FORM

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

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

Address City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

This questionnaire is designed to assist in providing a general overview of your child's health habits and history. Please be as detailed as possible when answering!

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

A) _____

B) _____

C) _____

2. What is the reason for this visit? _____

LIFESTYLE INDICATORS

1. Does your child consume any of the following? Check the appropriate answer. < meaning "less than" > meaning "greater than"

Soda:	○ None	○ < 2 cans/day	○ > 2 cans/day	
Sweets/Carbs:	○ None	○ < twice/day	○ > twice/day	
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. How much water does your child drink each day? _____

3. Are there smokers in the child's home? ○ No ○ Yes

4. Does your child get consistent physical activity? ○ No ○ Yes; please list any regular exercise or sports your child participates in: _____

5. List any medications your child is currently taking, or has taken in the past _____

6. Are there any known drug allergies? _____

7. Do you suspect your child to use recreational drugs? If so, what _____

8. List supplements, herbs, remedies, including athletic performance supplements that your child is currently taking _____

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YOUTH NUTRITIONAL HEALTH FORM 2/10

SIGNS & SYMPTOMS	Severity (check one)			Comments
Low Mood	○ Mild	○ Moderate	○ Severe	
Lowered Self-Esteem	○ Mild	○ Moderate	○ Severe	
Discouragement	○ Mild	○ Moderate	○ Severe	
Sadness / Crying	○ Mild	○ Moderate	○ Severe	
Reserved / Withdrawn	○ Mild	○ Moderate	○ Severe	
Decreased Interest in Activities	○ Mild	○ Moderate	○ Severe	
Decreased Initiative / Motivation	○ Mild	○ Moderate	○ Severe	
Behavior Problems	○ Mild	○ Moderate	○ Severe	
Aggression	○ Mild	○ Moderate	○ Severe	
Anger	○ Mild	○ Moderate	○ Severe	
Anxiety	○ Mild	○ Moderate	○ Severe	
Fear	○ Mild	○ Moderate	○ Severe	
Difficulty Concentrating	○ Mild	○ Moderate	○ Severe	
Foggy Thinking	○ Mild	○ Moderate	○ Severe	
Memory Problems	○ Mild	○ Moderate	○ Severe	
Constant Hunger	○ Mild	○ Moderate	○ Severe	
Never Hungry / Anorexia	○ Mild	○ Moderate	○ Severe	
Weight loss	○ Mild	○ Moderate	○ Severe	
Weight gain	○ Mild	○ Moderate	○ Severe	
Decrease in Strength / Stamina	○ Mild	○ Moderate	○ Severe	
Decrease in Athletic Performance	○ Mild	○ Moderate	○ Severe	
Fatigue	○ Mild	○ Moderate	○ Severe	
Anemia	○ Mild	○ Moderate	○ Severe	
Headaches / Migraines	○ Mild	○ Moderate	○ Severe	
Body / Joint / Backaches	○ Mild	○ Moderate	○ Severe	
Digestive Problems	○ Mild	○ Moderate	○ Severe	
Irritable Bowel	○ Mild	○ Moderate	○ Severe	
Constipation	○ Mild	○ Moderate	○ Severe	
Loose Stool / Diarrhea	○ Mild	○ Moderate	○ Severe	
Bloating	○ Mild	○ Moderate	○ Severe	
Frequent Urination	○ Mild	○ Moderate	○ Severe	
Bedwetting	○ Mild	○ Moderate	○ Severe	
Allergies	○ Mild	○ Moderate	○ Severe	
Asthma	○ Mild	○ Moderate	○ Severe	
Throat Clearing	○ Mild	○ Moderate	○ Severe	
Excessive Mucous / Runny Nose	○ Mild	○ Moderate	○ Severe	
Dry Skin	○ Mild	○ Moderate	○ Severe	
Acne	○ Mild	○ Moderate	○ Severe	
Cold Sores	○ Mild	○ Moderate	○ Severe	
Infections / Lowered Immunity	○ Mild	○ Moderate	○ Severe	

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YOUTH NUTRITIONAL HEALTH FORM 3/10

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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YOUTH NUTRITIONAL HEALTH FORM

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G	5	Dizziness	○ Mild	○ Moderate	○ Severe	Hair growth on face or body (female)	○ Mild	○ Moderate	○ Severe
		Headaches	○ Mild	○ Moderate	○ Severe	Sugar in urine (not diabetes)	○ Mild	○ Moderate	○ Severe
		Hot flashes	○ Mild	○ Moderate	○ Severe	Masculine tendencies (female)	○ 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
FEMALE ONLY		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				
J		Prostate trouble	○ Mild	○ Moderate	○ Severe	Lack of energy	○ Mild	○ Moderate	○ Severe
MALE ONLY		Urination difficult or dribbling	○ Mild	○ Moderate	○ Severe	Migrating aches and pains	○ Mild	○ Moderate	○ Severe
		Night urination frequent	○ Mild	○ Moderate	○ Severe	Tire too easily	○ Mild	○ Moderate	○ Severe
		Depression	○ Mild	○ Moderate	○ Severe	Avoids activity	○ Mild	○ Moderate	○ Severe
		Pain on inside of legs or heels	○ Mild	○ Moderate	○ Severe	Leg nervousness at night	○ Mild	○ Moderate	○ Severe
		Feeling of incomplete bowel evacuation	○ Mild	○ Moderate	○ Severe	Diminished sex drive	○ Mild	○ Moderate	○ Severe

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YOUTH NUTRITIONAL HEALTH FORM 6/10

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
IJ Female & Male

HISTORY Please fill in or circle the appropriate answer.

1. Please list any known health conditions that your child has been diagnosed with
2. List any hospital procedures/surgeries that your child has had
3. Please indicate any history of antibiotic use, listing when, what, and for what purpose
4. Did your child have colic as an infant? O No O Yes
5. How was your child fed as an infant? O Breast O Bottle; what brand / kind of formula?
6. Has your child had any respiratory infections? O No O Yes; how often?
4. Does your child ever complain of back or neck pain? O No O Yes, explain
7. Does your child ever complain of arm or leg pain? O No O Yes, explain
8. Does your child ever complain of headaches? O No O Yes; how often?
9. Has your child had ear infections? O No O Yes; age of the first occurrence:
   Frequency
10. Do they typically occur in the same ear? O No O Yes; which ear? O Right O Left O Both
11. Please list any illnesses that your child has had and approximate dates of occurrence:
12. Has your child been vaccinated? O No O Yes; recently? O No O Yes
13. Please describe any reactions that your child has had to past or recent vaccinations:
14. Please list any other concerns you have regarding your child's health:

SLEEP HABITS Please fill in or check the appropriate answer.

1. How well does your child sleep? O Well O Trouble falling asleep O Trouble staying asleep O Insomnia

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YOUTH NUTRITIONAL HEALTH FORM 7/10

2. Does your child wake up tired? ○ No ○ Yes
4. How many hours does your child sleep on an average night? _____
5. Does your child take naps? ○ No ○ Yes
6. Does your child have nightmares ○ No ○ Sometimes ○ Often

REPRODUCTIVE For Cycling Females ONLY Please fill in or circle the appropriate answer.

1. Age of onset of menarche (first period) _____ Approximate Date _____
2. Is your child currently using any method of birth control? ○ No ○ Yes; for how long? _____
   what kind? ○ Oral ○ Pill ○ Injected ○ Patch ○ Ring
3. Please describe any symptoms that your child may have experienced while using birth control (i.e. yeast infections, heavy / light bleeding, moodiness, weight gain, acne, sweet cravings, palpitations, fatigue): _____
4. First day of last period _____ Length of typical period _____
5. Is menstrual cycle regular? ○ No ○ Yes ○ Not Always Details: _____
6. How many pads and / or tampons are used on heavy days? _____
7. Any knowledge of passing clots? ○ No ○ Yes; how often? _____
8. Any spotting between periods? ○ No ○ Yes; at what point in the cycle? _____
9. Does your child experience cramping? ○ None ○ Mild ○ Moderate ○ Severe
   At what point in the cycle? _____

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?**

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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.

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

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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 = _____

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 your child? Check all that apply.

- ○ 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. Has your child 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 child's potential for gluten intolerance is: **Not likely**

If your score is between **5 thru 8**, your child's potential for gluten intolerance is: **Suspected**

If your score is **9 or more**, your child's potential for gluten intolerance is: **Very likely**

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YOUTH NUTRITIONAL HEALTH FORM 10/10

REGARDING PAYMENT AND AUTHORIZATION TO TREAT A MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. The parent also agrees that he/she is responsible for all bills incurred at this office for their child and agrees to pay minimal charges for all services and products rendered. To waive 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. As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Child's name _____ **Signature of parent/guardian** _____ **Date** M/D/Y _____

RELEASE AND WAIVER

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

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 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 procedures do not diagnose or treat any disease or physical illness. I understand that Dermatome Compression Analysis evaluation 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.

Child's name _____ **Signature of parent/guardian** _____ **Date** M/D/Y _____

Name of parent/guardian _____ **Description of representative's authority** _____