The Symptoms, 3 Day Diet Recall, Scar/Trauma, and Nutrition Consent Forms

Please fill out the following information that our **office requires you to complete and hand back to us at least 1 week prior to your first visit**. **We would greatly appreciate it if you would complete and return all forms including the 3-day diet recall as soon as possible**, as our team requires time to review and prepare for your first visit.

Please submit them back to our office by:

- *Attaching* them to the Health Survey
- *Faxing* them to 262-253-0391
- *Scanning and emailing* them to: clinic@totalhealthinc.com
- *Mailing* them to: Total Health Nutrition Center Attn: Clinic
  N82W15485 Appleton Ave.
  Menomonee Falls, WI 53051
- Or if you're local, please drop them off and say hello!

NOTE: If you are having any trouble filling out these forms,

please contact out office at: 262-251-2929

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

0 = Never had the symptom
1 = Occasionally have it, mild effect
2 = Occasionally have it, severe effect
3 = Frequently have it, mild effect
4 = Frequently have it, severe effect

Column #1	
	Anxiety
	Mood swings
	Enraged behavior or anger for no reason
	Excessive shyness, timidity, social phobia (not typical to your personality)
	Irritability (not typical to your personality)
	Low body temperature (below 97.5°)
	Insomnia (can't get to sleep or return to sleep
	Dizziness
	Sound in ears (ringing or hearing your heart beat)
	Psychological symptoms, even thoughts of suicide
	Sensitivity to sound

Column #2	
	Sensitivity to light
	Fatigue after exercise (feeling worse)
	Poor night vision or seeing halos around lights
	Shortness of breath, with very little effort
	Excessive thirst and/or frequent urination
	Red eyes or tearing
	Blurred vision at times
	Morning stiffness
	Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Chronic fatigue or weakness
	Non-restful sleep

	Indecisiveness
	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Floaters, shadows or swimmers when you read or look into the sky
	Dyslexia or loss of place while reading, even as a child
	Swelling eyelids
	Peeling of top layer of skin (hands, feet)
	Dry skin
	Heart pain (angina) and you are under 45 years old
	Depression
	Gout (arthritic pain, especially in big toes)
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muscles
	Hairloss (not normal male pattern baldness)

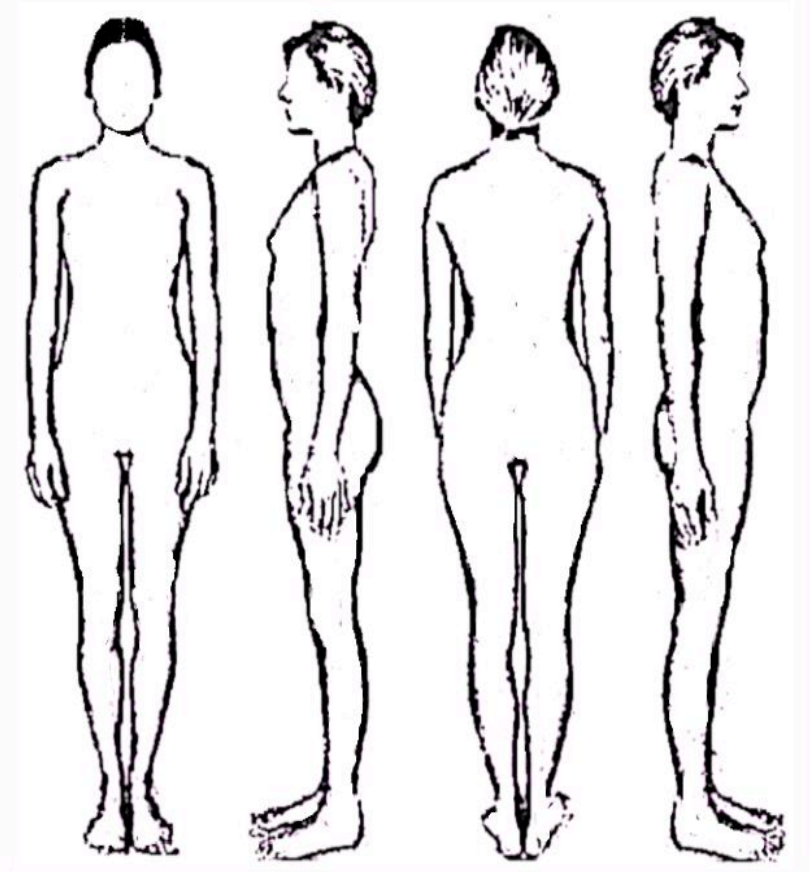
	Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
	Trouble processing new information
	Word reversal or trouble finding words
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry non-productive cough
	Muscle twitching
	Excessive sweating, especially at night
	Joint pain-not necessarily true arthritis-can move from joint to joint
	Difficulty losing weight regardless of diet or exercise
	Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
	Frequent illness, prolonged illness or sick days
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing numbers in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Frequent muscle aches, cramps, unusual sharp sudden pains
	Rashes or rosacea
	Cold extremities (hands and feet)

	Total Columns 1 & 2

Scar/Trauma Sheet

Name: _____
Date: _____

Directions: **Please draw an "S" where you have scars, even if they are old (don't forget C-sections, episiotomies, surgeries, childhood injuries, etc.). Please draw an "X" where you have had trauma (for example, put an "X" on neck area if you had a whiplash injury from a car accident or an "X" on your hip if you fell on your hip at one time, etc.).**



Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term “DRUG” is defined to mean:
“Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, supplement recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient’s diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I have read and understand the above information:

_____ _____
Signature Date

www.totalhealthinc.com 262-251-2929

Name: _____ Date: _____

	DAY ONE	DAY TWO	DAY THREE
BREAKFAST			
SNACK			
LUNCH			
SNACK			
DINNER			

Please keep an accurate three day food and drink diary.

Name: _____ Date: _____

Please list how many meals you eat out per week and where you typically consume these meals.

Breakfast: _____ Days per week.

Where: _____

Lunch: _____ Days per week.

Where: _____

Dinner: _____Days per week.

Where: _____

What time do you wake up in the morning? _____

Do you wake up hungry? _____

What time do you leave your house for work/school/errands? _____

What is your favorite food? _____

What is your favorite restaurant? _____

How many adults and children do you need to feed in your family?_____

Do you have a monthly food budget? _____

Where do you grocery shop? _____

Do you like to entertain or go to gatherings? _____

What appliances do you use to prepare your food? _____

_____

Have you ever seen any of the documentary's on how food is processed? (Exp- Food Inc., King Corn, Food Matters)_____