Preferences and Tendencies

Today's Date March 28

Name ___ Test # ___

Street Address ___ Phone # ___

City / State / ZIP ___

Age 10 Birth Date ___-98 Male / Female

Height 53" Weight 52 Name of my MD ___

Please share your preferences and tendencies by circling and/or entering details:

On the average...

How many hours of sleep do you get each night? 8 hours

Y (N) Do you exercise? If YES, how often? Daily? Weekly? Monthly?

What form of exercise? ___

Y (N) Do you smoke cigars? If yes, how many? ___ How often? ___

Y (N) Do you smoke cigarettes? If yes, how many? ___ How often? ___

How long have you been smoking? ___

Y (N) Did you previously smoke cigars/cigarettes? If so, when did you quit? ___

How long did you smoke? ___

Why/how did you quit? ___

Y (N) Do you use recreational drug(s)? If yes, which one(s)? ___

___

Y (N) Do you take hormones? If yes, which ones? ___

Y (N) Do you take oral insulin?

Y (N) Do you inject insulin? If yes, for how long? ___

Currently how much? ___ How often? ___

(Y) (N) Are you currently using any medications? If yes, which ones and for what purpose?

- Listed on other sheet

(Y) N Are you currently taking vitamins/minerals/herbs? If yes, which and for what purpose?

- Listed on other sheet

(Y) N Do you eat breakfast? If YES, which applies?

everyday 3-6 days a week 1-2 days a week 1-4 days a month

If NO, how long has it been since you stopped eating breakfasts?

Y (N) Do you eat your heaviest meal at noon?

Y (N) Do you drink coffee? If YES, how many cups/day? ___ Caff? Decaf?

Y (N) Do you drink tea (both hot and iced)? If YES, how many cups/day? ___

Y (N) Do you drink soda pop? If YES... Decaf? Diet? Quantity ___

Y (N) Do you drink alcoholic beverages? If YES... Beer? Wine? Liquor?

How much? ___ How often? ___

Y (N) Do you add salt to your food? If YES... Light? Medium? Heavy?

Y (N) Do you crave any foods? Which ones? ___

(Y) (N) Do you drink water? How many glasses each day? 6 each week? 42

Size of water glass... 6 oz. or less 8 oz. 12 oz. (16 oz. or more)

Please share your preferences and tendencies by circling and/or entering details:

Section 1A - ***On the average...*** — Don't know about preferences since She's non-verbal

Y N Appetite at breakfast is strong.
Y N Appetite at lunch is strong.
Y N Appetite at dinner is strong.
Y N Eating before bedtime improves my sleep.
Y N I live to eat, not to subsist.
Y N Often I get hungry between meals.
Y N Fasting makes me feel bad.
Y N I crave salt.
Y N A meal heavy with fat agrees with me.
Y N Going without food for four hours is uncomfortable.
Y N Meat or fish for breakfast makes me more energetic.
Y N Meat or fish for lunch makes me more energetic.
Y N Meat or fish for dinner makes me more energetic.
Y N Eating meats or fatty foods restores my energy.
Y N I feel bloated after I eat.

Section 1B

Y N Fruits generally agree with me.
Y N Orange juice in the AM agrees with me.
Y N I crave sweet desserts.
Y N Vegetarian meals satisfy me.

Count your YES answers and your NO answers in this section; write the numbers here.

1A Total YES ___ **Total NO** ___
1B Total YES ___ **Total NO** ___

Section 2 — Sleeps in diaper — Not potty-trained

Y (N) Do you have to get up at night to urinate? (The need to urinate awakening you, not just urinating because you are already up.) How many times per night? _____
Y N Do you tend toward constipation?
Y N Do you tend toward polyuria (overly frequent urination, with volume)?
Y N Do you tend toward somnolence (difficulty awakening in the morning)?

Count your YES answers and your NO answers in this section; write the numbers here.

Total YES ___ **Total NO** ___

Section 3 — Non-verbal

Y N Do you feel you are a "morning person"?
Y N Do you tend toward oliguria (insufficient urination, perhaps often but small amounts)
Y N Do you tend toward diarrhea?
Y N Do you tend toward insomnia (difficulty falling asleep or staying asleep)?
Y N Do you get up easily in the morning but find yourself tired in two + hours?

Count your YES answers and your NO answers in this section; write the numbers here.

Total YES ___ **Total NO** ___

Have you noticed? *Please indicate **CURRENT** conditions and the severity:*
Blank = never** **1 = rarely** **2 = occasionally
3 = sometimes** **4 = most of the time** **5 = constant

2. Y N ____ Overweight
3. Y N ____ Coughing or spitting blood
4. Y N ____ Chronic fever
5. Y N ____ Rectal itching
6. Y N ____ Itching of the nose
7. Y N ____ otion sickness
8. Y N 4 Seizures
9. Y N ____ Forgetful (long-term memory)
10. Y N ____ Absent-minded (short-term memory)
11. Y N ____ Head tilts to one side ... Right? Left?
12. Y N ____ Headaches
13. Y N ____ Hair dull (lacking sheen)
14. Y N ____ Eyes bulging/protruding... Both? Right? Left?
16. Y N ____ Dimness of vision. Have cataracts. Which eye? Both?
17. Y N ____ Blindness or glass eye ... Both? Right? Left?
20. Y N ____ Gums receding _____
21. Y N ____ Teeth glassy on the ends? Teeth rough on edges? Which? Both?
Have cavities or fillings ... Few? Many?
22. Y N ____ Tongue coated
23. Y N ____ Tongue dry
24. Y N ____ Tongue hot
25. Y N ____ Missing limb(s) Which? _____
26. Y N ____ Athlete's foot
27. Y N ____ Numbness of hands or feet Which? _____
28. Y N ____ Cold hands or feet Which? _____
29. Y N ____ Fingernails ... Split? Brittle? Rough? Soft? Ridges?
30. Y N ____ Skin abnormally colored? Skin oily? Skin dry?
Skin with reddish, scaly patches? Psoriasis?
32. Y N ____ Burning urination
33. Y N ____ Urine lost its force. Urine difficult to start or stop.
34. Y N ____ Wake at night to urinate. Times per night ____ Times per week ____
35. Y N ____ Bowel movements. Times per day ____ Times per week ____
36. Y N ____ Abnormal stool consistency... Hard Soft Loose
37. Y N ____ Pain with bowel movements
38. Y N ____ Blood in stool
39. Y N ____ Muscular pains
40. Y N ____ Do muscular pains move or travel from one area of body to another?
41. Y N ____ Pain in bladder area
42. Y N ____ Pain in joints
43. Y N ____ Pain in legs
44. Y N ____ Pain in lower back (especially after prolonged sitting or riding)
45. Y N ____ Chest pains

Non-verbal

46. Y N ____ Pain in left arm
47. Y N ____ Insomnia? Sleep soundly? Wake up tired?
48. Y N ____ Sluggish in the morning
49. Y N ____ Cold most of the time
50. Y N ____ Tendency to anemia
51. Y N ____ Nausea
52. Y N ____ Poor appetite
53. Y N ____ Crave sweets or coffee - Feel shaky when hungry - Irritable before meals
54. Y N ____ Do these foods upset you? Raw cabbage? Cole slaw?
55. Y N ____ Do these foods upset you? Onions? Green peppers? Cucumbers? Radishes? Rich foods? Greasy foods? Spicy foods? Other _____

56. Y N ____ Male - prostate trouble
57. Y N ____ Male - Lump(s) in testicle
58. Y N ____ Male - Difficult urination
59. Y N ____ Female - Painful periods
60. Y N ____ Female - Menstrual cramps
61. Y N ____ Female - Clots in flow
62. Y N ____ Female - Backache with period
63. Y N ____ Female - Hot flashes
64. Y N ____ Female - Birth control pills. If YES, how long? _____
65. Y N ____ Female - Regular periods? Irregular periods?

Comments Many are difficult to answer because she doesn't speak.

I give a sample of my own blood, urine, and saliva to be used for my personal education and am participating in this educational exercise at my own initiative; in fact, I request that the Nutritional Consultant supply me information of a health-related nature. This information is for educational purposes only, intended neither as a substitute for nor as a prescription for medical treatment.

I understand the Nutritional Consultant is not a medical doctor and does not diagnose, prescribe, treat nor make claims to cure. Any consequences resulting from application of the information will be my sole responsibility.

I am responsible for my own health and health-care choices.

Signature: _____ _____ Date March 28, 2009

Print Name: _____