

Preferences and Tendencies

Name _____ Today's Date _____
Street Address _____ Test # _____
City / State / ZIP _____ Phone # _____
Age _____ Birth Date _____ Male / Female _____
Height _____ Weight _____ 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? _____ 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?

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

- 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? _____ each week? _____
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...**

- 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

- 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

- 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 _____ Motion sickness
8. Y N _____ 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

Name _____

- 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 _____

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 _____

Print Name: _____