Personal Information

First Name : * M I : * Last Name :

Street : City : Zip Code : State : Select State

Home Phone : Work Phone : Cell Phone : Email :

D O B : SSN : Marital Status : Select Status Sex : Select Sex

Emergency Contact

Name : Relationship : Home Phone : Cell Phone :

Employer Information

Employer : Occupation : Status : Select Status

Family Information

Spouse Last Name : First Name : SSN : D O B :

Name and Age of Children :

Complaints

Review of System

Name	Values	Notes
Constitutional:	☐ Unexplained Weight Loss ☐ Night Sweats ☐ Fatigue, malaise, lethargy ☐ Loss of apetite ☐ Fever/Chills ☐ hernia ☐ Itch/rash ☐ varicose veins ☐ Lumps,Bumps, Masses ☐ leg cramps ☐ Unexplained Falls	
ENMT:	☐ Runny Nose ☐ Frequent Nose Bleeds ☐ Sinus Pain ☐ Stuffy Ears ☐ Laryngitis ☐ Hoarseness ☐ Sore Throat ☐ Tonsilitis ☐ Congestion	
Gastrointestinal:	☐ Unintentional Weight Loss ☐ Difficulty Swollowing ☐ Abdominal Pain ☐ Bloating/Cramping ☐ Indigestion ☐ Heartburn ☐ Neasuea/Vomiting ☐ Obstipation ☐ Constipation ☐ Diarrhea	
Integumentary:	☐ Pruritus ☐ Eczema ☐ Shingles ☐ Hives ☐ Excessive Dryness ☐ Lesions ☐ Rashes ☐ Incision ☐ Tumor	
Eyes:	☐ Visual Changes ☐ Headache ☐ Eye Pain ☐ Double Vision ☐ Blind Spots	

Cardiovascular:	☐ Shortness of Breath ☐ Heart Palpations ☐ Chest Pain ☐ High Blood Pressure ☐ Faintness ☐ Exercise Intolerance	
Endocrine:	☐ Insomnia ☐ Hyperthyroid ☐ Mood Swings ☐ Sterility ☐ Female Cramps ☐ Difficulty with Erection ☐ Diabetes ☐ Weight Loss/Gain ☐ Chronic Low Blood Pressure	
Genitourinary:	☐ Kidney Problems ☐ Pyelitis ☐ Nephritis ☐ sterility ☐ bladder problems ☐ impotentcy ☐ difficulty or too frequent urination	
Hematological/Lymph:	☐ Swollen adenoids ☐ rheumatism	
Respiratory:	☐ Tiredness ☐ asthma ☐ breathing problems ☐ shortness of breath ☐ pleurisy ☐ chronic tiredness ☐ difficulty breathing	
Musculoskeletal:	☐ neck pain, stiff or sore ☐ hand, wrist or finger numbness or pain ☐ upper arm pain ☐ shoulder pain ☐ bursitis ☐ chest pain ☐ mid back pain ☐ arthritis ☐ mid back burning ☐ sore mid back ☐ back pain ☐ cramps ☐ knee pain ☐ sciatica ☐ Low back pain or aches ☐ pain burning numbness in legs ☐ weak ankles ☐ plantar facitis ☐ foot pain ☐ weakness in legs ☐ heel spurs ☐ low back pain into hips legs ☐ spinal curvature ☐ pain in tailbone with sitting	
Psychological:	☐ amnesia ☐ ADD/ADHD ☐ nervousness ☐ bed wetting	
Immunological:	☐ Colds ☐ allergies ☐ hay fever ☐ runny nose ☐ chronic cough ☐ croup ☐ bronchitis ☐ pneumonia ☐ influenza ☐ fever ☐ lowered immune system ☐ hives	
Neurological	☐ headaches ☐ numbness ☐ tingling ☐ loss of sensation ☐ tremors ☐ balance problems ☐ dizziness ☐ tinnitus ☐ vertigo ☐ pins & needles ☐ radiating pain ☐ blurred vision ☐ vision difficulties	
All Others		

Family History :

	Back Problem	Heart Problem	Stroke	Cancer	Diabetes	High BP	Arthritis	High Cholesterol	Osteoporosis	Thyroid	Good health	Deceased	Unknown
Mother :	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father :	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
No. of Sisters :													
No. of Brothers :	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
No. of Children :	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Social History :

	Daily	3x/wk	2x/wk	1x/wk	2x/mo	1x/mo	Never
Work							
Standing :	○	○	○	○	○	○	○
Sit at a Desk :	○	○	○	○	○	○	○
Work on a Computer :	○	○	○	○	○	○	○
Work on a Phone :	○	○	○	○	○	○	○
Moderate/Heavy labor :	○	○	○	○	○	○	○
Stay at home :	○	○	○	○	○	○	○
Deliver packages :	○	○	○	○	○	○	○
Retired :	○	○	○	○	○	○	○
Habits							
Tobacco/Smoke :	○	○	○	○	○	○	○
Alcoholic beverages :	○	○	○	○	○	○	○
Caffeine :	○	○	○	○	○	○	○
Exercise :	○	○	○	○	○	○	○

Surgical History

Surgery	Date of Performance

Allergies History

Description	Date of Detected

Current Medications :

Name	Reason

Condition List :

☐ ADD/ADHD	☐ Alcohol/drug addiction	☐ Anemia	☐ Appendicitis
☐ Arrhythmia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Backaches	☐ Bleeding disorder	☐ Blood clots	☐ Blood transfusions
☐ Blurred Vision	☐ Bowel Problems	☐ Broken bones	☐ Cancer
☐ Carpal Tunnel	☐ Cataracts	☐ Chickenpox	☐ Cold Sores
☐ Colitis	☐ Collagen vascular disease	☐ Constipation	☐ Depression/anxiety
☐ Diabetes	☐ Digestive Disorders	☐ Dizziness	☐ Eating disorder
☐ Emphysema	☐ Epilepsy	☐ Fatigue	☐ Female Health Challenges
☐ Fibromyalgia	☐ Gallbladder disease	☐ Genital Herpes	☐ Glaucoma
☐ Gluten Intolerance	☐ Goiter	☐ Gout	☐ Headaches
☐ Hearing Loss	☐ Heart Disease/Attacks	☐ Heart murmur	☐ Hemorrhoids
☐ Hepatitis	☐ High Blood pressure	☐ High cholesterol	☐ HIV/AIDS
☐ Joint/back pain	☐ Kidney infections	☐ Kidney stones	☐ Liver disease/problems
☐ Lung disease	☐ Measles	☐ Menstrual Cramps	☐ Mental disorder
☐ Migraines	☐ Miscarriage	☐ Multiple Sclerosis	☐ Neck Pain

☐ Nervousness	☐ Night Sweats	☐ Osteoporosis	☐ Paralysis
☐ Pneumonia	☐ Polio	☐ Prostate problems	☐ Reflux/ulcers
☐ Rheumatic fever	☐ Scoliosis	☐ Seizures/epilepsy	☐ Sexual dysfunction
☐ Sickle cell	☐ Sinus Trouble	☐ Stress/Tension	☐ Stroke
☐ Suicidal tendencies	☐ Thyroid disease	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Urine discoloration	☐ Vertigo	☐ Whooping Cough

Notes :

Accident History

Please enter all accidents, slips and falls, sports or work related injuries that you had in the past.

Accident	Date	Chiro Treatment Recd.
		○ Yes ○ No
		○ Yes ○ No
		○ Yes ○ No
		○ Yes ○ No
		○ Yes ○ No
		○ Yes ○ No
		○ Yes ○ No
		○ Yes ○ No
		○ Yes ○ No
		○ Yes ○ No

Auto-Accident History :

Date of Accident : Time of Accident AM

Accident City : Accident State : Select State

What type of vehicle were you in? : Make : Year :

Where were you in the vehicle? : ☐ Passenger ○ Front ○ Back ○ Left-Side ○ Right-Side

What was the speed of your vehicle?

Was it ? ○ DayLight ○ Night ○ Dusk ○ Dawn

What was the visibility? ○ Excellent ○ Reduced

Type of Road? ○ 2-Lane ○ 3-Lane ○ 4-Lane ○ Gravel ○ Tar

What were the Road conditions? ○ Slippery ○ Wet ○ Dry ○ Damp ○ Muddy ○ Sandy ○ Icy

Did it happen at? ○ Traffic Light ○ Stop Sign ○ Intersection ○ HighWay

Was your Car Hit? ○ Front ○ Back ○ Left-Side ○ Right-Side

If you Struck another car, did you strike it at? ○ Front ○ Back ○ Left-Side ○ Right-Side

Damage to your Car?

Damage to the another Car?

Air Bags Deployed? ○ Yes ○ No

Was Police Report Filed? ○ Yes ○ No

Did you hit any part of your body during the collision, for example: head on dash, chest on steering wheel? ○ Yes ○ No

If yes, which part and how :

What was the position of your head and neck prior to impact : ○ Up ○ Down ○ Level ○ Straight

Were you reclined? ○ Yes ○ No

Seats Belt On? ○ Yes ○ No Shoulder Harnest On : ○ Yes ○ No

Position of Headrest? ○ Adjusted Low ○ Adjusted High ○ Improperly Adjusted ○ Normal

Were you conscious after the accident? ○ Yes ○ No

Did you receive emergency care at the scene? ○ Yes ○ No

Were you hospitalized? ○ Yes ○ No If yes, for how long? :

Describe any additional details about the Accident :

Have you retained an Attorney? ○ Yes ○ No

If yes, Name and Address of Attorney:

Insurance Information

Carrier Name :

Insured's Name :

Insured DOB :

Relationship to Insured : Self

Insured's Policy Number :

Group Number :

Claim Number :

Phone Number:

HIPAA Form

Patient Health Information and Privacy Policy This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and

records. You must read and consent to this policy before receiving services. For more information about Health Information Portability and Accountability Act (HIPAA) and health information privacy visit: hhs.gov - Understanding Health Information Privacy The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. Patients have the right to file a formal complaint with our privacy official about any suspected violations. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Electronically Signed by :

Patient/Guardian Name :

I Consent I do NOT Consent

Consent Form

Consent to Professional Treatment I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that may refuse treatment at any time. I hereby request and consent to the performance of chiropractic examinations, adjustments, and any other associated procedures on me at Infinity Chiropractic and Nutrition. I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. I have had an opportunity to discuss the nature, purpose, and risks of chiropractic care and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment. Consent to Perform and Interpret X-rays I hereby consent to the performance of diagnostic x-rays as deemed necessary by the attending physician of this practice and acknowledge that certain risks are associated with x-rays. If applicable, I certify that I am a parent or legal guardian of the patient and I hereby authorize the performance of diagnostic x-rays on said minor as requested by the physician. At this time, I know of no condition which the taking of x-rays would further complicate. I further agree that this practice may seek outside interpretation of my x-rays by a qualified professional not employed by this practice. I agree to any additional fees associated with this service and assigns benefits to be paid directly to that professional by my third-party payor. 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, Herb or Homeopathic Remedy 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 a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin 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 biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment. Cancellation/No show policy: I understand that I need to give a 24 hour advance notice to Infinity Chiropractic and Nutrition if I cannot make my scheduled appointment. I also understand that I will be subject to a fee if I am not able to notify Infinity Chiropractic and Nutrition 24 hours in advance. 1st offense- No fee 2nd offense- $25 fee 3rd+ offense- $45 fee I also understand that treatment may not be rendered at future visits if those fees are owed and not paid. I understand that Infinity Chiropractic and Nutrition reserves the right to dismiss me as a patient after my 4th offense.

Electronically Signed by :

Patient/Guardian Name :

I Consent I do NOT Consent

Pregnancy Affirm Form

Females: Regarding Possibility of Pregnancy This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to a fetus.

Electronically Signed by :

Patient/Guardian Name : Date of last menstrual Period :

Yes, I affirm No, I do NOT affirm

ASSESSMENT FORMS

NAME .....

DATE .....

Mitochondrial Dysfunction

	Never	Occasionally	Often	Regularly
History of infections (EBV, Lyme, etc.)?		N	Y	
Dizziness upon standing up quickly	0	1	2	3
Unable to tolerate much exercise	0	1	2	3
Poor exercise or muscle stamina	0	1	2	3
Low muscle tone?		N	Y	
Brain fog	0	1	2	3
Difficulty focusing	0	1	2	3
Vision or hearing problems	0	1	2	3
General or chronic fatigue	0	1	2	3
Afternoon headaches	0	1	2	3
Migraines or seizures	0	1	2	3
Mood problems: anxiety, depression, or bipolar	0	1	2	3
Poor brain processing (cognition)	0	1	2	3
Blood sugar issues	0	1	2	3
Breathing problems	0	1	2	3
Overweight?		N	Y	
Low body temperature		N	Y	
Intolerant to heat	0	1	2	3
Low thyroid lab numbers?		N	Y	
Little or no skin sweating?		N	Y	
Suppressed immune system?		N	Y	
Catch colds or get sick easily?		N	Y	
Chronic inflammation	0	1	2	3
Cannot fall asleep	0	1	2	3
Cannot stay asleep	0	1	2	3
Slow mover in the morning (hard to get going)	0	1	2	4
Wake up tired, even after 6 or more hours of sleep	0	1	2	3
Eyes sensitive to bright or direct light	0	1	2	3
Weight gain when under stress	0	1	2	3
Loss of libido		N	Y	

Mitochondrial Dysfunction Total .....

GREEN	YELLOW	RED
0-16	17-45	46-107

Drainage Dysfunction Susceptibility

	Never	Occasionally	Often	Regularly
Constipation (pooping one or fewer times daily)	0	1	2	3
Feeling that bowels do not empty completely	0	1	2	3
General or chronic fatigue	0	1	2	3
Mood problems: anxiety, depression, or bipolar	0	1	2	3
Poor brain processing (cognition)	0	1	2	3
Chronic inflammation	0	1	2	3
Wake up between 1 a.m. to 4 a.m.	0	1	2	3
Edema, swelling or retain extra fluids	0	1	2	3
Skin problems, rashes, itches, hives, eczema, or acne	0	1	2	3
Yellowish skin, face	0	1	2	3
Suppressed immune system	0	1	2	3
Can't clear infections, despite following pathogen protocols	0	1	2	3
Sore or swollen breast tissue	0	1	2	3
Heart palpitations or irregular heartbeat	0	1	2	3
Light, sound, or EMF sensitivities	0	1	2	3
Morning stiffness	0	1	2	3
Brain fog	0	1	2	3
Swollen glands	0	1	2	3
Cellulite or flabby skin	0	1	2	3
Varicose or spider veins	0	1	2	3
Kidney problems	0	1	2	3
Breathing or lung issues	0	1	2	3
Skin doesn't sweat	0	1	2	3
Puffy Eyes	0	1	2	3

Drainage Dysfunction Total .....

GREEN	YELLOW	RED
0-14	15-35	36-72

ASSESSMENT FORMS

NAME

DATE

Minerals & Electrolytes

	Never	Occasionally	Often	Regularly
Edema (swelling) in ankles or wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Unable to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3
History of carpal tunnel syndrome		N	Y	
History of lower right abdominal pains or ileocecal valve problems		N	Y	
History of stress fracture		N	Y	
Bone loss (reduced density on bone scan)	0	1	2	3
Crave chocolate	0	1	2	3
Feet have a strong odor	0	1	2	3
History of anemia	0	1	2	3
Whites of eyes (sclera) are blue-tinted	0	1	2	3
Hoarse voice	0	1	2	3
White spots on fingernails	0	1	2	3

Minerals & Electrolyte Total .....

GREEN	YELLOW	RED
0-19	20-35	36-59

Blood Sugar

	Never	Occasionally	Often	Regularly
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Fatigue after meals	0	1	2	3
Must have sweets after meals	0	1	2	3
Forgetful; poor memory	0	1	2	3
Feel better or calmer after eating	0	1	2	3
Prone to infections and colds	0	1	2	3
History of diabetes in your family		N	Y	
Sugar (glucose) detected in urine test?		N	Y	
Hair loss at ankles/frictional alopecia?		N	Y	

Blood Sugar Total .....

GREEN	YELLOW	RED
0-10	11-24	25-45

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

Organs

NAME .....

DATE .....

Stomach

	Never	Occasionally	Often	Regularly
Belching or burping	0	1	2	3
Gas quickly following a meal	0	1	2	3
Bad breath	0	1	2	3
Feel full while eating and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Stomach pain, burning, or aching 1 to 4 hours after eating	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, or caffeine	0	1	2	3
Indigestion	0	1	2	3
Abdominal bloating	0	1	2	3
Constipation	0	1	2	3
Diminished appetite	0	1	2	3

Stomach Total .....

GREEN	YELLOW	RED
0-11	12-26	27-36

Small Intestine

Increased gut motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Mucus in stool	0	1	2	3
Poorly formed or loose stools	0	1	2	3
Four or more large stools daily	0	1	2	3
Stools have foul odor	0	1	2	3
Suspect nutrient malabsorption	0	1	2	3
Diagnosed with celiac disease, irritable bowel syndrome (IBS), or diverticulosis/diverticulitis	0	1	2	3
Stomach cramps	0	1	2	3
Flatulence (gas)	0	1	2	3
Fiber-rich diet doesn't help constipation	0	1	2	3
History of pimples or skin eruptions?		N	Y	
Any known food allergies?		N	Y	

Small Intestine Total .....

GREEN	YELLOW	RED
0-10	11-24	25-45

Colon

	Never	Occasionally	Often	Regularly
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or buildup of debris on tongue	0	1	2	3
Use laxatives	0	1	2	3
History of bladder and/or kidney infection	0	1	2	3
Yeast infection (including vaginal)	0	1	2	3
Fingernail and/or toenail fungus	0	1	2	3
Use of antibiotics in past year?		N	Y	

Colon Total .....

GREEN	YELLOW	RED
0-9	10-24	25-36

Intestinal Permeability

Adverse reactions to foods	0	1	3	4
Unpredictable food reactions	0	2	4	6
Aches, pains, and swelling throughout your body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Food allergies	0	2	4	5
Frequent bloating and distention after eating	0	1	2	3

Leaky Gut Total .....

GREEN	YELLOW	RED
0-7	8-15	16-24

Organs

NAME .....

DATE .....

Hypothyroid

	Never	Occasionally	Often	Regularly
Tired or sluggish	0	1	2	3
Feel cold (hands, feet, or your whole body)	0	1	2	3
Require an excessive amount of sleep to function properly	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression or lack of motivation	0	1	2	3
Thinning of outer third of eyebrows	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dry skin and/or scalp	0	1	2	3
Slow brain processing	0	1	2	3
Lack of or diminished sex drive	0	1	2	3
Infertility or impotency		N	Y	
Heavy or profuse menstrual bleeding (women only)	0	1	2	3

Hypothyroid Total .....

GREEN	YELLOW	RED
0-11	12-22	23-40

Hyperthyroid

	Never	Occasionally	Often	Regularly
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse, even at rest	0	1	2	3
Nervous or emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Eyes appear bulging or swollen	0	1	2	3
Difficulty gaining weight	0	1	2	3

Hyperthyroid Total .....

GREEN	YELLOW	RED
0-5	6-10	11-24

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

Pathogens

NAME ..... DATE .....

Parasites

	Never	Occasionally	Often	Regularly
Restless sleep (toss, turn, or wake up often)	0	1	2	3
Skin issues, rashes, itches, hives, eczema, or acne	0	2	4	6
Frequent diarrhea or loose stools	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
SIBO (small intestinal bacterial overgrowth), feel bloated or gassy	0	1	2	3
Bowel urgency, occasional accidents	0	1	2	3
Abdominal pains, cramps, or burning	0	1	2	3
Rectal, anal itch	0	2	4	6
Anal fissures (small, painful tears or cracks)	0	2	4	6
Stomach or small intestinal ulcers or lesions	0	1	2	3
Grinding of teeth when asleep	0	2	4	6
Picking at nose, boring nose with finger	0	2	4	6
Excess boogers in nose and scab-like boogers	0	2	4	6
Fingernail biting	0	1	2	3
Headaches/Migraines	0	2	4	6
Irritable (no apparent reason)	0	1	2	3
Mood disorder, depression, anxiety, or suicidal thoughts	0	1	2	3
Hyperactive tendency (nervous)	0	1	2	3
Dark circles under eyes	0	2	4	6
Need for extra sleep, wake unrefreshed	0	1	2	3
Allergies and/or food sensitivities	0	2	3	4
Fevers of unknown origin	0	1	2	3
Night sweats (not menopausal)	0	1	2	3
Kiss pets, allow pets to lick your face	0	1	2	4
Increase of symptoms around a full moon	0	2	6	8
Anemia (low iron/hemoglobin on blood test)	0	1	2	4
Iron deficiency	0	2	4	6
Vitamin B6 deficiency	0	2	4	6
Zinc deficiency and/or white spots on nails	0	2	4	6
Frequent colds, flu, sore throats	0	1	2	3

	Never	Occasionally	Often	Regularly
Travel in developing nations	0	2	4	6
Eat pork products	0	1	2	3
Eat sushi, raw fish	0	2	4	6
Sleep with pets on bed	0	1	2	3
Bed-wetting	0	1	2	3
Frequent vomiting	0	1	2	3
Loss of appetite	0	1	2	6
Hungry all the time, bottomless pit, hungry after meals	0	2	4	6
Strong sugar and processed food cravings	0	1	2	3
Breathing problems, asthma	0	2	4	6
Pain in belly button area (umbilicus)	0	1	2	4
Blurry, unclear vision	0	1	2	3
Eye floaters	0	2	4	6
Lethargy, apathy (disinterest)	0	1	2	3
Menstrual problems	0	1	2	3
Dry lips	0	1	2	3
Drooling while asleep	0	1	2	3
Occult blood in stool (from lab test)	0	1	2	3
Swim in creeks, rivers, lakes	0	2	4	6
History of *Giardia*, pinworms, or other parasites?		N	Y	
Do you work in childcare?		N	Y	
History of or currently have cancer?		N	Y	

Parasite Infection Total .....

GREEN	YELLOW	RED
0-46	47-96	97-242

Pathogens

NAME .....

DATE .....

SIBO (Small Intestinal Bacterial Overgrowth)

	Never	Occasionally	Often	Regularly
Abdominal distention after consuming fiber, starches, or sugar	0	1	2	3
Abdominal distention after taking certain probiotics or other dietary supplements	0	1	2	3
Abdominal distention, bloating, or a noisy gut after eating healthy vegetables	0	1	2	3
Bloating or feeling full in upper abdominal area (just below rib cage)	0	1	2	3

SIBO Total .....

GREEN	YELLOW	RED
0-1	2-4	5-12

Lyme Disease Risks

	Never	Occasionally	Often	Regularly
Ever diagnosed with Lyme disease?	N	Y		
Dry sockets or infected tooth extractions	0	1	2	3
Ever bitten by a tick?	N	Y		
Ever had a bullseye rash on any part of your body?	N	Y		
Mother ever diagnosed with Lyme disease?	N	Y		
Spouse/partner/significant other diagnosed with Lyme disease?	N	Y		
Ever diagnosed with chronic fatigue syndrome, fibromyalgia, lupus, rheumatoid arthritis (RA), multiple sclerosis (MS), or an autoimmune condition?	N	Y		
Ever diagnosed with Parkinson's disease, Alzheimer's disease, or Tourette's syndrome?	N	Y		
Frequently go camping, hunting, or engage in outdoor activities?	N	Y		
History of a heart murmur or valve prolapse?	N	Y		

Lyme Disease Risks Total .....

GREEN	YELLOW	RED
0-9	10-18	19-59

Pathogens

NAME

DATE

Lyme

	Never	Occasionally	Often	Regularly
Arthritis-like joint pain or swelling	0	2	4	6
Pain migrates or moves around to different areas of your body	0	2	4	6
Forgetfulness or poor short-term memory	0	2	4	6
Confusion, difficulty thinking	0	1	2	3
Disorientation (getting lost; going to wrong places)	0	1	2	3
Difficulty with speech or writing	0	4	6	8
Tingling, numbness, burning, or stabbing sensations	0	4	6	8
Disturbed sleep: too much, too little, early awakening	0	2	4	6
Unexplained fevers, sweats, chills, or flushing	0	1	2	3
Unexplained weight change (loss or gain)	0	1	2	3
Difficulty swallowing	0	1	2	3
Fatigue, lack of energy	0	1	2	3
Sore throat or swollen glands	0	1	2	3
Pelvic or testicular pain	0	4	6	8
Crepitus (joint cracking)	0	4	6	8
Stiff neck	0	2	4	6
Twitching of facial or other muscles	0	1	2	3
Muscle pain or cramps	0	1	2	3
Costochondritis (sternum/breastbone and rib junction pain)	0	4	6	8
Right shoulder pain (AC joint)	0	1	2	3
Facial paralysis (Bell's palsy)	0	4	6	8
Unexplained menstrual irregularity	0	4	6	8
Unexplained breast milk production	0	4	6	8
Irritable bladder or bladder dysfunction	0	4	6	8
Sexual dysfunction or low libido	0	4	6	8
Blurry or double vision	0	1	2	3
Ear buzzing, ringing, or pain	0	1	2	3
Vertigo or increased motion sickness	0	4	6	8
Light-headedness, poor balance, difficulty walking	0	4	6	8

	Never	Occasionally	Often	Regularly
Woozy (mentally unclear or hazy)	0	2	4	6
Tremors	0	2	4	6
Headaches	0	1	2	3
Impulsivity, aggression, or bipolar	0	1	2	3
Depression	0	1	2	3
Hallucinations, paranoia, or schizophrenia	0	2	4	6
Panic attacks	0	1	2	3
Eating disorder	0	4	6	8
Pulse skips	0	4	6	8
Skin hypersensitivity	0	2	4	6
Gastrointestinal problems	0	4	6	8
Change in bowel function	0	4	6	8

Lyme Disease Current Symptoms Total

GREEN	YELLOW	RED
0-31	32-95	96-230

Pathogens

NAME .....

DATE .....

Babesia

	Never	Occasionally	Often	Regularly
Abdominal pain	0	2	4	6
Shortness of breath	0	1	2	3
Air hunger (episodes of breathlessness)	0	4	8	10
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Low back stiffness or pain	0	1	2	3
Low blood sugar	0	2	4	6
Cough	0	1	2	3
Disturbed sleep: frequent waking	0	4	6	8
Excessive sleepiness	0	1	2	3
Encephalopathy (brain malfunction, brain issues)	0	1	2	3
Fatigue, tiredness, poor stamina	0	1	2	3
Fevers	0	1	2	3
Headaches	0	4	6	8
Hemolysis (destruction of red blood cells)	0	2	4	6
Enlarged liver	0	2	4	6
Imbalance	0	2	4	6
Generalized ill feeling	0	1	2	3
Muscle pains or cramps	0	1	2	3
Nausea, vomiting	0	2	4	6
Neck stiffness, pain	0	1	2	3
Night sweats	0	1	2	3
Poor appetite	0	2	4	6
Shaking chills	0	4	6	8

	Never	Occasionally	Often	Regularly
Enlarged spleen	0	1	2	3
Heart palpitations, pulse skips, Tachycardia	0	4	6	8
Dark urine with or without blood	0	4	6	8
Weakness	0	1	2	3
Weight loss	0	1	2	3
Elevated sedimentation (sed) rate on lab test	0	1	2	3
Dizziness	0	1	2	3
Light headedness	0	1	2	3

Babesia Total .....

GREEN	YELLOW	RED
0-29	30-60	61-146

Pathogens

NAME

DATE

Bartonella

	Never	Occasionally	Often	Regularly
Abdominal pain	0	2	4	6
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Anxiety	0	2	4	6
Back stiffness	0	1	2	3
Chills	0	1	2	3
Disturbed sleep: too much, too little, fractionated, early awakening	0	1	2	3
Ear buzzing, ringing, pain, sound sensitivity	0	2	4	6
Brain dysfunction	0	1	2	3
Hemolysis (destruction of red blood cells)	0	2	4	6
Endocarditis	0	2	4	6
Myocarditis	0	2	4	6
Fatigue, tiredness, poor stamina	0	1	2	3
Low-grade fever	0	2	4	6
Headaches	0	1	2	3
Enlarged liver	0	2	4	6
Immune deficiency	0	2	4	6
Feeling of coming down with the flu	0	2	4	6
Insomnia	0	1	2	3
Jaundice (yellowing of skin)	0	4	6	8
Joint pain or swelling	0	1	2	3
Lymph nodes swollen	0	4	6	8
Generalized ill feeling	0	1	2	3
Muscle pains or cramps, especially in calves	0	4	6	8
Foot pain or plantar fasciitis-type pain (heels or soles of the feet)	0	4	6	8
Stretch mark-like rash (not from overweight)	0	6	8	12
Maculopapular rash (small red bumps)	0	4	6	8
Spider veins	0	2	4	6
Seizures	0	4	6	8
Sleepiness or drowsiness	0	2	4	6
Sore throat	0	2	4	6
Enlarged spleen	0	2	4	6
Shinbone pain	0	4	6	8
Tremors	0	2	4	6
Twitching of facial muscles	0	2	4	6
Weight loss	0	1	2	3
Eyes: blurred vision, red eyes, dry eyes, depth perception issue, light sensitivity	0	2	4	6
Anxiety, panic attacks, or excessive worry	0	2	4	6
Obsessive-compulsive disorder (OCD)	0	4	6	8

Bartonella Total .....

GREEN	YELLOW	RED
0-29	30-79	80-217

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided for each section. Compare your results with the rating system for each section. A score in the yellow or red range suggests this area is more likely a problem for you.

Toxicants & Toxins

General Toxicity

	Never	Occasionally	Often	Regularly
Live on or near a golf course?	N		Y	
Live near a freeway or high-tension wires?	N		Y	
Wear conventional sunscreen?	N		Y	
Wear perfume or cologne?	N		Y	
Use air fresheners in your house, car, or workplace?	N		Y	
Were you the first-born child?	N		Y	
Receive static shocks (doorknob, car, light switch, other people, etc.)	0	1	2	3
Headaches or migraines	0	1	2	3
Word reversal or trouble finding words	0	1	2	3
Sensitivity to skin or touch	0	1	2	3
Poor short-term memory	0	1	2	3
Chronic sinus issues or congestion	0	1	2	3
Difficulty losing weight regardless of diet or exercise	0	1	2	3
Excessive perspiring during day or night	0	1	2	3
Cold extremities (hands and feet)	0	1	2	3
Issues processing new information	0	1	2	3
Chronic fungal or viral infection, including *Candida*, foot fungus, warts, or jock itch	0	1	2	3
Get sick often	0	1	2	3
Weakness or numbness in extremities	0	1	2	3
Joint pain	0	1	2	3
Muscle cramps, aches, sharp pains	0	1	2	3
Muscle twitching	0	1	2	3
Stomach pain	0	1	2	3
Appetite swings	0	1	2	3
Rashes or rosacea	0	1	2	3

General Toxicity Total .....

GREEN	YELLOW	RED
0-19	20-50	51-81

Radioactive Elements

	Never	Occasionally	Often	Regularly
History of or currently have cancer?	N		Y	
Suppressed immune system?	N		Y	
Osteoporosis or osteopenia diagnosis?	N		Y	
Can't clear infections, despite following pathogen protocols?	N		Y	
Chronic *Candida* infection	0	2	4	6
Fatigue	0	2	4	6
Anemia	0	2	4	6
Skin (red, dry, itchy, color changes)	0	1	2	3
Hair loss	0	2	4	6
Loss of appetite	0	1	2	3
Nausea and vomiting	0	1	2	3
Low blood cell count	0	1	2	3
Seizures	0	1	2	3
Earaches or difficulty hearing	0	1	2	3
Hormone problems	0	1	2	3
Sore or dry mouth	0	1	2	3
Taste changes	0	1	2	3
Difficulty swallowing	0	2	4	6
Voice changes, hoarseness	0	1	2	3
Dry eyes	0	1	2	3
Stiff jaw	0	1	2	3
Tooth decay	0	1	2	3
Soreness or swelling of the breast	0	1	2	3
Heart palpitations	0	2	4	6
Irregular heartbeat	0	1	2	3
Stomach ulcers	0	2	4	6
Kidney problems	0	1	2	3
Bladder infection (cystitis)	0	2	4	6
Burning or pain during urination	0	1	2	3
Loss of bladder control	0	1	2	3
Fertility problems	0	1	2	3
Sexual problems (male & female)	0	1	2	3

Radioactive Elements Total .....

GREEN	YELLOW	RED
0-16	17-40	41-146

NAME

DATE

Mercury Toxicity

	Never	Occasionally	Often	Regularly
Do you have amalgam (silver) fillings in your teeth?	N	Y		
Have you ever had an amalgam removed?	N	Y		
If you had amalgams removed, was it done by a biological dentist using a safe protocol?	N	Y		
Were there amalgam fillings in your mother's mouth while she was pregnant with you?	N	Y		
Worked in a dental office?	0	1	2	3
Wore contact lenses during the 1980s or early 1990s	0	1	2	3
Took oral contraceptives during the 1980s or early 1990s	0	1	2	3
Have had flu shots	0	1	2	3
Have had allergy shots	0	1	2	3
Eat tuna, shark, swordfish or Atlantic salmon more than twice per week	0	1	2	3
Urinate frequently (during the day, night, or both)	0	1	2	3
Sleep issues	0	1	2	3
Do you have compact fluorescent (CFL) bulbs in your home?	N	Y		
Have you broken any CFL bulbs? (reference) 	N	Y		
Anxiety	0	1	2	3
Mood swings	0	1	2	3
Anger for no apparent reason	0	1	2	3
Excessive shyness, timidity, social phobia (not typical to your personality)	0	1	2	3
Irritability (not typical to your personality)	0	1	2	3
Dizzy or balance issues	0	1	2	3
Insomnia (can't get to sleep or return to sleep)	0	1	2	3
Low body temperature (below 97.5 degrees Fahrenheit or 36.4 degrees Celsius)	0	1	2	3
Sound in ears (ringing or hearing your heart beat)	0	1	2	3
Psychological symptoms, even thoughts of suicide	0	1	2	3
Sound sensitivities	0	1	2	3

Mercury Toxicity Total .....

GREEN	YELLOW	RED
0-30	31-64	65-130

Lead Toxicity

	Never	Occasionally	Often	Regularly
Have lived in a home built before 1978 using lead-based paint	0	2	4	6
Do home renovation, including sandblasting or moving walls	0	2	4	6
Currently live or previously lived in a mining community or area	0	2	4	6
Involved in construction, soldering, metal salvage, or stained glass	0	2	4	6
Are an electrician, handle electrical devices, electrical wiring, ballasts, or TV glass	0	2	4	6
Paint or handle/make ceramics, brass, bronze, or crystal	0	2	4	6
Handle and/or reload ammunition	0	2	4	6
Read the newspaper regularly before 1985	0	2	4	6
Previously or currently consume a coral calcium supplement	0	2	4	6
Wear lipstick	0	2	4	6
Previously wore or currently wear eye cosmetics containing kohl (a dark pigment that's not FDA-approved for makeup)	0	2	4	6
Are around or have a lot of fake leather or vinyl	0	2	4	6
Get your hair colored	0	2	4	6
Get stomachaches in the morning	0	1	2	3
Eyelid swelling	0	1	2	3
Eyelid twitching	0	1	2	3
Chest or heart pain	0	1	2	3
Metallic taste in mouth	0	1	2	3
Teeth sensitivity	0	1	2	3
Bleeding gums	0	1	2	3
High blood pressure	0	1	2	3
Inability to decide/indecisiveness	0	1	2	3
Overwhelmed or fearful feeling	0	1	2	3
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Peeling of top layer of skin (hands, feet)	0	1	2	3
Dry skin	0	1	2	3
Depression	0	1	2	3
Dyslexia or loss of your place while reading, even as a child	0	1	2	3
Gout (arthritic pain, especially in big toes)	0	1	2	3

Lead Toxicity Total .....

GREEN	YELLOW	RED
0-37	38-65	66-126

Toxicants & Toxins

NAME

DATE

Mycotoxins

	Never	Occasionally	Often	Regularly
See mold growing at home, work, or school?	N		Y	
Ever experienced water damage at home, work, or school?	N		Y	
Home, workplace, or school has a damp or mildewy odor	0	1	2	3
Spending time in basement causes or worsens symptoms	0	4	6	8
Basement ever wet?	N		Y	
Symptoms decrease when spend time in a different location for at least a few days?	N		Y	
Plumbing in your kitchen or bathroom leaks or has leaked in the past?	N		Y	
Wet spots anywhere in your home (whether currently or past)?	N		Y	
Often see condensation (fog) on the inside of windows and/or cold surfaces in your home?	N		Y	
Car has a mildewy smell?	N		Y	
Brain fog	0	1	2	3
Reactions to supplements opposite of expected	0	1	2	3
Nosebleeds	0	1	2	3
Body rashes	0	1	2	3
Any skin conditions?	N		Y	
Anyone in your home have asthma-like symptoms?	N		Y	
Sinus infections	0	1	2	3
One or more family members have chronic sinus infections or irritations	0	1	2	3
Runny, blocked, or stuffy nose	0	1	2	3
Experience static shocks	0	1	2	3
Wheezing or whistling in your chest	0	1	2	3
Wake up in the morning with a feeling of tightness in your chest	0	1	2	3
Wake up during the night with shortness of breath	0	1	2	3
Shortness of breath when you're not doing anything strenuous	0	1	2	3

	Never	Occasionally	Often	Regularly
Wake up during the night with an attack of coughing	0	1	2	3
Chest tightness when around animals or a dusty part of the house	0	1	2	3
Achy all over	0	1	2	3
Headaches	0	1	2	3
Extreme or unusual fatigue	0	1	2	3
Hoarse voice	0	1	2	3
Memory loss	0	1	2	3
Difficulty recalling names of people you know	0	1	2	3
Sensitive to chemicals and smells	0	1	2	3
Sensitive to EMF's	0	1	2	3
Bloating or SIBO	0	1	2	3
Blurry vision	0	1	2	3
Difficulty sleeping or insomnia	0	1	2	3
Anxiety or depression	0	1	2	3
Frequent urination, unable to hold bladder	0	1	2	3

Mold Total .....

GREEN	YELLOW	RED
0-19	20-68	69-138

Instructions

Rate each of the symptoms to the best of your ability based on the last **90 days**. For Yes/No answers, circle the number next to your answer, if there is a number. Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.