

Name:

DOB:

New Patient Acquaintance Comprehensive Questionnaire - Female

How to complete this questionnaire: Mail to:

Fenton Functional Nutrition, LLC
PO Box 9281
Calabasas, CA 91372

Or email to: FentonFunctionalNutrition@gmail.com

Thank you & I look forward to helping you regain full health

Today's Date: Name: Age DOB Female

Address:

Mobile: Home: Email:

Relationship Status: Name & Contact Number for Spouse/Partner:

Children & their ages: Occupation:

Emergency contact person & number: Height: Current Weight: Happiest Weight:

Provide details of any medical or allied health professionals you see on a regular basis:

Table with 3 columns: Name & Profession, Address & Contact Number, Reason for visiting

How did you find out about me? Please let me know the person who referred you so I may thank them.

What is your reason for visiting with us?

Please detail your current health concern - please think about the following and give as much detail as possible:

- Date of onset - when did it start?
• Frequency: daily, monthly, yearly?
• How long does it last (minutes, hours, weeks, etc.) or is it chronic?
• Severity of the symptoms: rate from 1 (lowest) to 10 (highest)
• Describe the symptoms in as much detail as possible and the area of your body affected.
• What (if anything) triggers the onset and exacerbates the symptoms?
• Have you sought medical treatment for this health issue? If so, what medication was prescribed, advice given? Has that provided any relief?
• What (if anything) helps alleviate the symptoms or resolves them completely?
• Is there any time of day/year that makes it worse? Or better?

Is there another MAIN health concern? If yes, provide details as listed above.

From your first visit with us what is the ONE MAIN thing you wish to achieve to feel better? i.e. What is having the most impact on your life? (Physical, mental, emotional) & how committed are you to making that happen?

What is your MAIN expectation of us?

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Major Illness & Surgery - Please list any instances where you suffered from a major illness, were admitted to hospital or underwent surgery from infancy to present time**

Age	Treatment/Surgery & Reason	Length of Stay

**Detail all CURRENT medications (prescribed/over the counter)**

Brand & Product name	Dose+Frequency	Reason for taking	Date Started

**Detail all PAST medications in last 5 years**

Brand & Product name	Dose+Frequency	Reason for taking	Date Started

**Detail all CURRENT supplements (e.g. vitamins/herbal medicines)**

Brand & Product name	Dose+Frequency	Reason for taking	Date Started

**What are your current lifestyle and health habits & challenges?**

e.g.- don't get enough sleep, no time to prepare healthy meals, drink too much alcohol on weekends, etc.

These are areas where you already know you may be compromising your health, or an issue that you know needs to change but you may not know how.

Food – do you regularly cook/eat healthy nourishing meals?

Sleep – how would you rate your sleep quality – 1 lowest & 10 highest quality? Do you wake up refreshed?

Energy - rate your average energy levels: 1 lowest to 10 highest

Stress: would you consider yourself stressed and if Y, what are the contributing factors? Work, Home, Family?

Self care, hobbies and relaxation? What do you do for these and how many times per week?

Occupational health & safety risks?

e.g. radiation from frequent flying, chemicals at work, etc.

Addictions - e.g. smoking, drugs, coffee/tea, alcohol

Please make note of past history for any of these substances.

Anything else you believe may be holding you back?

**Allergies** - Do you suffer from any allergies, sensitivities or intolerances? For example: prescribed/over the counter medications, foods, animals/insects, chemicals (food additives, cleaning/gardening chemicals), plants/grass/pollen, air pollution/petrol fumes/dust, skin reactions to plasters/lotions/fabrics/toiletries, etc. What are the details & reactions?

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International Travel & Infections	Answer Y/N. If Yes, provide all the details
In the past 2-3 years, have you travelled overseas?	
Did you have any infection while overseas or upon return?	
Has your health changed in anyway since you returned home? i.e. - digestive system never been the same as before the trip, headaches, foods that never upset you before now do, skin issues, etc?	
Did you receive any medical treatment for the issue?	

Please read the questions and **highlight** the appropriate boxes

**Diet** - Do you consume any of the following?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Alcohol                         | <input type="checkbox"/> Caffeinated Drinks                    | <input type="checkbox"/> Margarine                          |
| <input type="checkbox"/> Artificial sweeteners           | <input type="checkbox"/> Fast foods                            | <input type="checkbox"/> Milk products                      |
| <input type="checkbox"/> Sweets, deserts, refined sugars | <input type="checkbox"/> Fried Foods                           | <input type="checkbox"/> Diet frequently for weight control |
| <input type="checkbox"/> Carbonated drinks               | <input type="checkbox"/> Luncheon meats                        | <input type="checkbox"/> Cigarettes                         |
| <input type="checkbox"/> Chewing gum                     | <input type="checkbox"/> Processed meats e.g. salami, pastrami |   |

### Lifestyle

How many times per week do you exercise, what types of exercise & the duration?

Have you had any of the following events occur within the past 2 years?

- Changed Jobs     
  Separated or Divorced     
  Worked over 50 hours per week     
  Moved house     
  Grief/ lost loved one

### Group 1

- | Never                    | In the Past              | Occasionally             | Frequently               |   | Never                    | In the past              | Occasionally             | Frequently               |   |
|--------------------------|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Belching or gas within one hour of eating     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feel like skipping breakfast                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn or acid reflux                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feel better if you do not eat                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach bloating within one hour after eating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleepy after meals                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vegan Diet                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fingernails chip, peel or break easily          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bad Breath/Halitosis                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia that is unresponsive to iron supplements |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach pains or cramps                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of taste for meat                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea, chronic                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea shortly after meals                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sweat often has a strong odor                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach upset by taking vitamins                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Black or tarry coloured stools                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sense of fullness after meals                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Undigested food in stools                     |                          |                          |                          |                          |   |

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### Group 2

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheat or grain sensitivity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal bloating 1 to 2 hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dairy sensitivity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulse speeds after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma, sinus infections, stuffy nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Airborne allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bizarre vivid dreams, nightmares
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Experience hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use over-the-counter pain medication
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion "stuffy head"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel spacy or unreal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave bread or pasta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specific foods make you tired or bloated
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alternating constipation and diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are there any foods you could not give up
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have a history of or currently have Crohn's disease

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### Group 3

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anus itches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel or mucus colitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coating on the tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel worse in moldy or musty places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucus in stool
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fungus or yeast infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive foul smelling lower bowel gas
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ring worm, "jock itch", "athletes foot", nail fungus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bad breath or strong body odors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Symptoms above increase with sugar/starch/alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramping in lower abdominal region
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stools hard or difficult to pass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower abdominal pain, cramping and/or spasms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Less than one bowel movement per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Raw fruits/vegetables/stress aggravate bowel pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower abdominal pain, relief by passing stool or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	More than three bowel movements daily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea (Loose watery stool)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hard dry or pellet stool
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremely narrow/ribbon like stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alternating diarrhea/constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel bowels do not completely empty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of parasites (if yes, highlight box)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stools are not well formed (loose)					

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### Group 4

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aware of heavy and/or irregular breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ankles swell especially at end of day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Air hunger or sigh frequently
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blush or face turns red for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Compelled to open windows in a closed room
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dull pain or tightness in chest and/or radiate into right arm, worse with exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath with moderate exertion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramps with exertion					

### Group 5

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in mid back region	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy, bloody or darkened urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Puffy around the eyes, dark circles under the eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urine has a strong odor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of Kidney stones (if yes, highlight box)					

### Group 6

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach upset by greasy foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to chemicals (perfume, cleaning agents)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to tobacco smoke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light or clay colored stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to diesel fumes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache over eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain under right side of rib cage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consume artificial sweeteners (e.g. aspartame)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids or varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder removed (highlight box)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to artificial sweeteners (e.g. aspartame)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel sick if you drink wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue or fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily intoxicated if you drink wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stool color alternates from clay color to brown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of morning sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily hung over if you were to drink wine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry, flaky skin, hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bitter taste in mouth especially after meals
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yellowish color of skin or eyes

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### Group 7

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone loss (reduced density on bone scan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morning stiffness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Calf, foot or toe cramps on rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave chocolate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores, fever blisters or herpes lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent skin rashes and/or hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	White spots on fingernails
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessively flexible joints (double jointed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cuts heal slowly and/or scar easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joints pop or click	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herniated disc
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased sense of taste or smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of bone spurs

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### Group 8

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscles become easily fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Whole body or limb can jerk as falling asleep
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel exhausted or sore after moderate exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vulnerable to insect bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restless leg syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness, tingling or itching in hands and feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cracks at corner of mouth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fragile skin, easily chaffed, as in shaving
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worrier, apprehensive, anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Small bumps on back of arms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or agitated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds and/or tend to bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of insecurity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums especially when brushing teeth

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### Group 9

Never	In the Past	Occasionally	Frequently		Never	In the past	Occasionally	Frequently	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty gaining weight even with large appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen upper eyelids
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous, emotional, can't work under pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscles weak, cramp or tremble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inward trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow mental processes, forgetfulness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flush easily (go red)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fast pulse at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to high temperatures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal swelling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigued, sluggish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unsteady gait, movements
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel cold – hands, feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of interest in sex
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult, infrequent bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual tension
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness of skin, hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thick, brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy menstrual bleeding

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- |                          |                          |                          |                          |   |                          |                          |                          |                          |                      |
|--------------------------|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Outer third of eyebrow thinning/thinning hair – scalp/face/genitals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gain weight easily   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Puffy face, hands, feet   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swelling of the neck |

### Group 10

- |                          |                          |                          |                          |  |                          |                          |                          |                          |                         |
|--------------------------|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------|
| Never                    | In the Past              | Occasionally             | Frequently               |  | Never                    | In the past              | Occasionally             | Frequently               |                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Runny or drippy nose, post nasal drip  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acne (Adult)            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Catch colds at the beginning of winter | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Itchy skin (dermatitis) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mucus producing cough                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cysts Boils Rashes      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Never get sick                         |                          |                          |                          |                          |                         |

Do you have any history of Epstein Barr, Glandular Fever, Herpes, Shingles, Ross River Fever, Chronic Fatigue Syndrome or other chronic viral conditions?

1 / year	2 to 3 / year	4 to 5 / year	6 plus / year	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds or flu
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other infections (Sinus, ear, lung, skin, bladder, etc)

### Group 11

- |                          |                          |                          |                          |  |                          |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--------------------------|---|
| Never                    | In the Past              | Occasionally             | Frequently               |  | Never                    | In the past              | Occasionally             | Frequently               |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Awaken a few hours after falling asleep, hard to get back to sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches if meals are skipped or delayed     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crave sweets at any time   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irritable before meals/"hangry"               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Binge or uncontrolled eating                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shaky if meals delayed                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive appetite   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent thirst/urination                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crave coffee or sugar in the afternoon                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue is relieved by eating                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleepy in the afternoon  |                          |                          |                          |                          | Number of family members with diabetes? _____ |

### Group 12

- |                          |                          |                          |                          |   |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|--|
| Never                    | In the Past              | Occasionally             | Frequently               |   | Never                    | In the past              | Occasionally             | Frequently               |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tend to be a "night person"               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic low back pain, worse with fatigue  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty falling asleep                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Become dizzy when standing up too suddenly |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Slow starter in the morning               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crave salty foods                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tend to be keyed up, trouble calming down | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Salt foods before tasting                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood pressure above 120/80               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perspire easily                            |

Name:

DOB:

- |                          |                          |                          |                          |  |                          |                          |                          |                          |                                      |
|--------------------------|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headache after exercising                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic fatigue or get drowsy easily |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Feeling wired or jittery after drinking coffee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Afternoon yawning                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Clench or grind teeth                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Afternoon headache                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Calm on the outside, troubled on the inside    |                          |                          |                          |                          |                                      |

### Female Hormonal Health

#### **Menstruating Women Only: (Menopause is next section)**

Date of last Period:

Cycle duration & length of bleed, describe all details:

What do type of sanitary protection do you use? Tampons, sanitary pads?

Are you sexually active currently & what are you using for contraception?

- | Never                    | In the Past              | Occasionally             | Frequently               |   | Never                    | In the past              | Occasionally             | Frequently               |  |
|--------------------------|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression during periods                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breast fibroids/cysts/nipple discharge     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mood swings associated with periods (PMS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful intercourse (dyspareunia)          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crave chocolate around periods            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal discharge (odor/no odor?)          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breast tenderness associated with cycle   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal dryness                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive menstrual flow                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal itchiness                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Scanty blood flow during periods          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gain fluid/bloating around stomach/breasts |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Occasional skipped period                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excess facial or body hair                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Variations in menstrual cycle             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Night sweats                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis/Polycystic Ovaries          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pelvic inflammatory disease (PID)          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Uterine fibroids                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cystitis                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thrush/Candida (vaginal/systemic?)        |                          |                          |                          |                          |  |

Any other genito-urinary infections/sexually transmitted diseases (current/past history) e.g. Herpes/warts/blisters/chlamydia/HIV/AIDs/Syphilis?

Have you had any miscarriages/terminations?

Do you have any piercings/tattoos?

Do you have a history of eating disorders?

Have you had any abnormal pap smears?

Have you had Cancer of any type?

Do you have breast implants?

Any other information you feel I should know



Name:

DOB:

**Female Hormonal Health**

**Menopausal Women:** includes peri-menopause, surgically/drug induced menopause, post menopause

Date of last period:

Hysterectomy? Partial or full hysterectomy & date of surgery

History of female hormonal issues before surgery – please provide the details:

History of Cancer? If yes, provide details:

Never <input type="checkbox"/> In the Past <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/>	<input type="checkbox"/> Hot flushes <input type="checkbox"/> Excess facial or body hair <input type="checkbox"/> Depression/anxiety <input type="checkbox"/> Fatigue/lethargy <input type="checkbox"/> Insomnia/Poor Sleep/Non Restorative	Never <input type="checkbox"/> In the past <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/>	<input type="checkbox"/> Painful intercourse (dyspareunia) <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Thinning skin <input type="checkbox"/> Loss of libido
--	---	--	---

Any other information you feel I should know?

<b>Family Health:</b> Please list any known family medical history & indicate if deceased due to health issue: e.g.- strokes, heart disease, high blood pressure, digestive disorders – Celiac, thyroid disorders – Hashimoto’s, mental illness/depression/anxiety etc				
Mother		Father		
Grand Parents (Maternal)		Grand Parents (Paternal)		
Siblings (Sisters)		Siblings (Brothers)		
<b>Your Gestational History:</b> did your mother suffer from any of the following while she was carrying you? Gestational diabetes, threatened miscarriage, high/low blood pressure, serious infections. If Y, provide details.				
<b>Your Birth History:</b> provide details if possible i.e. born prematurely, birth induced, birth trauma/injury, normal vaginal birth, cesarean section, prolonged labor/delivery, oxygen deprivation, forceps/vacuum				
<b>Childhood History: from birth to 18 years did you suffer from any of the following illnesses?</b> ADD, ADHD, Allergies, asthma, bronchitis, chickenpox, colic, croup, eczema, measles, mumps, newborn jaundice, psoriasis, rubella, scarlet fever, tonsillitis, whooping cough Please insert the condition as appropriate. Severity out of 10 where 1 = mild & 10 = very severe				
Health Condition	Age at onset	Age it resolved	Severity	Treatment Received
			/10	
			/10	
			/10	
<b>Immunizations:</b> Please list all vaccinations & dates received.				
Are you aware of any side effects or adverse reactions to any immunizations you have received?				

Name:

DOB:

Environmental Toxicity Screening	Answer Y/N. If Y, provide detail
In the past two years, have any of your activities involved frequent contact with chemicals including: manufacture or degrading of plastics; paints; new carpets; new car; refrigeration or air conditioning gases; glues; chemical cleansers or insecticides (pest control) or herbicides; frequent handling of carbonless copy paper; retail shop receipts; unfiltered water; chemical mold removal; hair chemicals such as coloring or perming agents? If yes, give details and dates:	
In the past two years have any of your activities involved contact with heavy metals? If yes, give details and dates:	
Mercury dental fillings: how many do you have? When was your last dental check-up?	
Xrays: Have you had any X-rays (including dental) in the past three years? If yes, give details and dates.	
Airline Flights in past 3 years: Number of international flights? Number of domestic flights? (radiation exposure)	
Do you use a computer? If yes, for how many hours per day? (laptop/desktop/flat screen) Do you use a laptop/tablet on your lap?	
Do hold your mobile phone to your head when using it? If Y, how many hours/day?	
Do you sleep near your mobile phone or ipad? Do you use it as an alarm? Do you have electrical devices in the bedroom, e.g. TV, etc? Do you sleep near a fuse box? What is on the other side of your bedroom wall where your head is located?	
Do you use a microwave oven? If yes, how often?	
Do you live/work near a transmitter/power lines?	
Do you live/work near a main road/flight path?	
Do you regularly travel in rush hour/busy traffic? If so how? Bike, bus, car, walk?	
Do you use chemical cleansers or insecticides in your kitchen or bathroom? If yes, give details	
Have you recently conducted any renovations/decorating and/or pest control?	
Do you use any recreational drugs including alcohol, marijuana? If yes, give details including type, amount and frequency & duration.	
Cigarettes: Do you smoke cigarettes? If yes, what strength and how many per day/week? Duration (number of years)? Have you stopped smoking cigarettes in the past four months? If yes, when?	
Are you exposed to passive smoking? If yes, how often?	
Do you drink coffee, caffeine containing drinks or tea? If yes, give details including what, how often and how much:	
Do you wash your fruit and vegetables really thoroughly before eating them?	
Do you have any mold in your home/work environment? Details?	

Name:

DOB:

Please complete the entire Questionnaire. Do complete by hand and return via mail 5 days prior to your Initial Consultation –

**Mail to:**

Fenton Functional Nutrition, LLC  
PO Box 9281  
Calabasas, CA 91372

**Or email to: [FentonFunctionalNutrition@gmail.com](mailto:FentonFunctionalNutrition@gmail.com)**

Please bring to the appointment:

1. Current medications – both prescription, herbal/nutritional supplements
2. Recent test results (within 12 months only): such as blood work, fecal test, saliva test, hair mineral analysis, ultrasounds and any other medical records or doctor reports.

<b>Signature:</b>	<b>Date:</b>
<b>Signature of Parent/Guardian for children under 18 years</b>	