The NEW Signs Symptoms™ survey

Version 8

The only questionnaire of its kind designed to identify dietary deficiencies of food components (protein, carbohydrate, and fat), food enzymes (such as lipase, protease, and amylase), and coenzymes (vitamins and minerals).

Name/ID _____

Food Enzyme Institute™

This survey is intended to be used as a screening procedure for nutritional health. The survey is not intended to be used to diagnose a specific medical condition, disease or illness, or to replace an evaluation by a health care professional.

PERSONAL HISTORY FORM

Name/ID _____ Date _____

Address _____

City _____ State _____ ZIP _____

Phone _____

Sex _____ Age _____ Height _____ Weight _____

Occupation _____

Please complete the following questions. This survey will give us a detailed understanding of your present health condition. If you have any questions or do not understand any portion of it, we will be happy to assist you.

Chief Complaint - Primary reason you are seeking treatment:

_____

_____

Surgeries you have had and your age at time of surgery:

1. _____ age _____ 3. _____ age _____

2. _____ age _____ 4. _____ age _____

Prescription medications you are presently taking:

1. _____ 3. _____

2. _____ 4. _____

Supplements or over-the-counter medications you are taking, such as vitamins or ibuprofen:

1. _____ 3. _____

2. _____ 4. _____

Habits (Please circle all that apply):

alcohol chocolate cigarettes coffee laxatives tea sugar or sugar substitutes

Do you consider yourself: overweight average underweight

Describe activity level: sedentary light moderate heavy

Are you primarily responsible for preparing your own meals? yes no

How many of your weekly meals do you eat out? _____

How many glasses of water do you drink each day? _____

List any foods you crave:

_____

_____

List any foods you avoid:

_____

_____

List any special diet or dietary restrictions: _____

_____

Are you following a dietary regimen (Weight Watchers®, etc.)? yes no

Family history of conditions (please list or mark accordingly):

	MOTHER	FATHER	SIBLINGS
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Heart disease	_____	_____	_____
Cancer	_____	_____	_____
Arthritis	_____	_____	_____
Kidney disease	_____	_____	_____
Diabetes	_____	_____	_____
Stomach disorders	_____	_____	_____
Other (please list)	_____	_____	_____

DIETARY PREFERENCES

The purpose of this survey is to discover what you usually eat and drink **five days** a week, not including weekends. The spaces below will help you record your dietary habits. Please be specific when indicating your food choices.

MORNING MEAL

1. Do you usually eat breakfast (five days a week)? Yes No
2. When you have breakfast, is it at home? Yes No
   If not, where? Restaurant Fast Food Cafeteria
3. Do you use a meal substitute, such as Slim-Fast, etc.? _____

Mid-Morning Snacks: _____

MID-DAY MEAL

1. Do you usually eat lunch (five days a week)? Yes No
2. Do you eat lunch at home? Yes No
   If not, where? Carry Lunch Restaurant Fast Food Cafeteria
3. Do you use a meal substitute, such as Slim-Fast, etc.? _____

Mid-Afternoon Snacks: _____

EVENING MEAL

1. Do you usually eat an evening meal (five days a week)? Yes No
2. When you have supper, is it at home? Yes No
   If not, where? Restaurant Fast Food Cafeteria
3. Do you regularly consume an alcoholic beverage before supper? Yes No
4. Do you use any meal substitutes, such as Slim-Fast, etc.? _____

Evening Snacks: _____

OTHER DIETARY ITEMS

1. Do you chew gum? Yes No
2. Do you use breath mints? Yes No
3. Additional food items not listed: _____

_____

FOOD PREFERENCES FORM

Please indicate your food preferences. What do you usually eat and drink?
Based on a **five-day** week, indicate how many times per week you have each item.

	Morning	Snack	Mid-Day	Snack	Evening	Snack	Total
PROTEIN							
Eggs							
Fish							
Meat							
Poultry							
Beans/Tofu/Nuts							
CARBOHYDRATES							
Fruit							
Cooked							
Raw							
Vegetables							
Cooked							
Raw							
Grains							
Cereal							
Rice/Other							
Breads							
Pasta							
Dairy							
Milk							
Cheese							
Ice Cream							
Yogurt							
FATS							
Salad Dressing/Mayo							
Cooking Oil							
Butter/Margarine							
LIQUIDS							
Water							
Juice							
Milk							
Coffee							
Tea							
Soft Drinks							
Alcoholic Beverage							
SNACKS							
Chips							
Candy							
Gum							
Fruit							
Pastry							

Please complete <u>each</u> question; some may be repeated.

PLEASE score each question as follows:

3 = if this is a **MAJOR** problem (severe or happens frequently)
1 = if this is a **MINOR** problem (not severe or happens infrequently)
Blank = if you **NEVER** have this problem

If you do not understand a question, please circle it and we will discuss it.

SECTION ONE

Group A

____ 1. History of speech impediment, stuttering, or stammering
____ 2. Dry, itchy eyes or dry mouth
____ 3. Poor memory
____ 4. Unable to relax, become serene, or meditate
____ 5. Frequent sore or irritated throat

Group B

____ 1. History of diabetes in yourself or family
____ 2. Either functional or reactive hypoglycemia
____ 3. Uncontrollable appetite (i.e., eating when not hungry)
____ 4. Desire to lose weight
____ 5. In need of a meal replacement

Group C

____ 1. History of spinal disc problems or back surgery
____ 2. Unable to tolerate stress (i.e., unable to make decisions)
____ 3. Irritated or receding gums, loose teeth
____ 4. Cold hands and feet
____ 5. Clicking jaw or temporomandibular joint (TMJ) discomfort

Group D

____ 1. History of having difficulty healing after athletic injuries, surgery, or trauma
____ 2. Swelling of soft tissues
____ 3. Cold hands and feet
____ 4. Hot flashes, menopausal symptoms
____ 5. Chronic low back discomfort

Group E

____ 1. History of frequent canker sores, cold blisters, or boils
____ 2. Muscle and tendon weakness, discomfort in lower back and buttocks
____ 3. Slow morning starter, writer's cramp, or stiffness after sitting
____ 4. Dry skin, dandruff, hair falling out
____ 5. Discomfort in the shoulders and rib cage

Group F

____ 1. History of spontaneous abortion, inability to conceive or to induce labor; low sperm count
____ 2. Tremors, stiffness after rest
____ 3. Dry skin, skin manifestations or eruptions
____ 4. Hair loss
____ 5. Chronic shoulder problems

SECTION TWO

Group A

____ 1. History of lactose intolerance or gluten intolerance
____ 2. Craving or thirst for cold liquids or foods
____ 3. Intolerance of dairy products, grains, or sugar
____ 4. Sensitive to air pollutants (i.e., perfumes, smoke)
____ 5. Discomfort or soreness under the left rib cage after eating

Group B

____ 1. History of food sensitivity
____ 2. Bloating after eating dairy or grains
____ 3. Loose stools after eating dairy or grains

Group C

____ 1. History of gallbladder stones or gallbladder surgery
____ 2. Loss of appetite, especially for meat
____ 3. Frequent sour taste in the mouth, intolerance of fats and spicy foods
____ 4. Frequent constipation with light-colored stool
____ 5. Discomfort or soreness under right rib cage or in lower right abdomen after eating

Group D

____ 1. History of diabetes in yourself or family
____ 2. Excessive appetite
____ 3. Tongue coated with thick yellow film
____ 4. Frequent bitter taste in mouth
____ 5. Discomfort or soreness in temporal area on side of head

Group E

____ 1. History of ulcers or gastritis
____ 2. Frequent heartburn or indigestion with nausea and discomfort
____ 3. Acid reflux after eating
____ 4. Frequent use of antacids
____ 5. Stomach discomfort that is relieved by eating

Group F

____ 1. History of chronic gas, bloating, and distention
____ 2. Unusual fullness after eating
____ 3. Rapid ingestion of food without chewing food completely
____ 4. Avoidance of raw foods, especially vegetables
____ 5. Discomfort or soreness in the upper abdominal midline

Group G

____ 1. History of pernicious anemia
____ 2. Loss of taste for meat
____ 3. Strong desire to eat when not hungry
____ 4. Indigestion, particularly two to three hours after eating
____ 5. Lower bowel gas

Group H

____ 1. History of chronic indigestion
____ 2. Unusual fullness after eating
____ 3. Lower bowel gas, unaware of what foods cause the problem
____ 4. Undigested food, capsules, or tablets found in the stool
____ 5. Frequent abdominal cramping or discomfort after eating

SECTION THREE

Group A

____ 1. History of chronic frequent yeast infections
____ 2. Foul odor to stool, urine and/or breath
____ 3. Unusually large appetite (i.e., cannot control the urge to eat)
____ 4. Frequent or prolonged use of antibiotics
____ 5. Discomfort or soreness around navel

Group B

____ 1. History of constipation with infrequent bowel movements
____ 2. Frequent use of laxatives
____ 3. Hard, uncomfortable stools
____ 4. Less than one bowel movement a day
____ 5. Lower abdominal discomfort

Group C

____ 1. History of colitis or other disease of the large intestine
____ 2. Loose stools with mucous or blood in the stool
____ 3. Frequent bowel movements
____ 4. Discomfort with bowel movements
____ 5. Left lower bowel discomfort

Group D

____ 1. Always tired (i.e., unable to meet daily requirements)
____ 2. Loss of appetite or feel better when you don't eat
____ 3. Restless sleep, grinding of teeth
____ 4. Thin, difficult to gain weight
____ 5. Itching around rectum and groin

SECTION FOUR

Group A

____ 1. History of muscular weakness and/or atrophy
____ 2. Inability to tolerate potassium-rich foods (i.e., olives, vegetable juices, bananas)
____ 3. Frequent writer's cramp, stiffness especially after rest
____ 4. Muscle soreness and discomfort resulting from exercise
____ 5. Loss of joint range of motion, discomfort when stretching

Group B

____ 1. History of food sensitivity and non-specific digestive symptoms
____ 2. Frequent raised skin eruptions or hives in response to foods or chemicals
____ 3. Strong reactions to mosquito or insect bites
____ 4. Frequent histamine reactions (i.e., sneezing attacks)
____ 5. Discomfort associated with skin irritations

Group C

____ 1. History of deep bone or joint discomfort
____ 2. Frequent use or need for tranquilizers
____ 3. Frequent infections, need for antibiotics
____ 4. Symptoms of swelling of feet and ankles
____ 5. Any type of acute traumatic incidents/accidents

Group D

____ 1. History of osteoarthritis or gout
____ 2. Musculoskeletal discomfort, difficulty walking, etc.
____ 3. Bone and joint discomfort in the spine, hips, knees, feet, or hands
____ 4. Irritation from overuse or excessive exercise
____ 5. Discomfort or soreness in the knees

Group E

____ 1. History of tuberculosis or COPD
____ 2. Skin problems
____ 3. Being treated for psoriasis
____ 4. Frequent ear infections
____ 5. Discomfort or soreness in the temporal area

Group F

____ 1. History of lymphatic congestion
____ 2. Enlarged lymph nodes
____ 3. Localized swelling
____ 4. Congestion, soft tissue
____ 5. Discomfort or soreness in the shoulders and neck

Group G

____ 1. History of poor immune response or poor ability to heal
____ 2. Lack of appetite
____ 3. Decreased sense of taste
____ 4. Problems with foot odor
____ 5. Discomfort or soreness in the hip joint(s)

SECTION FIVE

Group A

____ 1. History of reactive hypoglycemia
____ 2. Suffer from airborne allergies
____ 3. Dark circles under the eyes
____ 4. Nausea or vomiting-type of indigestion, morning sickness
____ 5. Muscular lower back discomfort

Group B

____ 1. History of frequent bladder infections
____ 2. Frequent urination, urgency, or loss of control
____ 3. Pass small amounts of urine at each voiding
____ 4. Dry skin, flaking, dandruff
____ 5. Discomfort or soreness in the lower abdomen or genital area

Group C

____ 1. History of anemia or other blood disorder
____ 2. Fatigued, tired most of the time
____ 3. Pale skin, lips, and nails
____ 4. Low resistance (i.e., frequent colds and infections)
____ 5. Discomfort or soreness in the left flank area of the abdomen

Group D

____ 1. History of skin disorders, such as acne
____ 2. Frequent skin rashes or eruptions
____ 3. Have many warts or moles
____ 4. Excessive perspiration or lack of perspiration
____ 5. Muscular discomfort or soreness in the lower back

Group E

____ 1. History of hepatitis, jaundice, other liver disorder
____ 2. History of high blood pressure or medication
____ 3. Water retention, swelling of hands and feet
____ 4. Suffer from varicose veins, hemorrhoids
____ 5. Discomfort or soreness in the right flank area of the abdomen

SECTION SIX

Group A

____ 1. Type A personality (i.e., driven and aggressive)
____ 2. Tend to have problems with indigestion and constipation
____ 3. Stiff joints, especially after rest
____ 4. Sensitive to sudden sounds (i.e., startle easily)
____ 5. Headaches in back of the head and neck

Group B

____ 1. History of gallbladder stones or surgery
____ 2. Being treated for high blood pressure
____ 3. Frequent problems with dizziness or vertigo
____ 4. Frequent episodes of fearfulness and sleeplessness
____ 5. Frequent migraine-type headaches

Group C

____ 1. History of cataracts, glaucoma, poor vision
____ 2. Frequent head colds, runny nose, watery eyes
____ 3. Bruise easily, slow healing of cuts, sore or bleeding gums
____ 4. Frequent redness in the eyelids, "sand in your eyes"
____ 5. Frequent headaches associated with eye strain, discomfort when moving eyes

Group D

____ 1. History of chronic sinus problems
____ 2. Loss of sense of smell or an obstruction to nasal breathing
____ 3. Bothered by thick mucous discharges from the nose
____ 4. Frequent nosebleeds
____ 5. Facial discomfort or paralysis

Group E

____ 1. History of or taking medication for heart disease
____ 2. Irregular heartbeat, skipped beats
____ 3. Dryness of skin and hair, itching due to dryness
____ 4. Suffer from varicose veins, hemorrhoids
____ 5. Shoulder or chest discomfort on exertion

Group F

____ 1. History of asthma, emphysema, bronchitis, pneumonia
____ 2. Difficulty breathing, shortness of breath
____ 3. Frequent cough (dry or productive)
____ 4. Wheezing or having difficultly breathing when lying on back
____ 5. Difficult shoulder movement

Group G

____ 1. History of bone disorders, spurs, osteoporosis
____ 2. Muscle soreness and weakness
____ 3. Loose teeth or poor fitting dentures
____ 4. Restlessness, hyperirritability, or restless legs at night
____ 5. Low back discomfort, weak joints or ligaments, fallen arches

Group H

____ 1. History of injury to the tailbone
____ 2. Restlessness or difficulty sleeping
____ 3. Inability to concentrate, frequent daydreaming or nightmares
____ 4. Unresolved health problems
____ 5. Discomfort in the area of the tailbone (i.e., hurts to sit down)

SECTION SEVEN

Group A

____ 1. History of or taking medication for thyroid gland disorders
____ 2. Fast heartbeat (i.e., can feel heart racing)
____ 3. Swollen or uncomfortable breasts
____ 4. Moist warm skin (i.e., sweat easily)
____ 5. Neck, shoulder, arm, hand discomfort

Group B

____ 1. History of low blood pressure problems
____ 2. Awake after a few hours of rest and cannot go back to sleep
____ 3. Suffer from frequent periods of sadness or the inability to think clearly
____ 4. Become light-headed when meals are missed
____ 5. Suffer from frequent nightmares or panic attacks

Group C

____ 1. History of prostate disorders or medication
____ 2. Frequent night urination
____ 3. Dribbling
____ 4. Loss of sexual urge
____ 5. Discomfort radiating into the groin or testes

Group D

____ 1. History of hysterectomy or estrogen replacement therapy
____ 2. Vaginal discharge
____ 3. Excessive menstrual flow
____ 4. Lack of menstruation, scanty flow, irregular periods
____ 5. Symptoms of PMS

Group E

____ 1. Generally tired and lacking ambition or purpose
____ 2. Frequent lack of motivation, inability to get started
____ 3. Fatigued, easily tired
____ 4. Failure to meet ordinary requirements of daily activities
____ 5. Discomfort or soreness in calf muscles when climbing stairs

Thank you for taking the time to fill out this survey accurately and honestly. Your answers will assist us in making a thorough examination of your health and will help us more completely identify your health issues.

Part # 0-7525-1504