



# "Lose It" Intake Questionnaire



***Please answer the questions on this form as they relate to the person being evaluated.***

**Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:**

- *We do not treat symptoms, illness, conditions or diseases.*
- *This is not a treatment for allergies, this does not diagnose allergies or relieve allergies*
- *A symptom is an attempt by your body to tell you something.*
- *We identify substances that may cause stress on the body and work to reduce substance specific stress using a combination of Low Level Light Therapy, Acupoint Stimulation, Homeopathy, Nutrition and Energetic Information to help bring the body back into balance*
- *We do not use drugs in this program.*
- *There is no single method that will work for everyone but this integrative approach can help increase your core level energy, boost your immune system and help your body better deal with substance stressors leading to a higher quality of life • Just because certain substances are considered "healthy" or "safe", this does not mean they are appropriate, "healthy" or "safe" for you.*
- *Your diet and environment consists of everything you **eat, drink, rub on your skin, or inhale***
- *Our procedures are safe, non-invasive and painless.*
- *If you suffer from anaphylaxis, we recommended you consult your primary care physician for medical treatment appropriate for you.*
- *There is no single "healthy" diet that will work for everyone.*

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_

E-mail \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male/Female (circle one)

What do you consider your ideal weight \_\_\_\_\_ Any recent changes in weight?

What is your major nutritional/ health goals? \_\_\_\_\_

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Are you a Vegetarian? If yes, for how long? \_\_\_\_\_

Please list any supplements and/or medications you are currently taking. \_\_\_\_\_

\_\_\_\_\_

How many bowel movements do you have in one day? \_\_\_\_\_

Do you have a regular exercise program? \_\_\_\_\_. If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Do you consider your lifestyle stressful? \_\_\_\_\_

Do you typically eat breakfast, lunch and dinner? \_\_\_\_\_ If no, please explain \_\_\_\_\_

\_\_\_\_\_

***This information is provided for nutritional purposes only.*** The information I am seeking is of an educational and nutritional nature and not a medical diagnosis. It is considered confidential information, and any results received will be documented for research and development reasons only.

***\*Must be signed***

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of clinician \_\_\_\_\_ Date \_\_\_\_\_

# "Lose It" Intake Questionnaire

## DIET SECTION

PLEASE CIRCLE THE FOODS YOU ARE NOW OR HAVE BEEN IN THE PAST  
DRAWN TO

### ***PARA***

Snacks / Crackers / Chips  
Sweets / Candy  
Coffee / Tea  
Bread / Cakes  
Pies / Desserts  
Toast / Jam  
Pasta / Potatoes / Rice  
Fruit / Honey  
Vegetarian meals

### ***ESTRO***

Rich or Heavily Seasoned Foods  
Spicy Foods  
Fried Foods  
Mexican or Chinese Foods  
Pizza  
French Fries  
Creamy Dips  
Sauces / Gravies / Toppings  
Whipped Cream  
Ice Cream  
Butter  
Chocolate

### ***SUPRA***

Alcohol  
Chicken  
Pork Chops / Ham / Bacon  
Steak / Hamburger  
Seafood  
Hot Dogs / Salami  
Pickles  
Olives  
Garlic  
Nuts / Peanuts  
Eggs  
Salt / Salty Foods

### ***NEURO***

Dairy Products  
Milk  
Cheese (hard / cream)  
Ice Cream  
Yogurt  
Frozen Yogurt  
Cottage Cheese  
Fruit Cereal  
Whipped Cream  
Routine Meals  
Sweets

What foods do you like that cause digestive problems (gas, rash, allergies, belching)?

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Pretend you have no health concerns and can have any meal or food. What would it be?

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# "Lose It" Intake Questionnaire

## PAST HISTORY

PLEASE CIRCLE ANY OF THE FOLLOWING PROBLEMS WHICH YOU HAVE NOW OR HAVE EXPERIENCED IN THE PAST

### ***PARA***

PMS	Mood Swings
Cold hands/ feet	Neck/ Shoulder aches
Depression	Pancreatitis
Eczema	Skin eruptions
Fatigue	Sprue/ Wheat intolerance
Brain Fog	Thyroid
Headaches	Low Blood Pressure

### ***ESTRO***

Aching feet	Hepatitis/Jaundice
Arthritis	High Cholesterol
Diabetes	Gallbladder problems
Cirrhosis	Hysterectomy
Cataracts	Breast lumps/tumors
Psoriasis	Menstrual problems
Cystitis Hay	Urinary problems
Fever	Prostate problems

### ***SUPRA***

Alcohol addiction	Arteriosclerosis
Sciatica	High Blood Pressure
Back problems	Gingivitis/Bleeding gums
Belching	Kidney Disease (stones)
Gout	Cardio vascular disease
Loss of hearing	Acid Reflux
Ear infections	Heartburn/indigestion

### ***NEURO***

Aching knees	Crohn's Disease
Diverticulosis	Frequent Infections
Hives	Irritable Bowel
Colds	Milk intolerance
Colitis	Asthma
Weak Constitution	Chronic Allergies
(seasonal/food)	
Chemical/Environmental Sensitivity	

## “Lose It” Intake Questionnaire

Abscesses	Dizziness	HIV/ AIDS	Night blindness
Allergies	Emphysema	Insomnia	Osteoporosis
Anemia	Fainting spells	Lupus	Pneumonia
Bronchitis	Fungal Infections	Malaria	Polio
Cancer	Goiter	Measles	Rheumatic Fever
(type: _____ )	Gonorrhea	Mononucleosis	Scarlet Fever
Candidiasis	Heart disease	Mumps	Sinus Infection
Chicken Pox	Hemorrhoids	Nervous Breakdown	Stroke
Chronic Viral	Hiatal Hernia	Neuralgia	Ulcers
Infections			
Constipation			
Diarrhea			

Other health concerns not listed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REMEMBER: Disease is not bound to happen...it can be overcome!**

# "Lose It" Intake Questionnaire

## PERSONALITY

Choose the group of statements that best describe you in general

### ***PARA***

Outgoing and extroverted  
Sometimes scattered and forgetful  
A people person

### ***ESTRO***

Nurturing and caring  
Organized  
Concerned for other people

### ***SUPRA***

Stubborn and or hard headed  
Not concerned with details, more concerned with big picture  
Enjoy being in control or in charge

### ***NEURO***

Introverted and very analytical  
Detail oriented especially in making decisions  
Creative

Choose the group of traits that best describe your eating habits

### ***PARA***

I enjoy eating/It is entertaining  
Sometimes I forget to eat

### ***ESTRO***

I like to eat for comfort  
I don't like to eat in the mornings

### ***SUPRA***

I will sometimes go all day and without eating and eat a large dinner  
My meal is not complete without meat

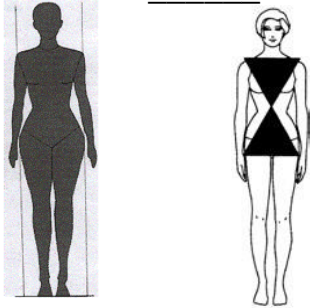
### ***NEURO***

I like to eat a little bit of food throughout the day  
I get sick if I eat too much

# "Lose It" Intake Questionnaire

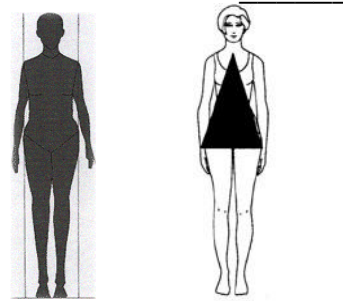
## WHICH ONE BEST DESCRIBES YOUR BODY?

**PARA** \_\_\_\_\_



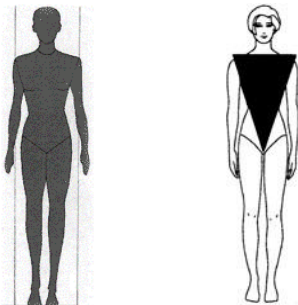
- ◆ Carries weight evenly, but can be held in the waist / stomach area
- ◆ Buttocks are high and round
- ◆ Width of clavicle and hips is equal

**ESTRO/ TESTRO** \_\_\_\_\_



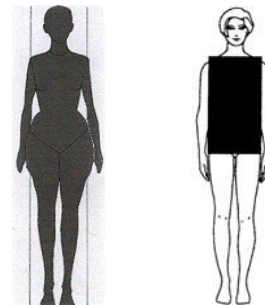
- ◆ Carries weight in the hips and thighs
- ◆ Buttocks are low and flat
- ◆ Width of clavicle are narrower than the distance between the hip points

- ◆ Carry weight in upper body, especially the stomach
- ◆ No buttocks
- ◆ Width of clavicle is wider than distance between the hip points



**SUPRA** \_\_\_\_\_

- ◆ Carry weight fairly evenly and body is soft
- ◆ Remained similar since teens
- ◆ No real distinction between width of clavicle, waist, and hip points



**NEURO** \_\_\_\_\_