The NEW

# Signs Symptoms survey

## Version 5

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).

Patient Name/ID ____________________________

Loomis Institute™

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# PATIENT 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 (Monday–Friday)? 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 (Monday–Friday)? 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 (Monday–Friday)? 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 | | | | | | | |
| Pork/Meat | | | | | | | |
| Chicken | | | | | | | |
| Cheese | | | | | | | |
| Beans/Tofu/Nuts | | | | | | | |
| CARBOHYDRATES | | | | | | | |
| Fruit | | | | | | | |
| Cooked | | | | | | | |
| Raw | | | | | | | |
| Vegetables | | | | | | | |
| Cooked/Soup | | | | | | | |
| Raw/Salad | | | | | | | |
| Grains | | | | | | | |
| Cereal | | | | | | | |
| Rice/Other | | | | | | | |
| Breads/Pastry | | | | | | | |
| Pasta | | | | | | | |
| Dairy | | | | | | | |
| Milk | | | | | | | |
| 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 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) pain

### Group B

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

### Group C

____ 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, sores on tongue or in the mouth

### Group D

____ 1. History of frequent canker sores, cold blisters, or boils
____ 2. Muscle and tendon weakness, pain in lower back and buttocks
____ 3. Slow morning starter, writer's cramp, or stiffness after sitting
____ 4. Dry skin, dandruff, hair loss
____ 5. Painful ribs, pleurisy, or pain on inhalation

### Group E

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

### Group F

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

# SECTION TWO

## Group A

_____ 1. History of diabetes in yourself or family
_____ 2. Excessive appetite
_____ 3. High blood triglyceride levels
_____ 4. Tongue coated with thick yellow film
_____ 5. Frequent bitter taste in mouth

## Group B

_____ 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 C

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

## Group D

_____ 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 E

_____ 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 after eating

## Group F

_____ 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 G

_____ 1. Painful gas
_____ 2. Bloating after eating dairy
_____ 3. Diarrhea after eating dairy

### Group H

____ 1. History of chronic gas, bloating, and distention
____ 2. Unusual fullness after eating
____ 3. Craving or thirst for cold liquids or foods
____ 4. Avoidance of raw foods, especially vegetables
____ 5. Rapid ingestion of food without chewing food completely

## 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. Constipation with hard, dry stool

### Group B

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

### Group C

____ 1. History of colitis or other disease of the large intestine
____ 2. Diarrhea with mucous or blood in the stool.
____ 3. Frequent bowel movements
____ 4. Left lower bowel pain
____ 5. Painful bowel movements

### 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, gnawing of teeth
____ 4. Thin, difficult to gain weight
____ 5. Itching around rectum and groin

## SECTION FOUR

### Group A

____ 1. History of tuberculosis
____ 2. Skin problems, such as dermatitis or eczema
____ 3. Being treated for psoriasis
____ 4. Frequent ear infections
____ 5. Frequent episodes of chills

### Group B

____ 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 pain resulting from exercise
____ 5. Loss of joint range of motion, painful stretching

### Group C

____ 1. History of deep bone or joint pain, painful weak teeth
____ 2. Frequent anxiety, use or need tranquilizers
____ 3. Frequent infections, need for antibiotics
____ 4. Systems of edema (i.e., swelling of feet and ankles)
____ 5. Any type of acute traumatic incidents/accidents

### Group D

____ 1. History of osteoarthritis or gout
____ 2. Musculoskeletal pain, difficulty walking, etc.
____ 3. Bone and joint pain in the spine, hips, knees, feet, or hands
____ 4. Inflammation (i.e., fever, redness, swelling, or pain)
____ 5. Stiff joints/sore muscles, diagnosed with fibromyalgia

### Group E

____ 1. History of chronic herpes-type skin eruptions (i.e., canker sores, cold blisters, boils)
____ 2. Raised and red skin eruptions (i.e., hives, strong reactions to food or chemicals)
____ 3. Strong reactions to mosquito or insect bites
____ 4. Frequent histamine reactions (i.e., sneezing attacks)
____ 5. Painful skin irritations (i.e., sunburn, rashes, chapped lips)

### Group F

____ 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. Pain in the hip joint

## SECTION FIVE

### Group A

____ 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. Getting sleepy after eating

### Group B

____ 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. Varicose veins, hemorrhoids
____ 5. Shoulder and neck stiffness or soreness

### Group C

____ 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 pain

### Group D

____ 1. History of skin disorders, such as acne
____ 2. Dermatitis, eczema, or psoriasis
____ 3. Have many warts or moles
____ 4. Frequent episodes of hives due to food allergies
____ 5. Excessive perspiration or lack of perspiration

### Group E

____ 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. Bladder pain or discomfort

## SECTION SIX

### Group A

____ 1. History of gallbladder stones or surgery
____ 2. High blood pressure
____ 3. Frequent problems with dizziness or vertigo
____ 4. Frequent episodes of fearfulness and insomnia
____ 5. Frequent migraine headaches

### Group B

____ 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 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, pain 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 pain 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. Have varicose veins, hemorrhoids
_____ 5. Shoulder or chest pain 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. Shoulder pain or bursitis

## 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 pain, weak joints or ligaments, fallen arches

## Group H

_____ 1. History of injury to the tailbone
_____ 2. Restlessness or insomnia
_____ 3. Inability to concentrate, frequent daydreaming or nightmares
_____ 4. Unresolved health problems
_____ 5. Painful 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 painful breasts
____ 4. Moist warm skin (i.e., sweat easily)
____ 5. Neck, shoulder, arm, hand pain

### 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 depression 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. Pain 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. Painful periods, 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. Failure to respond to specific nutritional schedules

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.

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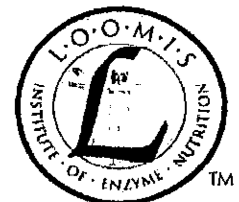


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