

GENERAL INFORMATION SHEET

This questionnaire is for educational purposes only and is not intended to treat individuals. If clients have a medical diagnosis, they are encouraged to seek out treatment from a qualified medical doctor. **Check any boxes if the question applies to you. Please fill out and return to Pam Killeen at her fax 519-204-7953. For more information visit: www.pamkilleen.com.**

Name _____ Age ____ Sex: M F

Date _____

Address _____

City _____ State/Prov. _____

Zip/Postal Code _____

Home Phone _____ Other Phone _____

E-Mail Address _____

Height _____ Weight _____

Occupation _____

How were you referred? _____

What are your main health concerns or conditions?

Please list any medications or food supplements you are currently taking:

Please list any recent medical tests results you have, such as blood tests:

Please list illnesses in your family such as heart disease, cancer, TB, diabetes or arthritis. _____

DIET: What are examples of typical breakfasts for you?

Beverages

**Mid-morning
Snacks**

What are typical lunches for you?

**Mid-afternoon
Snacks**

What are typical dinners for you?

Evening Snacks

How often and what kind of exercise do you do?

About how many hours of sleep do you get per day?

I understand that nutritional balancing is a means to reduce stress and balance body chemistry. It is not intended as diagnosis, treatment or prescription for any condition or disease. I understand that Pam Killeen works as an unlicensed nutrition consultant.

Signed _____ **Date** _____

Name _____

SYMPTOMS SHEET

CIRCLE any conditions or symptoms that presently describe you.

PLACE A STAR next to the symptoms most important to you.

<p>Joint Pain Joint Stiffness Arthritis, Osteo Arthritis, Rheumatoid Muscle Pain Muscle Weakness Muscle Cramps Bursitis Fractures Osteoporosis Gout</p> <p>Sweet Cravings Sugar Reactions Irritable before meals Can't Skip Meals Hypoglycemia Crave Starches Fat Cravings Other Food Cravings Food Allergies Excessive hunger No hunger Diabetes</p> <p>Rapid Heart Rate Skipped Heart Beats Heart Palpitations Heart Attack Poor Circulation Dizziness Low or High Blood Pressure Angina Arteriosclerosis High Cholesterol_____</p> <p>Cough Bronchitis Asthma Post-nasal Drip Sinus Congestion Allergies Emphysema</p> <p>Fatigue Hypothyroidism Low Body Temperature Cold in Winter/Dry Skin Tend to Gain Weight Hyperthyroidism</p>	<p>Acne Eczema Fungal Infections/Candida Psoriasis Hives Hair Loss Slow Wound Healing Cataracts Glaucoma Meniere's Disease Tooth Decay Excessive Plaque on Teeth Gum Disease</p> <p>Infections/Viruses Tumors/Cancer Multiple Sclerosis Parkinson's Disease Scleroderma</p> <p>Anger Anxiety Bipolar Disorder Brain Fog Confusion Depression Irritability Mind Races Mood Swings Obsessive/Compulsive Panic Attacks Poor Memory Schizophrenia Trouble Sleeping</p> <p>Autism Attention Deficit Hyperactivity Dyslexia Seizures Learning Disability Mental Retardation Delayed Development</p> <p>Bladder Infections Kidney Infections Trouble Urinating Frequent Urination Painful Urination Kidney Stones Water Retention Kidney Stones Water Retention</p>	<p>Sinus Headaches Tension Headaches Migraine Headaches Neuritis Eye diseases</p> <p>Constipation Diarrhea Intestinal Gas Bloating Heartburn Ulcer Stomach Pain Colitis Gall Stones Fissures Hemorrhoids Cirrhosis Diverticulitis</p> <p>Tend to Gain Weight Tend to Lose Weight</p> <p>Anemia Easy Bruising</p> <p>Drug Addiction Alcoholism Smoking</p> <p>WOMEN: Premenstrual Syndrome Water Retention Cramps No Menstruation Heavy periods Light/Irregular Periods Ovarian Cysts Fibroid Tumors Abnormal Pap Smear Menopause Fibrocystic Breasts Breast Tumors Yeast Infections Hot Flashes</p> <p>MEN: Prostate Problems Impotence Infertility</p>
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