Case History Questionaire

Please fill out this form, and fax to Vita Royal at *(605) 787-4178*, or mail it to us at *840 Husker Pl, Rapid City SD 57701*. If you have any questions, call us at *(605) 787-5488*. Thank you.

Name: ____________________________________

Best time to call: ______________________________

Home Telephone: ______________________________

Cell Phone: ______________________________

Delivery Address: ______________________________

City, State, Zip: ______________________________

Birth Date: ________________ Height: ________ Weight: ________

Shampoo Brand: ____

Temperatures taken on arising, both oral and axial (under arm), for five consecutive days, before getting up. For menstruating women, on the 4th, 5th, 6th, 7th and 8th day of cycle.

Oral: _____ _____ _____ _____ _____

Axial: _____ _____ _____ _____ _____

Please answer the following questions:

1. Do you sleep on a heated surface? _______
2. Are you cold all of the time? ______
3. How many diets have you been on? _____
4. Which diets were successful? ________________________
5. Do you crave carbohydrates? _____ Chocolate _____

   Breads _____ Cheese _____ Sugar _____ Other _____

6. Are you always fatigued? ______
7. How much caffeine do you drink per day? ________________
8. Do you have ridges on your fingernails? ______
9. Do you have white spots on your fingernails? ______
10. Do you have age spots? ______
11. Do you have any sinus problems? _______
12. What are your sleep habits? Do you have expressive dreams and/or nightmares? ________

____

13. Is there mucus on your stools? ______
14. Do you have pets in the house? ______ Do you worm them on a regular basis? ______
How often? ______________________
15. Do you have problems with bloating? ______
16. Are you tired after eating? ______
17. Do you have food allergies? ______ If yes please list: ______________________________

____

18. Do you exercise? ______ What kind? ____

How often? ____________________

19. Do you smoke? ______ Please give a short history of when and how much, etc.

____

20. Do you drink alcohol? ______ Please give a short history of when and how much, etc.

____

21. Do you use recreational drugs? (to be kept confidential)

____

22. Please list current and past medications ____

____

23. Did you have any problems with pregnancy or childbirth? ___________________________
24. Do you suffer from PMS? ______
25. Do you have irregular menstrual periods? ______
26. Were you hyperactive as a child? ______
27. Do you have bouts with depression and/or crying? ______
28. Do you have heart palpitations? ______
29. Do you have hypertension? ______
30. Do you have diabetes? ______ Which kind? _______________________
31. Do you, or have you ever had cancer? ______ Which kind? _______________________

When? _______________________________

What kind of treatment? ____

32. Do you have high blood fats? ______

33. Please list any unusual childhood diseases ______________________________________

____

34. Do you have digestive problems? _____
35. Do you have bowel problems? _____
36. Have you, at any time in your life, taken antibiotics for respiratory, urinary, acne or other infections (for two months or longer, or in shorter courses four or more times in a one year period? _________
37. Have you at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affecting your reproductive organs? __________________________________38. Have you been pregnant two or more times? _____ Once? _____
39. Have you taken birth control pills for two or more years? _____
For six months to two years? _____
40. Have you taken prednisone, decadron or other cortisone type drugs for more than two weeks? _____ For two weeks or less? _____
41. Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke moderate to severe symptoms or mild symptoms?

____

42. Have you had athlete's foot, ring worm, "jock itch" or other chronic fungus infections of the skin or nails and have such infections been severe and/or persistent or mild to moderate?

____

43. Do you crave alcoholic beverages? _____
44. Does tobacco smoke really bother you? _____

OTHER SYMPTOMS (yes or no)

1. Poor memory? _____
2. Feeling "spacey or unreal"? _____
3. Inability to make decisions? _____
4. Numbness, burning or tingling? _____
5. Insomnia? _____
6. Muscle aches? _____
7. Muscle weakness or paralysis? _____
8. Pain and/or swelling in joints? _____
9. Abdominal pain? _____
10. Constipation? _____
11. Diarrhea? _____
12. Bloating, belching or intestinal gas? _____
13. Troublesome vaginal burning, itching or discharge? _____
14. Impotence? _____
15. Loss of sexual desire or feeling? _____
16. Endometriosis or infertility? _____
17. Attacks of anxiety or crying? _____
18. Cold hands or feet and/or chilliness? _____
19. Shaking or irritable when hungry? _____

20. Irritability or jitteriness? _____
21. Drowsiness? _____
22. Incoordination? _____
23. Inability to concentrate? _____
24. Frequent mood swings? _____
25. Headache? _____
26. Dizziness/loss of balance? _____
27. Pressure above ears, feeling of head swelling? _____
28. Tendency to bruise easily? _____
29. Chronic rashes or itching? _____
30. Numbness, tingling? _____
31. Indigestion or heartburn? _____
32. Food sensitivity or intolerance? _____
33. Rectal itching? _____
34. Dry mouth or throat? _____
35. Rash or blisters in mouth? _____
36. Bad breath? _____
37. Foot, hair or body odor not relieved by washing? _____
38. Nasal congestion or post nasal drip? _____
39. Nasal itching? _____
40. Sore throat? _____
41. Laryngitis, loss of voice? _____
42. Cough or recurrent bronchitis? _____
43. Pain or tightness in chest? _____
44. Wheezing or shortness or breath? _____
45. Urinary frequency or urgency? _____
46. Burning or tearing or eyes? _____
47. Ear pain or deafness? _____
48. Have you ever had, or do you have seizures? _____
49. Do you have severe muscle cramps or spasms? _____ If yes, where? ______________________

The following questions may seem irrelevant, however, understanding your thinking patterns is important to help make this program effective for you.

1. Are you now or have you ever been prone to violent outbursts? _____
2. Do you or did you ever break things? _____
3. Do you have a short temper? _____
4. Do you tend to overreact emotionally to situations & feel guilty afterwards? _____
5. Were you severely disciplined as a child? _____
6. Do you or have you ever felt anger inside for no explained reason? ______
7. Were you involved in a lot of fights as a child? _____
   How about now? _____
8. Are you a strict disciplinarian with your children? _____ Your pets? _____
9. Were you strictly disciplined as a child? _____
10. What was the last grade you completed in school? _____
11. If you attended college, what was your major? _____
12. What is your profession? _____
13. Do you consider yourself religious? _____ Spiritual? _____
14. Are your religious/spiritual beliefs conservative, liberal or in between? ___________