



Denver Nutrition, LLC
Transformation Through Nutrition
303-782-4842 * Fax 720-222-8789

Leave blank if it doesn't apply. Write (1) for Mild, (2) for Moderate, and (3) for Severe.

S Y M	<input type="checkbox"/> Acid food upset <input type="checkbox"/> Get chilled, often <input type="checkbox"/> Lump in throat <input type="checkbox"/> Dry mouth-eyes-nose <input type="checkbox"/> Pulse speeds after meals <input type="checkbox"/> Keyed up- Fail to calm <input type="checkbox"/> Cuts heal slowly	<input type="checkbox"/> Gag easily <input type="checkbox"/> Unable to relax <input type="checkbox"/> Startles easily <input type="checkbox"/> Extremities, cold and clammy <input type="checkbox"/> Strong light irritates <input type="checkbox"/> Urine amount reduced <input type="checkbox"/> Heart Pounds when resting <input type="checkbox"/> Nervous stomach	<input type="checkbox"/> Appetite reduced <input type="checkbox"/> Cold sweats often <input type="checkbox"/> Fever easily raised <input type="checkbox"/> Neuralgia-like pain <input type="checkbox"/> Staring, blinks little <input type="checkbox"/> Sour stomach often
P A R A S	<input type="checkbox"/> Joint stiffness after rising <input type="checkbox"/> Muscle-toe-leg cramps <input type="checkbox"/> Butterfly stomach, cramps <input type="checkbox"/> Eyes or nose watery <input type="checkbox"/> Eyes blink often <input type="checkbox"/> Eyelids swollen, puffy <input type="checkbox"/> Indigestion soon after meals <input type="checkbox"/> Always seems hungry <input type="checkbox"/> Feel lightheaded often	<input type="checkbox"/> Digestion rapid <input type="checkbox"/> Vomiting frequent <input type="checkbox"/> Hoarseness frequent <input type="checkbox"/> Breathing irregular <input type="checkbox"/> Pulse slow, irregular <input type="checkbox"/> Gagging reflex slow <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Constipation and diarrhea alternating	<input type="checkbox"/> Slow starter <input type="checkbox"/> Get chilled frequently <input type="checkbox"/> Perspire easily <input type="checkbox"/> Circulation poor, Sensitive to cold <input type="checkbox"/> Subject to colds, asthma or bronchitis
B S U G	<input type="checkbox"/> Eat when nervous <input type="checkbox"/> Excessive appetite <input type="checkbox"/> Hungry between meals <input type="checkbox"/> Irritable before meals <input type="checkbox"/> Get shaky if hungry <input type="checkbox"/> Fatigue, eating relieves <input type="checkbox"/> Lightheaded with out food	<input type="checkbox"/> Heart palpitates if meals missed <input type="checkbox"/> Afternoon headaches <input type="checkbox"/> Overeating sweet upsets <input type="checkbox"/> Awaken after few house sleep <input type="checkbox"/> Hard to get back to sleep	<input type="checkbox"/> Crave candy or coffee in afternoons <input type="checkbox"/> Moods of depression <input type="checkbox"/> Crave sweets throughout day
C A R D I O	<input type="checkbox"/> Hands and Feet go to sleep <input type="checkbox"/> Sigh frequently <input type="checkbox"/> Aware of breathing heavy <input type="checkbox"/> High altitude discomfort <input type="checkbox"/> Opens windows in closed rooms <input type="checkbox"/> Susceptible to cold and fevers <input type="checkbox"/> Afternoon yawner	<input type="checkbox"/> Get drowsy often <input type="checkbox"/> Swollen ankles worse at night <input type="checkbox"/> Muscle cramps, worse during exercise, get charley horses <input type="checkbox"/> Shortness of breath on exertion <input type="checkbox"/> Dull pain in chest or radiating Into left arm, worse on exertion	<input type="checkbox"/> Bruise easily, black and blue spots <input type="checkbox"/> Tendency to anemia <input type="checkbox"/> Nose bleeds frequent <input type="checkbox"/> Noises in head, or ringing in ears <input type="checkbox"/> Tension under the breastbone, feeling of tightness
L I V G A L	<input type="checkbox"/> Dizziness <input type="checkbox"/> Dry skin <input type="checkbox"/> Burning feet <input type="checkbox"/> Blurred vision <input type="checkbox"/> Itching skin and feet <input type="checkbox"/> Excessive falling hair <input type="checkbox"/> Frequent Skin Rashes <input type="checkbox"/> Bitter, metallic taste in mouth in morning <input type="checkbox"/> Bowel movement difficult	<input type="checkbox"/> Worrier, feel insecure <input type="checkbox"/> Feeling queasy <input type="checkbox"/> Headache over eyes <input type="checkbox"/> Greasy foods upset <input type="checkbox"/> Stools light-colored <input type="checkbox"/> Skin peels on foot soles <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Use laxatives <input type="checkbox"/> Stools alternate soft to watery	<input type="checkbox"/> Gallbladder attacks or stones <input type="checkbox"/> Sneezing attacks <input type="checkbox"/> Dreaming, nightmare type <input type="checkbox"/> Bad breath (halitosis) <input type="checkbox"/> Milk products cause distress <input type="checkbox"/> Sensitive to hot weather <input type="checkbox"/> Burning or itching anus <input type="checkbox"/> Crave sweets
D I G	<input type="checkbox"/> Loss taste for meat <input type="checkbox"/> Lower bowel gas <input type="checkbox"/> Burning stomach sensation <input type="checkbox"/> Eating relieves stomach	<input type="checkbox"/> Coated tongue <input type="checkbox"/> Pass large amounts of foul smelling gas <input type="checkbox"/> Indigestion	<input type="checkbox"/> Mucous colitis <input type="checkbox"/> Irritable bowel <input type="checkbox"/> Gas shortly after eating <input type="checkbox"/> Stomach bloating after eating
T H Y (+)	<input type="checkbox"/> Insomnia <input type="checkbox"/> Nervousness <input type="checkbox"/> Can't gain weight <input type="checkbox"/> Intolerance to heat <input type="checkbox"/> Highly emotional	<input type="checkbox"/> Flush easily <input type="checkbox"/> Night sweats <input type="checkbox"/> Thin, moist skin <input type="checkbox"/> Inward trembling <input type="checkbox"/> Heart palpitates	<input type="checkbox"/> Increased appetite without weight gain <input type="checkbox"/> Pulse fast as rest <input type="checkbox"/> Eyelids and face twitch <input type="checkbox"/> Irritable and restless <input type="checkbox"/> Can't work under pressure
T H Y (-)	<input type="checkbox"/> Increased weight gain <input type="checkbox"/> Decreased in appetite <input type="checkbox"/> Fatigue easily <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sleepy during day	<input type="checkbox"/> Sensitive to cold <input type="checkbox"/> Dry or scaly skin <input type="checkbox"/> Constipation <input type="checkbox"/> Mental sluggishness <input type="checkbox"/> Hair coarse, falls out	<input type="checkbox"/> Headaches upon arising wears off during day <input type="checkbox"/> Slow pulse, below 65 <input type="checkbox"/> Frequency of urination <input type="checkbox"/> Impaired hearing <input type="checkbox"/> Reduced initiative





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P I T (+)	<input type="checkbox"/> Failing Memory <input type="checkbox"/> Low Blood pressure <input type="checkbox"/> Increased Sex drive	<input type="checkbox"/> Headaches splitting or rending type <input type="checkbox"/> Decreased sugar tolerance	
P I T (-)	<input type="checkbox"/> Abnormal thirst <input type="checkbox"/> Bloating of abdomen <input type="checkbox"/> Weight gain around hips or waist	<input type="checkbox"/> Sex drive reduced or lacking <input type="checkbox"/> Tendency to ulcers or colitis <input type="checkbox"/> Increased sugar tolerance	<input type="checkbox"/> Women: menstrual disorder <input type="checkbox"/> Young girls: lack menstrual function
A D R (+)	<input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Increased Blood pressure	<input type="checkbox"/> Hair growth on face of body (female) <input type="checkbox"/> Sugar in urine and not diabetic	<input type="checkbox"/> Masculine tendencies in female
A D R (-)	<input type="checkbox"/> Weakness, dizziness <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Nails weak, rigid <input type="checkbox"/> Tendency to hives <input type="checkbox"/> Arthritic tendencies	<input type="checkbox"/> Perspiration increased <input type="checkbox"/> Bowel disorders <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Crave salt <input type="checkbox"/> Brown spots on skin	<input type="checkbox"/> Allergies <input type="checkbox"/> Tendency towards asthma <input type="checkbox"/> Weakness after colds and flu <input type="checkbox"/> Exhaustion: muscular and nervous <input type="checkbox"/> Respiratory disorders
B	<input type="checkbox"/> Muscle weakness <input type="checkbox"/> Lack of stamina <input type="checkbox"/> Drowsiness after eating <input type="checkbox"/> Muscular soreness	<input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Hyperirritable <input type="checkbox"/> Feeling of a band around your head <input type="checkbox"/> Melancholia	<input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Diminished urination <input type="checkbox"/> Tendency to consume sweet or large amts of carbs.
G	<input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Loss of Muscular Control <input type="checkbox"/> Numbness <input type="checkbox"/> Night Sweat <input type="checkbox"/> Rapid digestion <input type="checkbox"/> Sensitivity to noise	<input type="checkbox"/> Redness of palms of hands and bottom of feet <input type="checkbox"/> Visible veins- chest or abdomen <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Thinning Hair	<input type="checkbox"/> Apprehension <input type="checkbox"/> Nervousness causing loss of appetite <input type="checkbox"/> Nervousness with Indigestion <input type="checkbox"/> Gastritis
F E M A L E	<input type="checkbox"/> Very easily fatigued <input type="checkbox"/> Premenstrual tension <input type="checkbox"/> Painful menses <input type="checkbox"/> Depressed feelings <input type="checkbox"/> Menstruation excessive & long <input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Hysterectomy/ovaries removed <input type="checkbox"/> Menopausal hot flashes <input type="checkbox"/> Menses scanty or missed <input type="checkbox"/> Acne worse during menses <input type="checkbox"/> Depression long standing	
M A L E	<input type="checkbox"/> Prostate trouble <input type="checkbox"/> Urination difficult or dribbling <input type="checkbox"/> Night urination is frequent <input type="checkbox"/> Depression <input type="checkbox"/> Migrating aches and pains	<input type="checkbox"/> Pain on inside of legs or heels <input type="checkbox"/> Feeling of incomplete bowel evacuation <input type="checkbox"/> Lack of energy	<input type="checkbox"/> Tired too easily <input type="checkbox"/> Avoids activity <input type="checkbox"/> Leg nervousness at night <input type="checkbox"/> Diminished sex drive

List 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

List or attach recent (within the past 6 month) lab (blood, saliva, urine, stool) results:

List any other health concerns though up while filling out this form:

