## *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.**

Joint Pain
Joint Stiffness
Arthritis, Osteo
Arthritis, Rheumatoid
Muscle Pain
Muscle Weakness
Muscle Cramps
Bursitis
Fractures
Osteoporosis
Gout

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

Rapid Heart Rate
Skipped Heart Beats
Heart Palpitations
Heart Attack
Poor Circulation
Dizziness
Low or High Blood Pressure
Angina
Arteriosclerosis
High Cholesterol_______
High Triglycerides_____

Cough
Bronchitis
Asthma
Post-nasal Drip
Sinus Congestion
Allergies
Emphysema

Fatigue
Hypothyroidism
Low Body Temperature
Cold in Winter/Dry Skin
Tend to Gain Weight
Hyperthyroidism

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

Infections/Viruses
Tumors/Cancer
Multiple Sclerosis
Parkinson's Disease
Scleroderma

Anger
Anxiety
Bipolar Disorder
Brain Fog
Confusion
Depression
Irritability
Mind Races
Mood Swings
Obsessive/Compulsive
Panic Attacks
Poor Memory
Schizophrenia
Trouble Sleeping

Autism
Attention Deficit
Hyperactivity
Dyslexia
Seizures
Learning Disability
Mental Retardation
Delayed Development

Bladder Infections
Kidney Infections
Trouble Urinating
Frequent Urination
Painful Urination
Kidney Stones
Water Retention
Kidney Stones
Water Retention

Sinus Headaches
Tension Headaches
Migraine Headaches
Neuritis
Eye diseases

Constipation
Diarrhea
Intestinal Gas
Bloating
Heartburn
Ulcer
Stomach Pain
Colitis
Gall Stones
Fissures
Hemorrhoids
Cirrhosis
Diverticulitis

Tend to Gain Weight
Tend to Lose Weight

Anemia
Easy Bruising

Drug Addiction
Alcoholism
Smoking

**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

**MEN:**
Prostate Problems
Impotence
Infertility

**Other Symptoms or Comments:**