Health Questionnaire (NTAF)

Name: _____ Age: _____ Sex: _____ Date: _____

Please circle the appropriate number '0-3' on all questions below. 0 as the least/never to 3 as the most/always.

SECTION A

Is your memory noticeably declining?	0	1	2	3
Are you having a hard time remembering names and phone numbers?	0	1	2	3
Has it become harder for you to learn things?	0	1	2	3
How often do you have a hard time remembering your appointments?	0	1	2	3
Is your temperament worse in general?	0	1	2	3
Are you losing your attention span endurance?	0	1	2	3
How often do you find yourself down or sad?	0	1	2	3
How often do you fatigue when driving when compared to the past?	0	1	2	3
How often do you fatigue when reading compared to the past?	0	1	2	3
How often do you walk into rooms and forget why?	0	1	2	3
How often do you pick up your cell phone and forget why?	0	1	2	3

SECTION B

How high is your stress level?	0	1	2	3
How often do you feel that you have something that must be done?	0	1	2	3
Do you feel you never have time for yourself?	0	1	2	3
How often do you feel you are not getting enough sleep or rest?	0	1	2	3
Do you find it difficult to get regular exercise?	0	1	2	3
Do you feel uncared for by the people in your life?	0	1	2	3
Do you feel you are not accomplishing your life's purpose?	0	1	2	3
Is sharing your problems with someone difficult for you?	0	1	2	3

SECTION C

SECTION C1

How often do you get irritable, shaky, or have lightheadedness between meals?	0	1	2	3
How much are you losing your enthusiasm for your favorite activities?				
How much are you losing enjoyment for your favorite foods?	0	1	2	3
How much are you losing your enjoyment of friendships and relationships?	0	1	2	3
How often do you have difficulty falling into deep restful sleep?	0	1	2	3
How often do you have feelings of dependency on others?	0	1	2	3
How often do you feel more susceptible to pain?	0	1	2	3
How often do you have feelings of unprovoked anger?	0	1	2	3
How much are you losing interest in life?	0	1	2	3

SECTION 2 - D

How often do you have feelings of hopelessness?	0	1	2	3
How often do you have self-destructive thoughts?	0	1	2	3
How often do you have an inability to handle stress?	0	1	2	3
How often do you have anger and aggression while under stress?	0	1	2	3
How often do you feel you are not rested even after long hours of sleep?	0	1	2	3
How easily are you distracted from your tasks?	0	1	2	3
How often do you have an inability to finish tasks?	0	1	2	3
How often do you feel the need to consume caffeine to stay alert?	0	1	2	3
How often do you feel your libido has been decreased?	0	1	2	3
How often do you lose your temper for minor reasons?	0	1	2	3
How often do you have feelings of worthlessness?	0	1	2	3

SECTION 3 - G

How often do you feel anxious or panic for no reason?	0	1	2	3

How often do you feel energized after eating?	0	1	2	3
How often do you have difficulty eating large meals in the morning?	0	1	2	3
How often does your energy level drop in the afternoon?	0	1	2	3
How often do you crave sugar and sweets in the afternoon?	0	1	2	3
How often do you wake up in the middle of the night?	0	1	2	3
How often do you have difficulty concentrating before eating?	0	1	2	3
How often do you depend on coffee to keep yourself going?	0	1	2	3
How often do you feel agitated, easily upset, and nervous between meals?	0	1	2	3
SECTION C2				
Do you get fatigued after meals?	0	1	2	3
Do you crave sugar and sweets after meals?	0	1	2	3
Do you feel you need stimulants such as coffee after meals?	0	1	2	3
Do you have difficulty losing weight?	0	1	2	3
How much larger is your waist girth compared to your hip girth?	0	1	2	3
How often do you urinate?	0	1	2	3
Have your thirst and appetite been increased?	0	1	2	3
Do you have weight gain when under stress?	0	1	2	3
Do you have difficulty falling asleep?	0	1	2	3
SECTION 1 – S				
Are you losing your pleasure in hobbies and interests?	0	1	2	3
How often do you feel overwhelmed with ideas to manage?	0	1	2	3
How often do you have feelings of inner rage?	0	1	2	3
How often do you feel feelings of paranoia?	0	1	2	3
How often do you feel sad or down for no reason?	0	1	2	3
How often do you feel like you are not enjoying life?	0	1	2	3
	0	1	2	3

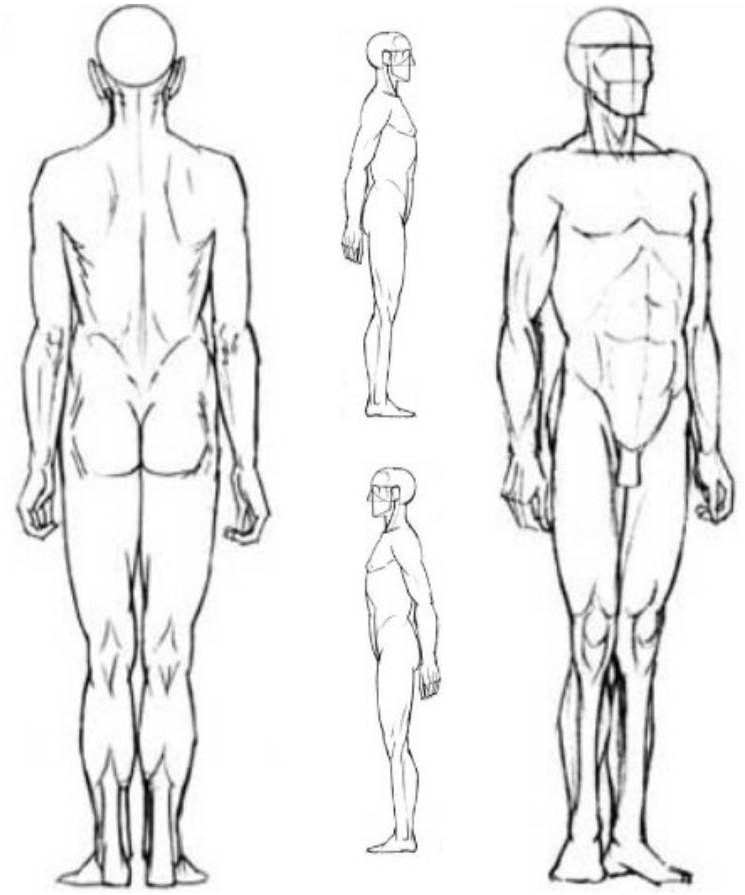
How often do you have feelings of dread or impending doom?	0	1	2	3
How often do you feel knots in your stomach?	0	1	2	3
How often do you have feelings of being overwhelmed for no reason?	0	1	2	3
How often do you have feelings of guilt about everyday decisions?	0	1	2	3
How often does your mind feel restless?	0	1	2	3
How difficult is it to turn your mind off when you want to relax?	0	1	2	3
How often do you have disorganized attention?	0	1	2	3
How often do you worry about things you were not worried about before?	0	1	2	3
How often do you have feelings of inner tension and inner excitability?	0	1	2	3
SECTION 4 - ACH				
Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
Do you feel your verbal memory is decreased?	0	1	2	3
Do you have memory lapses?	0	1	2	3
Has your creativity been decreased?	0	1	2	3
Has your comprehension been diminished?	0	1	2	3
Do you have difficulty calculating numbers?	0	1	2	3
Do you have difficulty recognizing objects & faces?	0	1	2	3
Do you feel like your opinion about yourself has changed?	0	1	2	3
Are you experiencing excessive urination?	0	1	2	3
Are you experiencing slower mental response?	0	1	2	3

How often do you feel you lack artistic appreciation?					
How often do you feel depressed in overcast weather?	0	1	2	3	

NAME: _____ DATE: _____

TRAUMA HISTORY

Natural Health and Healing Center



DIRECTIONS

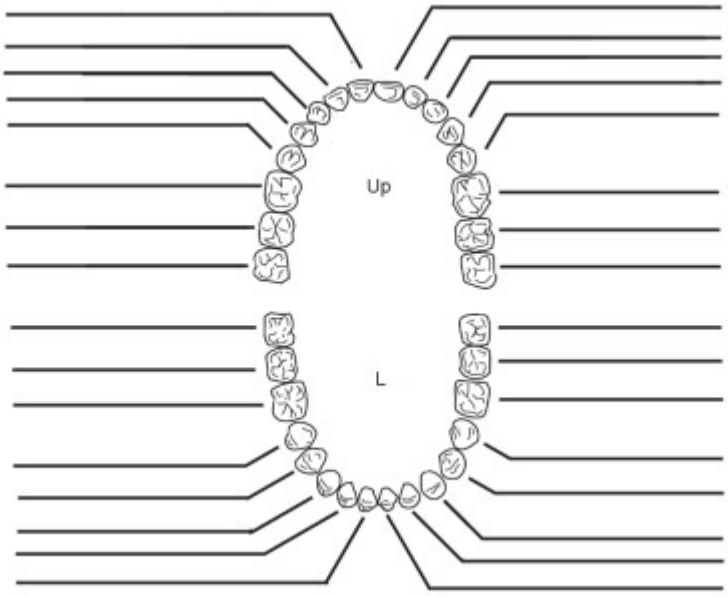
Scars	Please draw a zig-zag over areas where you have scars, even if they are very old or difficult to see. Don't forget C-sections, episiotomies, vaccinations cars, surgeries, body piercings, tattoos, cosmetic surgeries, vasectomies etc. Please note the approximate age you were when you got each scar.
Surgery	Please circle the location of any surgeries, including exploratory surgeries, laparoscopies etc. Please write the year of the surgery on the drawing.
Internal Metal	Please put a square around any internal metal objects, such as surgical pins, metal plates, hip replacements etc.

DENTAL HISTORY

Name: _____ Date: _____

DIRECTIONS: To fill out the chart, briefly describe what type of dental work has been done on each tooth and your approximate age at the time. Include any of the following procedures you have undergone:

- ☐ Silver fillings
- ☐ Composite or porcelain fillings
- ☐ Gold fillings or crowns
- ☐ Root canals
- ☐ Veneers
- ☐ Bridge
- ☐ Dentures
- ☐ Extracted teeth



Area of Primary Concerns(s) *(please circle any or all that apply)*					
ENERGY	PAIN	WEIGHT LOSS	ANTI-AGING	HORMONE BALANCING	CHRONIC SYMPTOMS
Other					

What foods do you crave? Or What foods do you love to eat often?				
Comfort Foods, Hamburgers, Stews, Fried Foods, etc...	Salty or crunchy foods	No specific foods, but I want what I want when I want it	Dairy, Ice Cream, Cheese	Sugar, Sweets, Deserts

If we could wave a magic wand and make one thing better, resolve one issue, what would that be?

Natural Health & Healing Center

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Permission and Authorization Form
Regarding the use of Nutrition Response Testing

I specifically authorize the natural health practitioners at the Natural health & Healing Center to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc in order to assist me in improving my health and not for the treatment, or 'cure' of any disease.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalances in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for 'diagnosing' or 'treating' any disease and that no promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended.

This permission form applies to subsequent visits and consultations.

Print name: _____

Signature: _____
(signature of parent or guardian required for minors)

Date: _____