



IMMUNE SYSTEM

1). Have you ever been diagnosed with an autoimmune disease? Please specify

2). Have you ever had asthma, allergies or acid reflux? Please specify when

3). Have you ever been diagnosed with a virus? When were you diagnosed?
(i.e. Mono, Epstein-Barr, Herpes, chickenpox/shingles?)

4). When stressed, do you experience:
cold sores,
hives,
shingles
or chronic fatigue?



HORMONE

1). Any sleep disturbances?

2). When you wake up in the morning do you feel energized or do you feel you want to sleep longer?

3). Do you feel tired regardless the amount of hours you sleep?

4). Do you get cravings for sugar OR salt? Please specify

5). Do you have difficulty losing and/or gaining weight regardless of diet/exercise regimen you follow?



THYROID

1). Do you get cold hands/feet?

2). Do you easily gain weight?

3). Do you experience constipation?

4). Do you have history of high cholesterol?

ESTROGEN (for Females)

1). Have you ever been diagnosed with PCOS? Fibroids? Endometriosis?

2). Do you have history of migraines?

3). Do you experience hair loss? Low sex drive? Hot flashes?



4). Have you experienced irregular menstrual cycles?

5) Are you getting hair in unwanted places, face, chin, body?

BLOOD SUGAR

1). Have you ever been diagnosed with Diabetes?

2). Do you frequently get thirsty?

3). Do you frequently feel the urge to urinate?

4). Do you feel tired/fatigued after a meal? OR Do you feel energized after a meal?

5). Do you feel "hangry" in the morning before breakfast? (Hungry and angry)



TESTOSTERONE (for Males)

1). Do you urinate frequently and/or have difficulty urinating?

2). Do you suffer from baldness?

3). Do you have difficulty gaining muscle weight when working out?

4). Do you have difficulty losing weight?

5). Do you experience low sex drive?

DIGESTION

1). Do you experience gas and/or bloating after eating?

2). How do you feel after taking probiotics? Any problems?



3). Have you been diagnosed with stomach ulcers or gastritis? SIBO (*Small Intestinal Bacterial Overgrowth*)? Candida? Depression? ADHD?

4). Do you experience skin itching/irritation frequently?

5). Have you recently been experiencing food sensitivity/allergies to food not previously experienced?

6). Do you have any skin conditions? (i.e. psoriasis, eczema, rosacea, acne, etc.)

7) Do you tolerate alcohol badly?

8) How do you feel after taking Kombucha tea?



GENERAL

1). List of medications

a). What do you take them for?

b). Do they help you with your symptoms?

2). List of supplements.



a). What do you take them for?

b). Do they help you with your symptoms?

3). Any history of surgeries? If so when?

Signature: _____ Date: _____