Personal Information:

Name: ____ Age: _______ Date: __________

Gender: __Male__Female   Phone: _____________ Email: ________________________________

Would you like to improve your current state of health and fitness? ☐ Yes ☐ No

Medications:

☐ **Allergy**
Allegra, Benadryl, Claritin, Flonase, Zyrtec, and others

☐ **Antacids/Ulcer/Digestion**
Pepcid, tagamet, zantac, prevacid, prilosec, magnesium, aluminum antacids, & protonix

☐ **Antibiotics**
Gentomycin, neomycin, streptomycin, cephalosporins, penicillins, tetracyclines & gentamicin,fluoroquinolones, cipco, leuaquin, aneiox

☐ **Anticonvulsants**
Phenobarbital & barbiturates, dilantin, tegretol, mysoline, depakane/depakote

☐ **Anti-Depressants**
Adapin, aventyl, elavil, pamelor, & others. Major tranquilizers (thorazin, mellaril, prolixin serentil & others)

☐ **Anti-inflammatories**
Corticosteriods: prednisone, medrol, aristocort, decadron, NSAIDS: (motrin, aleve, advil, anaprox, dolobid, feldene naprosyn, aspirin & salicylates

☐ **Antiviral Agents**
Zidovudine (Retrovir, AZT & other related drugs) & zovirax, foscarnet

☐ **Blood Thinners / Coumadin/Warfarin**
Alteplase, Danaparoid, and others

☐ **Cardiovascular / Blood Pressure**
Antihypertensives (Catapres, aldomet), ACE inhibitors (Capoten, Vasotec, Monopril, & others) beta blockers (Inderal, corgard, lopressor and others)

☐ **Cholesterol**
Lipitor, crestor, zocor, and others

☐ **Diabetic**
Metformin, sulfonylureas (dymelor, tolinase, micronase/glynase/diabeta)

☐ **Diuretics**
Loop diuretics (lasix, buinex, edecrin) tzide diuretics (HCTZ, enduron, diuril, lozol, zaroxolyn, hygroton and others). Potassium sparing diuretics

☐ **Female Hormones/Male Hormones**
Estrogen/hormone replacement, oral contraceptives, Testosterone, Bio-indentical hormones

☐ **Pain**
Aleve, Aspirin, Vicodin, Hydrocodone-acetaminophen, oxycodone, and others

☐ **Sleep**
Ambien, Lunesta, Rozerem, Sonata, Silenor, and others

☐ **Thyroid**
Levothroid, Levoxyl, Synthroid, Cytomel, and others

Others:

____

____

____

Supplements:

☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin E
☐ Fish Oils
☐ GLA (evening primose)
☐ Calcium, source _______________
☐ Magnesium
☐ Zinc
☐ Minerals, describe ______________
☐ Friendly Flora (Acidophilus)
☐ Digestive enzymes
☐ Amino Acids
☐ Antacids

☐ Cholesterol
☐ Antibiotics
☐ CoQ10
☐ Antioxidants (Lutein, resveratrol, etc.)
☐ Herbs-teas
☐ Herbs-extracts
☐ Chinese herbs
☐ Ayurvedic herbs
☐ Homeopathy
☐ Bach flowers
☐ Superfoods (bee pollen, phytonutrient blends)
☐ Liquid meals
☐ Other: ________________________

☐ Antidepressants
☐ Female hormones
☐ Anti-inflammatories
☐ Diuretics
☐ CVD
☐ Diabetic
☐ Blood pressure
☐ Pain
☐ Blood Thinners
☐ Digestion
☐ Heart
☐ Sleep
☐ Other Meds: ____________

Goals:

- ☐ Have more energy and longer endurance
- ☐ Have more motivation
- ☐ Be less tired
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Stop using laxatives
- ☐ Be free of pain
- ☐ Reduce my risk of degenerative disease
- ☐ Slow down my accelerated aging
- ☐ Monitor biomarkers of aging
- ☐ Change from a "treating illness" orientation to creating a wellness lifestyle.
- ☐ Be stronger
- ☐ Be more flexible
- ☐ Get Leaner
- ☐ Be happier
- ☐ Be less moody
- ☐ Be more focused
- ☐ Improve my memory
- ☐ Learn how to reduce stress
- ☐ Learn how to meditate

Would you be interested in a gentle cleansing program to help you achieve your health and fitness goals? ☐**Yes** ☐**No**

Food:

1) Check the following statements that apply:

- ☐ Occasionally or frequently skip meals
- ☐ Currently overweight
- ☐ Crave sweets or carbohydrates
- ☐ Crave stimulants such as coffee/tea/ soda
- ☐ Suffer from chronic pain
- ☐ Suffer from headaches
- ☐ Use artificial sweeteners/diet drinks or diet products
- ☐ Eat fast food/fried foods

2) Balanced eating- Check the following statements that apply:

- ☐ Mixed food diet (animal & vegetable sources)
- ☐ Vegetarian/Vegan
- ☐ Salt Restriction
- ☐ Fat Restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction
- ☐ Specific food restriction
  - ☐ Dairy ☐ Wheat ☐ Eggs
  - ☐ Soy ☐ Corn ☐ All Gluten
  - ☐ Other: ______________________________

3) Eating Frequency- Check the following statements that apply:

- ☐ Skip breakfast or other meals

Meals Per Day:

☐ Five ☐ Four ☐ Three ☐ Two ☐ One

- ☐ Graze-small frequent meals (How many/day): _____________
- ☐ Generally eat on the run
- ☐ Eat fruits everyday
- ☐ Eat Vegetables every day
- ☐ Eat at least one salad per day

Activity:

1) Activity Level:

- ☐ Level 1- Very light work: sitting, standing, driving, reading, computer.
- ☐ Level 2- Light work: Light housework, labor, childcare, mechanic, some sitting.
- ☐ Level 3- Moderate work: Heavy gardening, housework, labor, no sitting.
- ☐ Level 4- Heavy work: Heavy manual labor, construction, digging.

2) Exercise Frequency & Schedule:

- ☐ Number of days per week:________
- ☐ Duration of workout:_____________
- ☐ Use of personal trainer
- ☐ Member of a fitness club
- ☐ Own exercise equipment
- ☐ Walk: days/week _______________
- ☐ Run, Bike, Stairmaster, Eliptical
- ☐ Weight lift
- ☐ Stretch
- ☐ Yoga

3) Digestion:

# of bowel movements per day:________

- ☐ Bloating
- ☐ Gas
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Pain
- ☐ Heartburn
- ☐ Acid Reflux

Stress:

1) Stimulant Use Habits

- ☐ Sugar
- ☐ Tobacco
- ☐ Cigarettes: #/day _________________
- ☐ Cigars: #/day ____________________
- ☐ Alcohol
  - Wine: # glasses/day or week _______
  - Liquor: # glasses/day or week ______
  - Beer: # glasses/day or week________
- ☐ Caffeine:
  - Coffee/tea: # of 6oz. cup/day ___________
  - Soda w/ caffeine: # of cans/day ________
  - Soda w/o caffeine: # of cans/day ________
  - Other sources: ______________________
- ☐ Water:
  - # of 8oz. glasses/day ________________

Circle the level of stress you are experiencing on a scale from 1to 10 (1 being the lowest)

1 2 3 4 5 6 7 8 9 10

Sleep:

Average hours per night of sleep: ___________

Are you able to fall asleep? ☐Y ☐N

Do you suffer from insomnia or sleep disorders? ☐Y ☐N

Do you remember your dreams? ☐Y ☐N

Do you sleep with any electronic devices on (including: light, TV, radio, computer, etc.) ☐Y ☐N

Do you often abruptly awake from sleep? ☐Y ☐N

Do you suffer from depression or mood swings? ☐Y ☐N

DETOXIFICATION QUESTIONNAIRE

Patient Name: ______________________________ **Date:** ______________

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past month ❒ Past week ❒ Past 48 hours

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **TOTAL** _____

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision **TOTAL** _____

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **TOTAL** _____

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **TOTAL** _____

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores **TOTAL** _____

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **TOTAL** _____

HEART
_____ Chest pain
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat **TOTAL** _____

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **TOTAL** _____

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **TOTAL** _____

JOINTS/ MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness or tiredness
_____ Pain or aches in muscles **TOTAL** _____

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ Compulsive eating **TOTAL** _____

ENERGY/ ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **TOTAL** _____

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ Poor concentration
_____ Poor physical coordination **TOTAL** _____

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **TOTAL** _____

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **TOTAL** _____

GRAND TOTAL **TOTAL** _____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
❒ Yes (1 pt.)
If yes, how many are you currently taking? _____ (1 pt. each)
❒ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?
❒ Cimetidine (2 pts.)
❒ Acetaminophen (2 pts.)
❒ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
❒ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
❒ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
❒ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
❒ Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
❒ Yes (2 pts.) ❒ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
❒ Yes (1 pt.) ❒ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

10. Do you have a personal history of
❒ Environmental and/or chemical sensitivities (5 pts.)
❒ Chronic fatigue syndrome (5 pts.)
❒ Multiple chemical sensitivity (5 pts.)
❒ Fibromyalgia (3 pts.)
❒ Parkinson's type symptoms (3 pts.)
❒ Alcohol or chemical dependence (2 pts.)
❒ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
❒ Yes (1 pt.) ❒ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

GRAND TOTAL: ____________

III. Alkalizing Assessment

1. Do you have a history or currently have kidney dysfunction?
❒ Yes ❒ No

2. Have you ever been diagnosed with a condition known as hyperkalemia?
❒ Yes ❒ No

3. Are you currently on diuretics or blood pressure medication?
❒ Yes ❒ No

Note: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.

For Practitioner Use Only:

OVERALL SCORE TABULATION

See doctor brochure for protocol suggestions.

MSQ SCORE __________ (High >50; moderate 15-49: Low <14)
XTT SCORE __________ (High >10; moderate 5-9: Low <4)
URINARY pH __________

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

FirstLineTherapy®

Diet Diary / Exercise Log

Name:_______________________________

Please complete your "Diet Diary / Exercise Log" every day.

1.) Make note of the time you wake up.

2.) List and describe in detail all foods and drinks including the amount of each. Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc. Note the time of each meal or snack. Be sure to list everything you eat or drink, including any condiments used (i.e. mayonaise, mustard, relish, etc.).

3.) Keep track of how much water you drink and list the amount in ounces in the section provided. Also note the type and amount of any other drinks you consume.

4.) Write down any activity or exercise you do in the section at the bottom, listing the kind of exercise you did and for how long you did it.

5.) Note any periods of relaxation and what kind of relaxation it was.

6.) Note the time you go to sleep.

Day 1	Date:
Wake up:	
Morning Meal Time:	
Snack Time:	
Mid-Day Meal Time:	
Snack Time:	
Evening Meal Time:	
Snack Time:	
Water (ounces)	
Other Drinks (that are not listed with meals or snacks above)	
Activity/Exercise What kind: How long:	
Relaxation type: How long:	
sleep time:	

FirstLineTherapy®

Diet Diary / Exercise Log

	Day 2 - Date:	Day 3 - Date:
Wake up:		
Morning Meal Time:		
Snack Time:		
Mid-Day Meal Time:		
Snack Time:		
Evening Meal Time:		
Snack Time:		
Water (ounces)		
Other Drinks (that are not listed with meals or snacks above)		
Activity/Exercise What kind: How long:		
Relaxation type: How long:		
sleep time:		

FirstLineTherapy®

Diet Diary / Exercise Log

	Day 4 - Date:	Day 5 - Date:
Wake up:		
Morning Meal Time:		
Snack Time:		
Mid-Day Meal Time:		
Snack Time:		
Evening Meal Time:		
Snack Time:		
Water (ounces)		
Other Drinks (that are not listed with meals or snacks above)		
Activity/Exercise What kind: How long:		
Relaxation type: How long:		
sleep time:		

FirstLineTherapy®

Diet Diary / Exercise Log

	Day 6 - Date:	Day 7 - Date:
Wake up:		
Morning Meal Time:		
Snack Time:		
Mid-Day Meal Time:		
Snack Time:		
Evening Meal Time:		
Snack Time:		
Water (ounces)		
Other Drinks (that are not listed with meals or snacks above)		
Activity/Exercise What kind: How long:		
Relaxation type: How long:		
sleep time:		