Thank you for your interest in receiving care. Enclosed you will find a collection of forms I ask you to complete and return. Please take your time and be very thorough and honest. This will best enable me to determine proper care recommendations.

I also ask that you send me copies of all recent lab work and imaging reports that you've had completed. The past six months is the most important, but earlier exams can prove helpful as well.

When you have completed the enclosed forms, please make a copy before returning. Email is most convenient (kevin@tbmseminars.com) but you may also send them to Kevin S. Millet, 8461 Farm Road, Suite 120-183 Las Vegas, Nevada 89131 USA.

Once I receive the packet, I will contact you to confirm receipt and schedule necessary follow-up. If you haven't heard back, feel free to phone me at +1 (435) 652-4340.

I am excited at this opportunity to be of assistance and look forward to beginning.

Cheers,

Dr. Kevin S. Millet

Please supply the following contact information, even if you believe we already have some or all of it:

Name:

Address:

Phone number(s):

Email:

TBM

Total Body Modification

TERMS OF ACCEPTANCE
For Kevin S. Millet & Attunement Services

This document constitutes informed consent for services provided by Kevin S. Millet.

> *When a client seeks my services and I accept that client, it is essential that we interact within the same framework to prevent confusion and disappointment, and to maximize efficiency and effectiveness. To that end, I offer the following.*
>
> *Thank you.*

A *dissonant bioprogram* is a stored memory constellation which elicits disadvantageous physiological responses. In my experience most acute and chronic pain, stress, and other unwanted symptoms are both initiated and maintained by dissonant bioprograms. Subtle-influence medicine (SIM), a tradition of healing which began being taught in Paris, France in 1783, aims to artificially adapt dissonant bioprograms into resonant ones. This is known as an *attunement*. SIM achieves attunements utilizing the natural mechanisms underlying the processing of incoming stimuli and the accessing of stored memories.

I do not offer to diagnose, treat, or cure any disease or condition, whether physical, mental, or emotional other than dissonant bioprograms. I do not offer to prescribe any medication. I do not offer therapy in any form. **I offer to solely address the pertinent dissonant bioprograms which interfere with the full expression of ease, vitality, and peace.** This is accomplished through conversations and directed contact.

Furthermore, while having received extensive medical training, including a Doctor of Chiropractic in 1989, and holding dormant licenses in two United States, neither of which are where I provide services (Nevada), none of the services I currently offer are under the auspices of any license, chiropractic or otherwise. All services are non-therapeutic and therefore do not include any elements which would require the maintenance of any medical license.

By signing below, you accept the responsibility to keep me informed and updated regarding any accidents, injuries, surgeries, illnesses, medications, or other factors that could relate to the safeness and effectiveness of receiving the services described above. You also affirm that you have read the preceding paragraphs and that all questions pertaining to receiving services subject to the above-described conditions have been answered to your satisfaction prior to placing your signature below. And that you accept those conditions and affirm your intent to work with me as I have outlined above.

Full Legal Name_____ DOB ____/____/____

Signature (actual)_____ Date____/____/____

Complete if client is a minor or declared mentally incompetent.

I, being the parent or legal guardian of the individual listed below, have read, had any questions I had answered to my satisfaction, and signed the above “terms of acceptance.” I hereby grant permission for the following individual to receive services as described above by Dr. Millet.

Minor’s Full Legal Name_____ DOB ____/____/____

Signature (actual)_____ Date____/____/____

Health and Lifestyle Questionnaire

Name _____Date _____DOB_____

Completed by (if different from above) _____

The information you provide below will be held strictly confidential. It will only be shared with those directly involved in providing services, including colleague consultations when called for.

What has brought you to desire care at this particular? Please describe what your primary health goals are. _____

Name _____DOB _____

What have you done already in an attempt to achieve these goals (e.g. health practitioners, treatments, nutrition)?_____

Kevin S. Millet 8461 Farm Road, Suite 120-183 Las Vegas, Nevada 89131 USA

Name _____DOB _____

What do you feel is a reasonable length of time in which to achieve these goals? _____

Kevin S. Millet 8461 Farm Road, Suite 120-183 Las Vegas, Nevada 89131 USA

Name _____DOB _____

In your opinion, is your overall health currently getting better, worse, or staying the same. How do you know?_____

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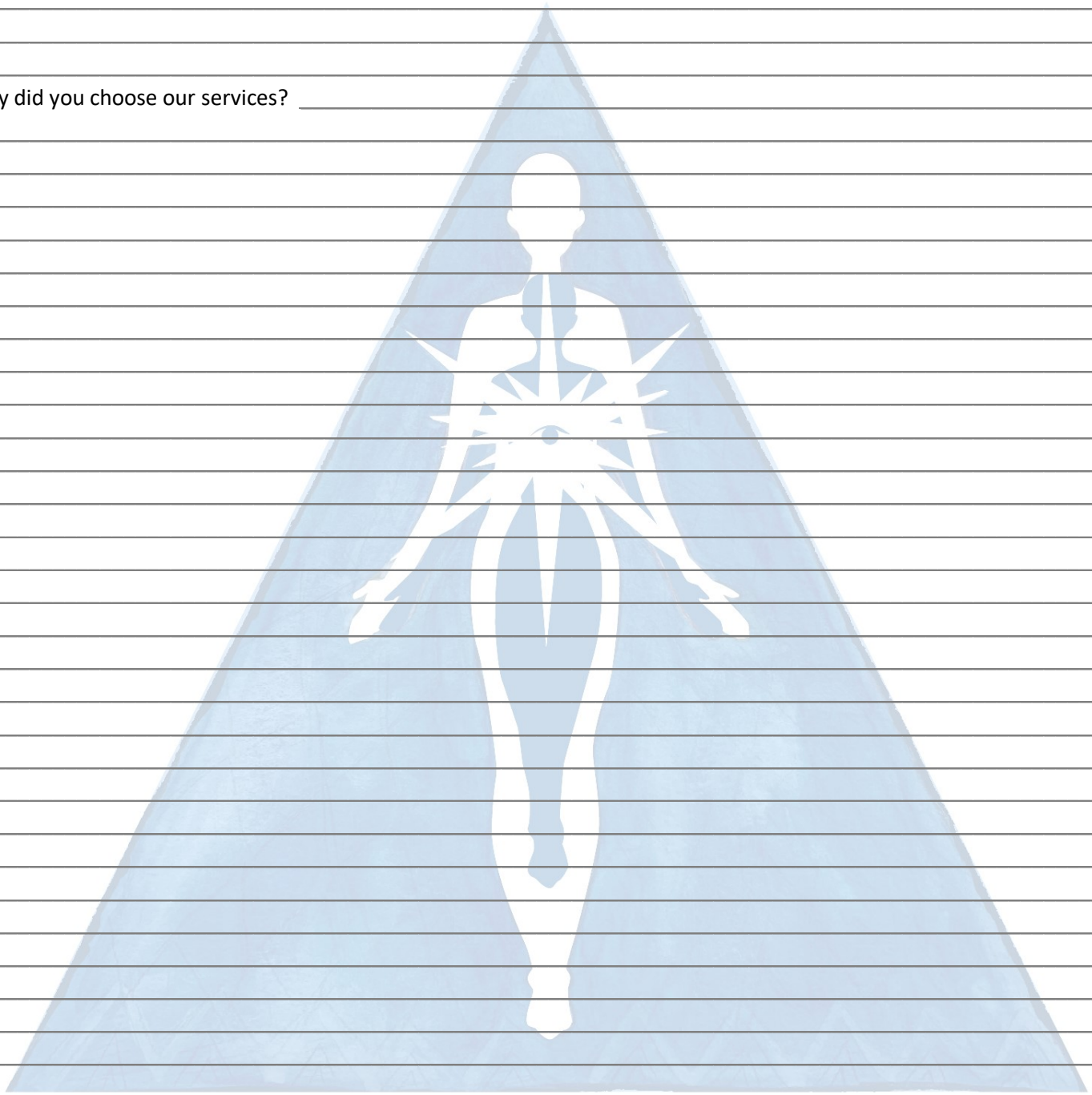
Name _____DOB _____

Why did you choose our services? _____



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Name _____DOB _____

The following questions pertain to activities that can significantly affect your program. Please check the box (☑) and provide details (e.g. degree, onset and termination of the practice) if you are currently or have ever done any of the following:

☐ Avoided salt? _____
☐ Abstained from beef and other red meats? _____
☐ Practiced vegetarianism? _____
☐ Practiced veganism? _____
☐ Has your principal beverage been something other than water (e.g. soda, coffee, juice, sports drinks, beer)? _____
_____
☐ Drank primarily water that has been "alkalized (e.g Kangen, PiMag)" or structurally altered water (e.g. Penta)? _____
_____
☐ Abused alcohol? _____
☐ Contemplated or attempted suicide? _____
☐ Used marijuana? _____
☐ Avoided dietary fat? _____
☐ Avoided animal fats? _____
☐ Fasted? _____
☐ Dieted? _____
☐ Cleansed?_____
☐ Received colonic irrigation? _____
☐ Took oral antibiotics? _____
☐ Received amalgam (metallic) dental fillings? If yes, intentionally removed?_____
☐ Received surgery to remove all or part of any organs? Please list._____
_____
_____
☐ Regularly skipped breakfasts?_____
☐ Regularly avoided sun exposure, including using sunscreen lotion? _____
_____

To the degree that you are aware, what foods and specific food preparation techniques were utilized by your ancestors?
_____
_____

To what degree have you maintained these customs?_____
_____

Do you now or have you ever taken fish oil? ☐ Yes ☐ No If so, do you have fishes burps following? ☐ Yes ☐ No
Do you awaken hungry during the night or in the morning? ☐ Yes ☐ No
Do you now or have you taken nutritional supplements? If so, please provide dosage, frequency, reason for taking and brand names to the degree you can remember._____
_____
_____

Name _____DOB _____

Exercise habits

Please describe the frequency and duration of all non-work-related physical activity (walking, cycling, yoga, qigong, weight training)?_____

Sleep habits

Do you awaken feeling refreshed? ☐ Yes ☐ No

Do you climb into bed and get out of bed on a regular schedule? ☐ Yes ☐ No

How long does it take for you to fall asleep?_____

Do you regularly awake during the night? If so, how many times? _____

Bowel patterns

Do you have a regular bowel pattern that include 2 – 4 bowel movements per day ? ☐ Yes ☐ No

Is your stool…Well-formed? ☐ Yes ☐ No Tapered on both ends? ☐ Yes ☐ No Caramel colored ☐ Yes ☐ No

Free from undigested food particles? ☐ Yes ☐ No If "No" to any of these, please describe _____

_____

Eating patterns

How many times a day do you eat a meal ? _____

Are your mealtimes generally consistent from day-to-day? ☐ Yes ☐ No

Do you snack? ☐ Yes ☐ No If so, on what and how often? _____

Please list any other lifestyle habits not previously discussed you believe may be adversely affecting your health (e.g. smoking, lack of exercise, addictions, not drinking enough water, workaholic) _____

Name _____DOB _____

What is your present level of commitment to change the underlying causes of problem(s) which relate to your lifestyle? (Rate from 1 to 10, with 10 beings 100% committed). _____

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Name _____DOB _____

What obstacles could prevent you from changing those lifestyle factors that are undermining your health? _____

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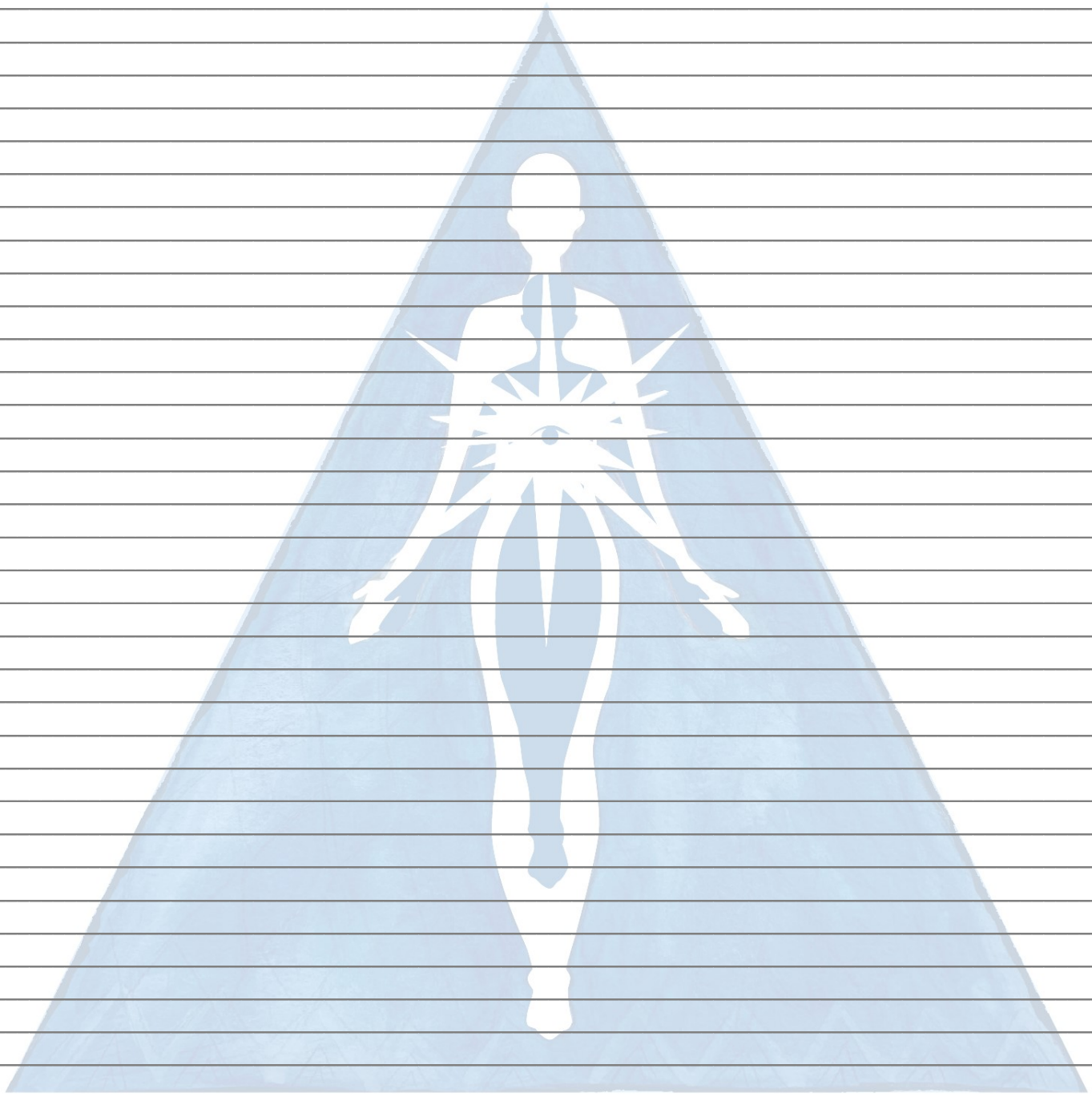
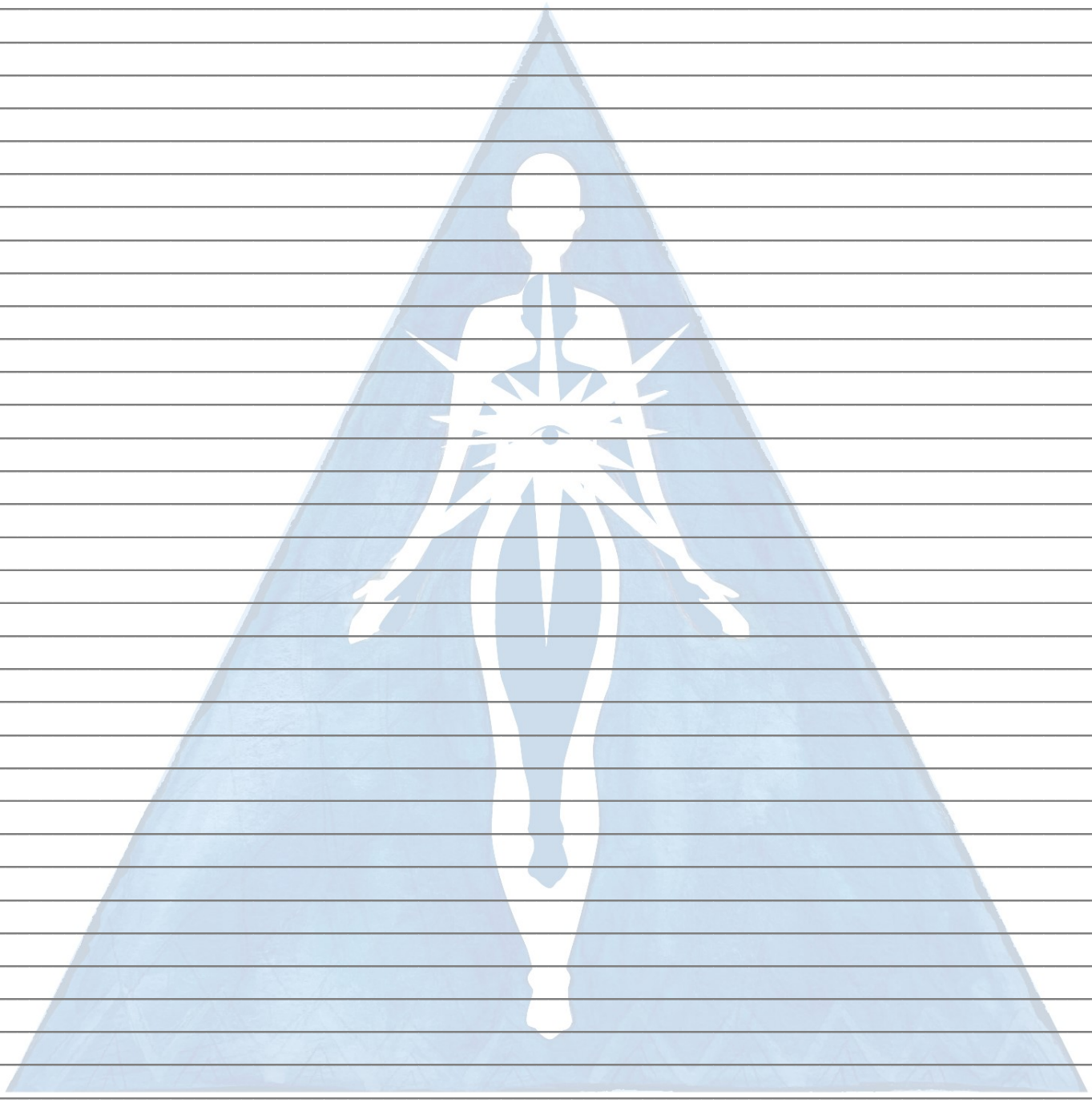
Name _____DOB _____



What concerns do you have that may prevent or make it difficult for you to participate in our program? (For example: participating in alternative health care, care for children while I'm at appointments, distance, financial limitations, taking supplements, time restraints, fear of medical testing)

Kevin S. Millet 8461 Farm Road, Suite 120-183 Las Vegas, Nevada 89131 USA

Name _____DOB _____



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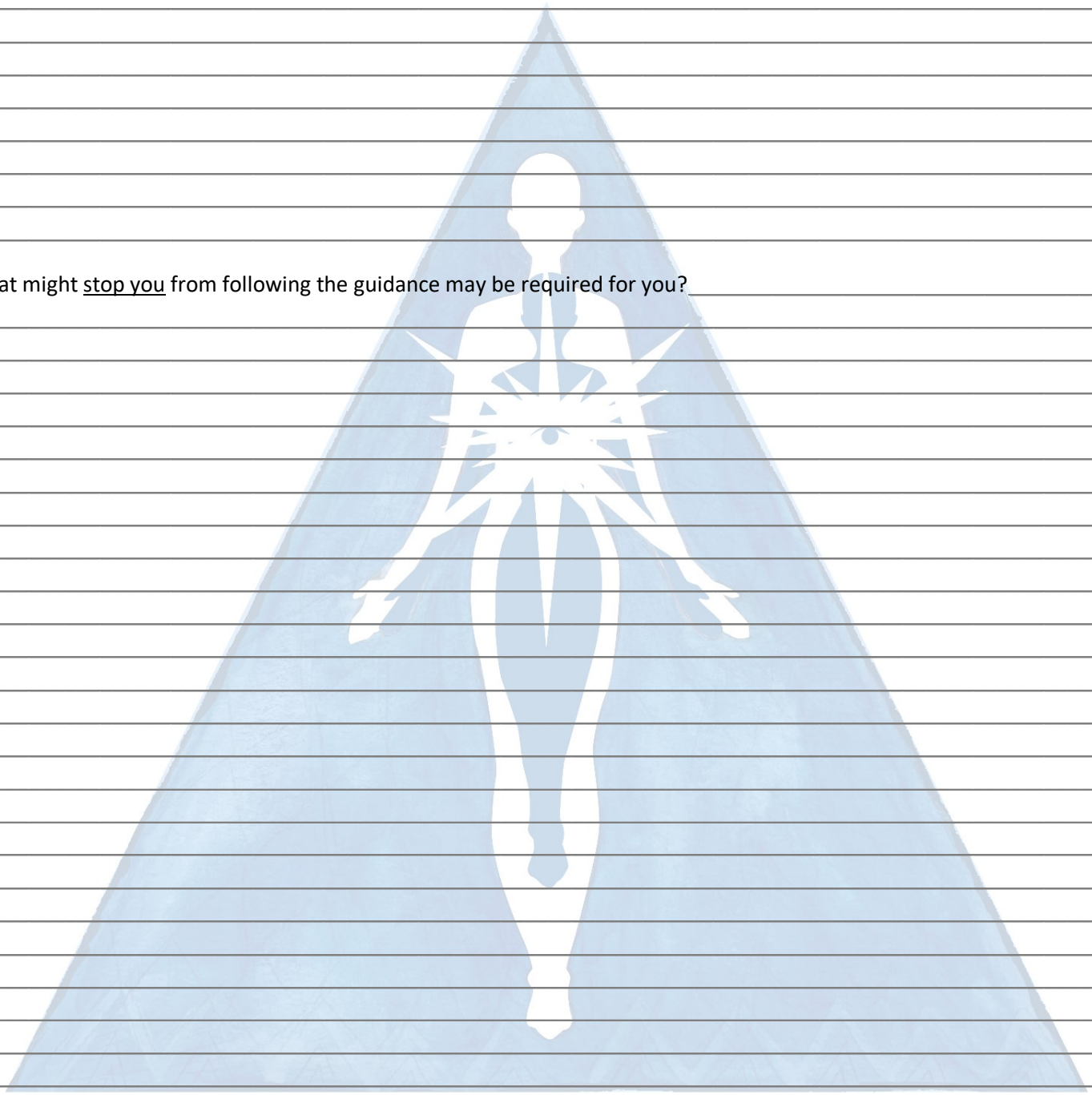
Name _____DOB _____

What might <u>stop you</u> from following the guidance may be required for you?_____



Kevin S. Millet 8461 Farm Road, Suite 120-183 Las Vegas, Nevada 89131 USA

Name _____DOB _____

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Current Medication and Supplementation Usage

Product	Dosage	Reason for Taking	How Long?

Medication Attunement Client Application Form

Name_____ DOB_____ Date_____

Please list below all medications, by their generic names rather than trade name, you can recollect, or obtain with a reasonable amount of research, having taken or having been administered throughout your entire lifetime. Please consult relevant medical facilities and other medical records to enhance completeness. Please list the **complete generic name** (e.g. Ethinylestradiol/etonogestrel for NuvaRing). Please also list **over-the-counter** medications as well. We offer you the following categories to help you in recalling past or current medicines as well as to assist your practitioner. Thank you.

Antimicrobial (e.g. antibiotics, antivirals)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Antineoplastic (e.g. chemotherapy)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Cardiovascular (e.g. cholesterol lowering, high blood pressure, heart meds)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Contraceptive & Abortifacient (e.g. birth control, “morning after,” medical abortion)

Dermatologic & Cosmetic (e.g. Botox, acid peels, acne, fillers, hair growth)

Diabetic (e.g. insulins, pancreas stimulators, insulin sensitizers)

Endocrinological (e.g. hormones, puberty blockers)

Gastrointestinal (e.g. acid blockers, laxatives)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Pain Management (e.g. pain killers, NSAIDs, anesthetics)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Psychotropic (e.g. anti-anxiety, antidepressants, antipsychotics)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Respiratory (e.g. cough suppressants, inhalers)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Vaccines/Inoculations (e.g. childhood vaccines, “flu shots,” COVID)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other (e.g. anticonvulsants, stimulants, anti-obesity)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Recreational (e.g. Exstacy, Magic Mushrooms, cannabis, LSD) *NOTE: may be shared orally during consultation.*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Total Body Modification

FACIT-Sp (Version 4)

Below is a list of statements that other people with your illness have said are important. **By circling one (1) number per line, please indicate how true each statement has been for you during the past 7 days.**

	PHYSICAL WELL-BEING	Not at all	A little bit	Some-what	Quite a bit	Very much
GP1	I have a lack of energy	0	1	2	3	4
GP2	I have nausea	0	1	2	3	4
GP3	Because of my physical condition, I have trouble meeting the needs of my family	0	1	2	3	4
GP4	I have pain	0	1	2	3	4
GP5	I am bothered by side effects of treatment	0	1	2	3	4
GP6	I feel ill	0	1	2	3	4
GP7	I am forced to spend time in bed	0	1	2	3	4

	SOCIAL/FAMILY WELL-BEING	Not at all	A little bit	Some-what	Quite a bit	Very much
GS1	I feel close to my friends	0	1	2	3	4
GS2	I get emotional support from my family	0	1	2	3	4
GS3	I get support from my friends	0	1	2	3	4
GS4	My family has accepted my illness	0	1	2	3	4
GS5	I am satisfied with family communication about my illness	0	1	2	3	4
GS6	I feel close to my partner (or the person who is my main support)	0	1	2	3	4
Q1	*Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please check this box* ☐ *and go to the next section.*					
GS7	I am satisfied with my sex life	0	1	2	3	4

By circling one (1) number per line, please indicate how true each statement has been for you during the past 7 days.

	EMOTIONAL WELL-BEING	Not at all	A little bit	Some-what	Quite a bit	Very much
GE1	I feel sad	0	1	2	3	4
GE2	I am satisfied with how I am coping with my illness	0	1	2	3	4
GE3	I am losing hope in the fight against my illness	0	1	2	3	4
GE4	I feel nervous	0	1	2	3	4
GE5	I worry about dying	0	1	2	3	4
GE6	I worry that my condition will get worse	0	1	2	3	4

	FUNCTIONAL WELL-BEING	Not at all	A little bit	Some-what	Quite a bit	Very much
GF1	I am able to work (include work at home)	0	1	2	3	4
GF2	My work (include work at home) is fulfilling	0	1	2	3	4
GF3	I am able to enjoy life	0	1	2	3	4
GF4	I have accepted my illness	0	1	2	3	4
GF5	I am sleeping well	0	1	2	3	4
GF6	I am enjoying the things I usually do for fun	0	1	2	3	4
GF7	I am content with the quality of my life right now	0	1	2	3	4

FACIT-Sp (Version 4)

By circling one (1) number per line, please indicate how true each statement has been for you during the past 7 days.

	ADDITIONAL CONCERNS	Not at all	A little bit	Some-what	Quite a bit	Very much
Sp1	I feel peaceful	0	1	2	3	4
Sp2	I have a reason for living	0	1	2	3	4
Sp3	My life has been productive	0	1	2	3	4
Sp4	I have trouble feeling peace of mind	0	1	2	3	4
Sp5	I feel a sense of purpose in my life	0	1	2	3	4
Sp6	I am able to reach down deep into myself for comfort	0	1	2	3	4
Sp7	I feel a sense of harmony within myself	0	1	2	3	4
Sp8	My life lacks meaning and purpose	0	1	2	3	4
Sp9	I find comfort in my faith or spiritual beliefs	0	1	2	3	4
Sp10	I find strength in my faith or spiritual beliefs	0	1	2	3	4
Sp11	My illness has strengthened my faith or spiritual beliefs	0	1	2	3	4
Sp12	I know that whatever happens with my illness, things will be okay	0	1	2	3	4

FIBROMYALGIA IMPACT QUESTIONNAIRE (FIQ)

Name: _____ Date: / /

Directions: For questions 1 through 11, please circle the number that best describes how you did overall for the *past week*. If you don't normally do something that is asked, cross the question out.

	Always	Most	Occasionally	Never
Were you able to:				
Do shopping? ……	*0*	*1*	*2*	*3*
Do laundry with a washer and dryer?	*0*	*1*	*2*	*3*
Prepare meals?	*0*	*1*	*2*	*3*
Wash dishes/cooking utensils by hand?.....	*0*	*1*	*2*	*3*
Vacuum a rug?.....	*0*	*1*	*2*	*3*
Make beds?	*0*	*1*	*2*	*3*
Walk several blocks?	*0*	*1*	*2*	*3*
Visit friends or relatives?	*0*	*1*	*2*	*3*
Do yard work?.....	*0*	*1*	*2*	*3*
Drive a car?	*0*	*1*	*2*	*3*
Climb stairs?	*0*	*1*	*2*	*3*

12. Of the 7 days in the past week, how many days did you feel good?

0 1 2 3 4 5 6 7

13. How many days last week did you miss work, including housework, because of fibromyalgia?

0 1 2 3 4 5 6 7

(continued)

FIBROMYALGIA IMPACT QUESTIONNAIRE (FIQ) – page 2

Directions: For the remaining items, mark the point on the line that best indicates how you felt overall for the past week.

14. When you worked, how much did pain or other symptoms of your fibromyalgia interfere with your ability to do your work, including housework?

No problem with work •___|___|___|___|___|___|___|___|___|___• Great difficulty with work

15. How bad has your pain been?

No pain •___|___|___|___|___|___|___|___|___|___• Very severe pain

16. How tired have you been?

No tiredness •___|___|___|___|___|___|___|___|___|___• Very tired

17. How have you felt when you get up in the morning?

Awoke well rested •___|___|___|___|___|___|___|___|___|___• Awoke very tired

18. How bad has your stiffness been?

No stiffness •___|___|___|___|___|___|___|___|___|___• Very stiff

19. How nervous or anxious have you felt?

Not anxious •___|___|___|___|___|___|___|___|___|___• Very anxious

20. How depressed or blue have you felt?

Not depressed •___|___|___|___|___|___|___|___|___|___• Very depressed

Metabolic Assessment Form

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

PART I

Please list the 5 major health concern in your order of importance:

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

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

Category I				
Feeling that bowels do not empty completely	**0**	**1**	**2**	**3**
Lower abdominal pain relief by passing stool or gas	**0**	**1**	**2**	**3**
Alternating constipation and diarrhea	**0**	**1**	**2**	**3**
Diarrhea	**0**	**1**	**2**	**3**
Constipation	**0**	**1**	**2**	**3**
Hard dry or small stool	**0**	**1**	**2**	**3**
Coated tongue of "fuzzy" debris on tongue	**0**	**1**	**2**	**3**
Pass large amount of foul smelling gas	**0**	**1**	**2**	**3**
More than 3 bowel movements daily	**0**	**1**	**2**	**3**
use laxatives frequently	**0**	**1**	**2**	**3**
Category II				
Excessive belching burping or bloating	**0**	**1**	**2**	**3**
Gas immediately following a meal	**0**	**1**	**2**	**3**
Offensive breath	**0**	**1**	**2**	**3**
Difficult bowel movements	**0**	**1**	**2**	**3**
Sense of fullness during and after meals	**0**	**1**	**2**	**3**
Difficulty digesting fruits and vegetables; undigested foods found in stools	**0**	**1**	**2**	**3**
Category III				
Stomach pain, burning or aching 1- 4 hours after eating	**0**	**1**	**2**	**3**
Do you frequently use antacids	**0**	**1**	**2**	**3**
Feeling hungry an hour or two after eating	**0**	**1**	**2**	**3**
Heartburn when lying down or bending forward	**0**	**1**	**2**	**3**
Temporary relief from antacids, food, milk, carbonated beverages	**0**	**1**	**2**	**3**
Digestive problems subside with rest and relaxation	**0**	**1**	**2**	**3**
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	**0**	**1**	**2**	**3**
Category IV				
Roughage and fiber cause constipation	**0**	**1**	**2**	**3**
Indigestion and fullness lasts 2-4 hours after eating	**0**	**1**	**2**	**3**
Pain, tenderness, soreness on left side under rib cage	**0**	**1**	**2**	**3**
Excessive passage of gas	**0**	**1**	**2**	**3**
Nausea and/or vomiting	**0**	**1**	**2**	**3**
Excessive passage of gas	**0**	**1**	**2**	**3**
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Category V				
Greasy or high fat foods cause distress	**0**	**1**	**2**	**3**
Lower bowel gas and or bloating several hours after eating	**0**	**1**	**2**	**3**
Bitter metallic taste in mouth, especially in the morning	**0**	**1**	**2**	**3**
Unexplained itchy skin	**0**	**1**	**2**	**3**
Yellowish cast to eyes	**0**	**1**	**2**	**3**
Stool color alternates from clay colored to normal brown	**0**	**1**	**2**	**3**
Reddened skin, especially palms	**0**	**1**	**2**	**3**
Dry or flaky skin and/or hair	**0**	**1**	**2**	**3**
History of gallbladder attacks or stones	**0**	**1**	**2**	**3**
Have you had your gallbladder removed	**Yes**		**No**	
Category VI				
Crave sweets during the day	**0**	**1**	**2**	**3**
Irritable if meals are missed	**0**	**1**	**2**	**3**
Depend on coffee to keep yourself going or started	**0**	**1**	**2**	**3**
Get lightheaded if meals are missed	**0**	**1**	**2**	**3**
Eating relieves fatigue	**0**	**1**	**2**	**3**
Feel shaky, jittery, tremors	**0**	**1**	**2**	**3**
Agitated, easily upset, nervous	**0**	**1**	**2**	**3**
Poor memory, forgetful	**0**	**1**	**2**	**3**
Blurred vision	**0**	**1**	**2**	**3**
Category VII				
Fatigue after meals	**0**	**1**	**2**	**3**
Crave sweets during the day	**0**	**1**	**2**	**3**
Eating sweets does not relieve cravings for sugar	**0**	**1**	**2**	**3**
Must have sweets after meals	**0**	**1**	**2**	**3**
Waist girth is equal or larger than hip girth	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst & appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**
Category VIII				
Cannot stay asleep	**0**	**1**	**2**	**3**
Crave salt	**0**	**1**	**2**	**3**
Slow starter in the morning	**0**	**1**	**2**	**3**
Afternoon fatigue	**0**	**1**	**2**	**3**
Dizziness when standing up quickly	**0**	**1**	**2**	**3**
Afternoon headaches	**0**	**1**	**2**	**3**
Headaches with exertion or stress	**0**	**1**	**2**	**3**
Weak nails	**0**	**1**	**2**	**3**

Category IX				
Cannot fall asleep	**0**	**1**	**2**	**3**
Perspire easily	**0**	**1**	**2**	**3**
Under high amounts of stress	**0**	**1**	**2**	**3**
Weight gain when under stress	**0**	**1**	**2**	**3**
Wake up tired even after 6 or more hours of sleep	**0**	**1**	**2**	**3**
Excessive perspiration or perspiration with little or no activity	**0**	**1**	**2**	**3**

Category X				
Tired, sluggish	**0**	**1**	**2**	**3**
Feel cold – hands, feet, all over .	**0**	**1**	**2**	**3**
Require excessive amounts of sleep to function properly	**0**	**1**	**2**	**3**
Increase in weight gain even with low-calorie diet	**0**	**1**	**2**	**3**
Gain weight easily	**0**	**1**	**2**	**3**
Difficult, infrequent bowel movements	**0**	**1**	**2**	**3**
Depression, lack of motivation	**0**	**1**	**2**	**3**
Morning headaches that wear off as the day progresses	**0**	**1**	**2**	**3**
Outer third of eyebrow thins	**0**	**1**	**2**	**3**
Thinning of hair on scalp, face or genitals or excessive falling hair	**0**	**1**	**2**	**3**
Dryness of skin and/or scalp	**0**	**1**	**2**	**3**
Mental sluggishness	**0**	**1**	**2**	**3**

Category XI				
Heart palpations	**0**	**1**	**2**	**3**
Inward trembling	**0**	**1**	**2**	**3**
Increased pulse even at rest	**0**	**1**	**2**	**3**
Nervous and emotional	**0**	**1**	**2**	**3**
Insomnia	**0**	**1**	**2**	**3**
Night sweats	**0**	**1**	**2**	**3**
Difficulty gaining weight	**0**	**1**	**2**	**3**

Category XII				
Diminished sex drive	**0**	**1**	**2**	**3**
Menstrual disorders or lack of menstruation	**0**	**1**	**2**	**3**
Increased ability to eat sugars without symptoms	**0**	**1**	**2**	**3**

Category XIII				
Increased sex drive	**0**	**1**	**2**	**3**
Tolerance to sugars reduced	**0**	**1**	**2**	**3**
"Splitting" type headaches	**0**	**1**	**2**	**3**

Category XIV (Male Only)				
Urination difficulty or dribbling	**0**	**1**	**2**	**3**
Urination frequent	**0**	**1**	**2**	**3**
Pain inside of legs or heels	**0**	**1**	**2**	**3**
Feeling of incomplete bowel evacuation	**0**	**1**	**2**	**3**
Leg nervousness at night	**0**	**1**	**2**	**3**

Category XV (Males Only)				
Decrease in libido	**0**	**1**	**2**	**3**
Decrease in spontaneous morning erections	**0**	**1**	**2**	**3**
Decrease in fullness of erections	**0**	**1**	**2**	**3**
Difficulty in maintain morning erections	**0**	**1**	**2**	**3**
Spells of mental fatigue	**0**	**1**	**2**	**3**
Inability to concentrate	**0**	**1**	**2**	**3**
Episodes of depression	**0**	**1**	**2**	**3**
Muscle soreness	**0**	**1**	**2**	**3**
Decrease in physical stamina	**0**	**1**	**2**	**3**
Unexplained weight gain	**0**	**1**	**2**	**3**
Increase in fat distribution around chest and hips	**0**	**1**	**2**	**3**
Sweating attacks	**0**	**1**	**2**	**3**
More emotional then in the past	**0**	**1**	**2**	**3**

Category XVI (Menstruating Females Only)				
Are you perimenopausal	**Yes**		**No**	
Alternating menstrual cycle lengths	**Yes**		**No**	
Extended menstrual cycle, greater than 32 days	**Yes**		**No**	
Shortened menses, less than every 24 days	**Yes**		**No**	
Pain and cramping during periods	**0**	**1**	**2**	**3**
Scanty blood flow	**0**	**1**	**2**	**3**
Heavy blood flow	**0**	**1**	**2**	**3**
Breast pain and swelling during menses	**0**	**1**	**2**	**3**
Pelvic pain during menses	**0**	**1**	**2**	**3**
Irritable and depressed during menses	**0**	**1**	**2**	**3**
Acne break outs	**0**	**1**	**2**	**3**
Facial hair growth	**0**	**1**	**2**	**3**
Hair loss/thinning	**0**	**1**	**2**	**3**

Category XVII (Menopausal Females Only)				
How many years have you been menopausal?	_____			
Do you ever have uterine bleeding since menopause?	**Yes**		**No**	
Hot flashes	**0**	**1**	**2**	**3**
Mental fogginess	**0**	**1**	**2**	**3**
Disinterest in sex	**0**	**1**	**2**	**3**
Mood swings	**0**	**1**	**2**	**3**
Depression	**0**	**1**	**2**	**3**
Painful intercourse	**0**	**1**	**2**	**3**
Shrinking breasts	**0**	**1**	**2**	**3**
Facial hair growth	**0**	**1**	**2**	**3**
Acne	**0**	**1**	**2**	**3**
Increased vaginal pain, dryness or itching	**0**	**1**	**2**	**3**

PART III

How many alcohol beverages do you consume per week? _____ How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you workout? _____

List the three worst foods you eat during the average week? _____, _____, _____

List the three healthiest foods you eat during the average week? _____, _____, _____

Do you smoke?_____ If yes, how many times a day _____ , a week _____.

Rate your stress levels on a scale of 1-10 during the average week. _____

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____