NAME ______________________________

DATE ___________

AGE ___________

Date of Birth _________________________

Nutritional Reflex Testing Questionaire

1.What is your main complaint?

2.How long have you had it?

3.What makes it better?

4.What makes it worse?

5.Do you have bowel movements each day?

6.Have you taken antibiotics before? How many times a year?

7.Have you ever been exposed to harmful chemicals, or been in a work/home environment that has made you sick?

8.What types of foods do you eat often?

9.Do you drink diet drinks, cokes, or tap water?

10.How often do you eat raw or steamed vegetables?

11.Do you cook your meat? Well done, medium well, medium, raw

12.Do you eat sushi?

13.Have you traveled to a foreign country? When? Where?

14.Do you suffer with allergies?

15.Are you fatigued daily? When? What do you feel makes you tired?

16.Do you exercise? What kind? How often?

17.Do you smoke? Have you ever been a smoker?

18.Do you take vitamins, herbs, or homeopathics? If yes, what?

19.How many hours of sleep do you get? Do you feel tired when you wake up?

20.Do you take aspirin or Tylenol? How often?

21.Do you take Tums, Rolaids, or any other antacid remedies? How often?

22.Do you take any medication? What for?

23.Have you had any surgeries? Where?

24.Have you ever had a root canal?

25.Do you have any scars? Where? How did you get the scars?

26.Do you have silver fillings? About how long have you had them?

27.On a scale of 1-10 with 10 being the most healthy and 1 being the least healthy, how would you rate yourself?

28.Do you feel that you are under a lot of mental or emotional stress?

29.Do you consume a lot of milk or dairy products?

30.Have you ever been diagnosed with any diseases?