Pre-Session Update Form

Please kindly complete all questions and email your completed form two days prior to your next session.

Name		Date	

What positive changes have you noticed since your last appointment?	
What are your main concerns at this time?	

Any changes with weight and/or waist size?		How is your sleep?	
Constipation or diarrhea? Gas or bloating? Which?		How is your mood?	
Is your energy level higher or lower lately?		To what do you attribute this energy level?	
Are you in any pain on a regular basis? Please describe.		If this is ongoing pain, is it better, same, or worse than before?	

Are you receiving good support from those around you for the changes you are making?	

Are you taking all supplements consistently? Any concerns?	

What do you see as a significant barrier to you making more/faster progress toward your health goals?	

Are you cooking more?	
What do you crave? What are you doing or feeling when you crave?	

Breakfast	Lunch	Dinner	Snacks	Liquids

Any other comments you wish to share?	

Do you have particular questions or topics you would like to cover in our next session?	

Please also complete the Symptom Questionnaire on the Following TWO Pages.

Symptom Questionnaire

Please use this scale to rate the frequency and severity of symptoms you have experienced over the past two weeks. If multiple choices are given, please specify what applies in the comment column.

- ☐ Leave the score **blank** if you **Never** have the symptom.
- ☐ Use a **1** if you **Occasionally** have it and the effect is **Mild**.
- ☐ Use a **2** if you **Occasionally** have it and the effect is **Severe.**
- ☐ Use a **3** if you **Frequently or Consistently** have it and the effect is **Mild**
- ☐ Use a **4** if you **Frequently or Consistently** have it and the effect is **Severe**.

Category	Symptom	Score	Comments or Details, if appl.
HEAD	Headache		
	Faintness		
	Dizziness		
	Insomnia		
NOSE	Stuffy nose		
	Sinus problems		
	Hay fever		
	Sneezing attacks		
	Excessive mucus formation		
MOUTH	Chronic coughing		
	Gagging or frequent need to clear throat		
	Sore throat, hoarseness, or loss of voice		
	Swollen or discolored tongue, gums, or lips		
	Tooth ache or gum pain or new dental work		
	Canker sores		
SKIN	Acne		
	Hives or other allergic breakout		
	Rash or persistently dry skin		
	Hair loss		
	Flushing or hot flashes		
	Frequently feel cold		
	Excessive sweating		
	Part of body frequently feeling numb. Which?		
HEART	Irregular or skipped heartbeat		
	Rapid or pounding heartbeat		
	Chest pain		
LUNGS	Chest congestion		
	Asthma, bronchitis		
	Shortness of breath		
	Difficulty breathing		
DIGESTION	Nausea or vomiting		
	Diarrhea		
	Constipation		
	Bloated feeling		
	Belching, burping		
	Passing gas, flatulence		
	Heartburn		
	Intestinal or Stomach pain. Which?		
	Other pain in GI tract? Where?		

BodyWisdom

Please use this scale to rate the frequency and severity of symptoms you have experienced <u>over the past two weeks</u>. If multiple choices are given, please specify what applies in the comment column.

- ☐ Leave the score **blank** if you **Never** have the symptom.
- ☐ Use a **1** if you **Occasionally** have it and the effect is **Mild**.
- ☐ Use a **2** if you **Occasionally** have it and the effect is **Severe.**
- ☐ Use a **3** if you **Frequently or Consistently** have it and the effect is **Mild**
- ☐ Use a **4** if you **Frequently or Consistently** have it and the effect is **Severe**.

Category	Symptom	Score	Comments or Details, if appl.
JOINTS AND MUSCLES	Pain or aches in joints		
	Arthritis		
	Stiffness or limitation of movement		
	Pain or aches in muscles		
	Tremor or restless leg		
	Feeling of weakness or tiredness		
WEIGHT	Binge eating/drinking		
	Craving certain foods		
	Excessive weight		
	Compulsive eating		
	Water retention		
	Underweight		
ENERGY	Fatigue, sluggishness		
	Apathy, lethargy		
	Hyperactivity		
	Restlessness		
MIND	Poor memory		
	Confusion, poor comprehension		
	Poor concentration or focus		
	Poor physical coordination		
	Difficulty in making decisions		
	Stuttering or stammering		
	Learning disabilities		
MOOD	Mood swings		
	Anxiety, fear, nervousness		
	Anger, irritability, aggressiveness		
	Depression		
	Other mood challenges?		
OTHER	Frequent illness		
	Frequent or urgent urination		
	Inability to urinate or low urine flow		
	Low libido or other sexual dysfunction		
	Genital itch or discharge		
	Women: Breast fibroids		
	Women: Painful or tender breasts		
	Women: Uterine/Ovarian fibroids		
	Other		
	Please tally your scores for this update here:		**Total Symptom Score**

Any further comments you wish to share?