

GENERAL INFORMATION SHEET

Name _____ Age _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

E-Mail Address _____ Height _____ Weight _____

Occupation _____ How were you referred? _____

What are your main health concerns or conditions? _____

Please list any medications or food supplements you are currently taking:

Please list any recent medical tests results you have, such as blood tests:

Please list illnesses in your family such as heart disease, cancer, TB, diabetes or arthritis.

DIET: What are examples of typical breakfasts for you?

Beverages

Mid-morning Snacks

What are typical lunches for you?

Beverages

Mid-afternoon Snacks

What are typical dinners for you?

Beverages

Evening Snacks

How often and what kind of exercise do you do? _____

About how many hours of sleep do you get per day? _____

I understand that nutritional balancing is a means to reduce stress by identifying and correcting nutritional deficiencies and imbalances. It is not intended as diagnosis, treatment or prescription for any condition or disease. Dr. Wilson has a medical degree and works as an unlicensed nutrition consultant.

Signed _____ Date _____

CIRCLE any conditions or symptoms that presently describe you.

PLACE A STAR next to the symptoms most important to you.

Joint Pain	Acne	Painful Urination
Joint Stiffness	Eczema	Kidney Stones
Arthritis, Osteo	Fungal Infections/Candida	Water Retention
Arthritis, Rheumatoid	Psoriasis	Sinus Headaches
Muscle Pain	Hives	Tension Headaches
Muscle Weakness	Hair Loss	Migraine Headaches
Muscle Cramps	Slow Wound Healing	Neuritis
Bursitis	Cataracts	
Fractures	Glaucoma	Constipation
Osteoporosis	Meniere's Disease	Diarrhea
Gout	Tooth Decay	Intestinal Gas
	Excessive Plaque on Teeth	Bloating
Sweet Cravings	Gum Disease	Heartburn
Sugar Reactions		Ulcer
Irritable before meals	Infections/Viruses	Stomach Pain
Can't Skip Meals	Tumors/Cancer	Colitis
Hypoglycemia	Multiple Sclerosis	Gall Stones
Crave Starches	Parkinson's Disease	Fissures
Fat Cravings	Scleroderma	Hemorrhoids
Other Food Cravings		Cirrhosis
Food Allergies	Anger	Diverticulitis
Excessive hunger	Anxiety	Tend to Gain Weight
No hunger	Bipolar Disorder	Tend to Lose Weight
Diabetes	Brain Fog	
	Confusion	Anemia
Rapid Heart Rate	Depression	Easy Bruising
Skipped Heart Beats	Irritability	
Heart Palpitations	Mind Races	Drug Addiction
Heart Attack	Mood Swings	Alcoholism
Poor Circulation	Obsessive/Compulsive	Smoking
Dizziness	Panic Attacks	
Low or High Blood Pressure	Poor Memory	WOMEN:
Angina	Schizophrenia	Premenstrual Syndrome
Arteriosclerosis	Trouble Sleeping	Water Retention
High Cholesterol _____		Cramps
High Triglycerides _____	Autism	No Menstruation
	Attention Deficit	Heavy periods
Cough	Hyperkinesia	Light/Irregular Periods
Bronchitis	Dyslexia	Ovarian Cysts
Asthma	Seizures	Fibroid Tumors
Post-nasal Drip	Learning Disability	Abnormal Pap Smear
Sinus Congestion	Mental Retardation	Menopause
Allergies	Delayed Development	Fibrocystic Breasts
Emphysema		Breast Tumors
	Bladder Infections	Yeast Infections
Fatigue	Kidney Infections	Hot Flashes
Hypothyroidism	Trouble Urinating	
Low Body Temperature	Frequent Urination	MEN:
Cold in Winter/Dry Skin	Painful Urination	Prostate Problems
Tend to Gain Weight	Kidney Stones	Impotence
Hyperthyroidism	Water Retention	Infertility

Other Symptoms or Comments:
