

GENERAL INFORMATION SHEET

Name _____ Age _____ Sex: M or F Date _____

Address _____

City _____ State/Prov. _____ 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 and balance body chemistry. 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 _____

Name _____

SYMPTOMS SHEET

CIRCLE any conditions or symptoms that presently describe you.

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

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

Other Symptoms _____