Introductory Letter

You are about to undergo a nutritional evaluation that will include interpretation of your Signs and Symptoms Survey form, a personal interview, and a reflex exam. A palpatory examination will be made while you are fasting and again 45 minutes after ingesting 1 tablespoon of food powder which is mixed in water. The powder is a food and contains a balanced amount of protein, lipids, fiber, simple and complex carbohydrates.

We provide you with a report at the conclusion of the evaluation and will recommend nutritional supplements using food enzymes, herbs, vitamins, and minerals.

All recommendations are nutrition-based and made for your general well-being and health. We will not make a medical diagnosis nor will we provide treatment recommendations for any medical condition. We recommend you consult with your primary care health practitioner for diagnosis and treatment of specific medical conditions or illnesses.

The cost of this evaluation is $______ to be paid at the time of the evaluation. Our services are not expected to be covered by insurance policies or Medicare. Please acknowledge your understanding of the above matters by signing below.

Date ________________________

Print name: ______________________________________

Signature: _______________________________________

PATIENT HISTORY FORM

NAME ______________________________ **DATE** ______________________________

SEX ______________ **AGE** ______________ **HEIGHT** ___________ **WEIGHT** __________

OCCUPATION ____

Please complete the following questions. This will give us a detailed understanding of your present health condition. We will review this form and review it with you. If you have any questions or do not understand any portion of it, we will be happy to assist you.

CHIEF COMPLAINT – Primary reason you are seeking treatment:

____

____

SURGERY YOU HAVE HAD AND YOUR AGE AT TIME OF SURGERY:

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

DO YOU CONSIDER YOURSELF TO BE:

OVERWEIGHT AVERAGE UNDERWEIGHT

DESCRIBE YOUR ACTIVITY LEVEL:

SEDENTARY LIGHT WORK MODERATE WORK HEAVY WORK

FAMILY HISTORY OF CONDITIONS (PLEASE LIST ACCORDINGLY):

	MOTHER	FATHER	SIBLINGS
ALLERGIES	_________	________	_________
ASTHMA	_________	________	_________
HEART DISEASE	_________	________	_________
CANCER	_________	________	_________
ARTHRITIS	_________	________	_________
KIDNEY DISEASE	_________	________	_________
DIABETES	_________	________	_________

STOMACH ________ ________ ________
DISORDERS
OTHER CONDITIONS ________ ________ ________

DIETARY PREFERENCES

NAME ______________________________ **DATE** ______________________________

SEX _____________ **AGE** ____________ **HEIGHT** __________ **WEIGHT** _________

Are you primarily responsible for preparing your own meals? Yes ______ No _______

Are you following a specific dietary regimen such as Weight Watchers, Nutri-System, Jenny Craig, etc. ____

How many of your weekly meals do you eat out? ______________________________

How many glasses of water do you drink each day? ____________________________

Describe your eating pace as: Fast _____ Moderate ______ Slow _______

Do you smoke? Yes No Do you drink alcohol? Yes No

If yes, describe ____

Do you crave any particular foods? ____________________________________

Do you avoid any particular foods? ____________________________________

Please list any dietary supplements you take regularly:

1. _________________________________
2. _________________________________
3. _________________________________
4. _________________________________
5. _________________________________
6. _________________________________
7. _________________________________
8. _________________________________

Instructions for filling out the rest of the form

On the following pages we have listed menu choices for the usual three meals a day. Some of the choices are not specific and we ask you for details; for

example, “Do you have juice in the morning?” is answered “Yes” or “No”. If the answer is “Yes”, we would like you to describe what kind of juice.

Rather than ask you to keep a detailed diary of everything you eat and drink for 3 to 7 days, we ask that you indicate your preferences – **WHAT YOU USUALLY HAVE FIVE DAYS A WEEK, NOT INCLUDING WEEKENDS**. There is room at the bottom of the pages for you to fill in those things that may not be listed.

BREAKFAST

Do you usually skip breakfast (five days a week)? Yes No

If you have breakfast, is it at home? Yes No

If not, where? Restaurant Fast Food Cafeteria

Do you use a meal substitute, such as Slim-Fast, etc?

____

If so, it may not be necessary to fill out the remainder of this menu.

BREAKFAST ITEM	YES	NO	DESCRIBE
Eggs or Egg Beaters			
Cheese			
Bacon – Ham - Sausage			
Potatoes			
Hot Cereal			Sugar or Sweetener
Cold Cereal			
Pancakes – French Toast			Syrup or Jelly/Jam/Honey
Toast or English Muffin			Butter or Margarine
Bagel or Croissant			Butter/Margarine/Cream Cheese
Doughnuts			
Sweet Rolls or Danish			Butter/Margarine
Milk			Whole – 2% – 1% – Skim
Yogurt			
Fresh Fruit			
Water			
Juice			
Coffee			Creamer or Sweetener?
How many cups per day?			Regular or Decaf?
Tea			Regular – Decaf or Herbal?
Soft Drink			Diet or Regular

NOTES

____

____

LUNCH

Do you usually skip lunch (five days a week)? Yes No

Do you eat lunch at home? Yes No

If not, where? Carry Lunch Restaurant Fast Food Cafeteria
Do you use a meal substitute, such as Slim-Fast, etc?

____

If so, it may not be necessary to fill out the remainder of this menu.

LUNCH ITEM	YES	NO	DESCRIBE
Lunch			
– Meat			
– Vegetable			
– Potato			
Bread or Rolls			
Fast Food			
– Burger and Fries			
– Pizza			
Soup and Sandwich			
Soup and Salad			Favorite Dressing
Dessert or Milk Shake			
Yogurt			
Milk			Whole – 2% – 1% – Skim
Water			
Juice			
Coffee			Creamer – Milk – Artificial?
How many cups per day?			Sugar or Sweetener
Tea			
Herbal Tea			
Soft Drink			Diet or Regular
Buttermilk – Chocolate Milk			
Beer – Wine – Mixed Drink			

EVENING MEAL

Do you usually skip the evening meal (five days a week)? Yes No

If you have supper, is it at home? Yes No

If not, where? Restaurant Fast Food Cafeteria

Do you usually have an alcoholic drink before supper? Yes No

Do you use a meal substitute, such as Slim-Fast, etc.?___________________

If so, it may not be necessary to fill out the remainder of this menu.

DINNER ITEM	YES	NO	DESCRIBE
Meat or Fish			
Soup			
Vegetables			
Salad			
Potato			
Rice			
Bread or Rolls			Butter/Margarine
Dessert			How many times per week?
Water			
Juice			
Coffee			Creamer or Sweetener
Tea			
Herbal Tea			Creamer or Sweetener
Soft Drink			Diet or Regular
Milk			Whole – 2% – 1% – Skim
Buttermilk or Chocolate Milk			
			Regular – Decaf or Herbal?
Beer – Wine – Mixed Drink			

NOTES

SNACKS

	Yes	No
Do you chew gum?	Yes	No
Do you use breath mints?	Yes	No

WHEN DO YOU SNACK?

	YES	NO	DESCRIBE
Mid-Morning			
Mid-Afternoon			
Evening			
Bedtime			

SNACK ITEM	YES	NO	WHAT KIND?
Chips			
Popcorn			
Candy			
– Chocolate			
– Hard Candy			
Cookies			
Ice Cream			

BEVERAGE ITEM	YES	NO	WHAT KIND?
Water			
Juice			
Coffee			Creamer or Sweetener?
Tea			Creamer or Sweetener?
Soft Drinks			Diet or Regular
Milk			Whole – 2% – 1% – Skim
Beer – Wine – Mixed Drink			

NOTES

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___

___

SIGNS and SYMPTOMS SURVEY

Please score each question as follows:
3 = if this is a **MAJOR** problem for you.
1 = if this is a **MINOR** problem for you.

If you NEVER have the problem, leave it blank.

If you do not understand a question,
please circle and discuss it with us.

SECTION ONE

Group 1 – Sym (C1 to C3) **Alternative Herbs**

1. Would you describe yourself as a Type A personality; for example driven and aggressive? ____________
2. Chronic problems with indigestion and constipation. ____________
3. Stiff joints, especially after rest, i.e. loss of mobility. ____________
4. Sensitive to sudden sounds, i.e. startle easily. ____________
5. Headaches in back of the head and neck. ____________

Group 2 – VSCLR **Lipotrophic Herbs**

1. History of diabetes in yourself or family. __________
2. High blood pressure. __________
3. High blood triglyceride levels. __________
4. Dizziness or light-headedness when changing positions. __________
5. Pain on the side of the head or in the temples. __________

Group 3 – Opt (T1 to T2) **Ophthalmic Herbs**

1. History of cataracts, glaucoma, or poor vision. __________
2. Frequent head colds, runny nose, and/or water eyes. __________
3. Bruise easily, slow healing of cuts, sore or bleeding gums. __________
4. Frequent redness in the eyelids or “sand” in your eyes. __________
5. Headaches associated with eye strain or pain when moving your eyes. __________

Group 4 – Nsl (T1 to T2) **Bioflavonoid Complex**

1. History of chronic sinus problems. __________
2. Loss of sense of smell, or obstruction to nasal breathing. __________
3. Bothered by thick mucous discharges from nose. __________
4. Frequent nosebleeds. __________
5. Facial pain or paralysis. __________

SECTION ONE con't.

Group 5 – IvD (C21 to L5) **Protein Nutritive Herbs**

1. History of spinal disc problems or back surgery. __________
2. Cannot tolerate stress, i.e. unable to make decisions. __________
3. Irritated or receding gums, loose teeth. __________
4. Cold hands and feet. __________
5. Clicking jaw or TMJ pain. __________

Group 6 – SvG (T1 to T3) **Carbohydrate Nutritive Herbs**

1. History of speech impediment, stuttering, or stammering. __________
2. Dry, itchy eyes or dry mouth. __________
3. Poor memory. __________
4. Inability to relax, become serene, or meditate. __________
5. Frequent sore, or sores on tongue or in mouth. __________

Group 7 – Thy (C8 to T1) **Herbal Demulcents w/ Ca & Mg**

1. History of thyroid gland disorders. __________
2. Fast heart beat, i.e. heart racing. __________
3. Swollen or painful breasts. __________
4. Moist warm skin, i.e. sweat easily. __________
5. Neck, shoulder, arm or hand pain. __________

SECTION TWO

Group 8 – Rbs (T1 to T12) **Herbal Emollients**

1. History of frequent canker sores, cold blisters, or boils. __________
2. Muscle weakness and pain in low back and buttocks. __________
3. Slow morning starter or stiffness after sitting. __________
4. Dry skin, dandruff, hair falling out. __________
5. Painful ribs, pain on inhalation, or sharp chest pain. __________

Group 9 – Circ (T1 to T6) **Cardiotrophic Herbs**

1. History of heart disease, taking medication, etc. __________
2. Irregular heart beat or skipped beats. __________
3. Dryness of skin and hair, itching due to dryness. __________
4. Have varicose veins and/or hemorrhoids. __________
5. Shoulder or chest pain on exertion. __________

Group 10 – Rsp (T1 to T7) **Expectorant Herbs**

1. History of asthma, emphysema, bronchitis, or pneumonia. __________
2. Difficulty breathing, shortness of breath. __________
3. Frequent cough (dry or productive). __________
4. Wheezing or difficult breathing when lying on your back. __________
5. Shoulder pain or bursitis. __________

SECTION TWO con't

Group 11 – Bil (T4 to T8) **Herbal Aromatics**

1. History of gallbladder stones or surgery. __________
2. Loss of appetite, especially for meat. __________
3. Frequent sour taste in the mouth, avoid fat or spicy foods. __________
4. Frequent constipation with light colored stool. __________
5. Discomfort under the rib cage after eating. __________

Group 12 – Stm (T5 to T9) **Herbal Mucilages**

1. History of ulcers or gastritis. __________
2. Frequent heartburn or indigestion with nausea and pain. __________
3. Acid reflux after eating. __________
4. Frequent use of antacids. __________
5. Pain or burning in the stomach that is relieved by eating. __________

SECTION THREE

Group 13 – Adr (T9 to T10) **Adrenal Herbal Tonic**

1. History of low blood pressure problems. __________
2. Awake after sleeping a few hours, cannot go back to sleep. __________
3. Frequent periods of depression or inability to think clearly. __________
4. Become light-headed when meals are missed. __________
5. Suffer from frequent nightmares or panic attacks. __________

Group 14 – Pan (T5 to T9) **Multiple Enzyme Formula**

1. History of lactose intolerance or gluten intolerance. __________
2. Craving or thirst for cold liquids or foods. __________
3. Intolerance of dairy products, grains, or sugar. __________
4. Sensitive to air pollutants, such as perfumes, smoke, etc. __________
5. Discomfort or soreness under the left rib cage after eating. __________

Group 15- Spl (T6 to T8) **Hematinic Nutritive Herbs**

1. History of anemia or other blood disorders. __________
2. Fatigued, tired most of the time. __________
3. Pale skin, lips, and nails. __________
4. Low resistance (frequent colds and infections). __________
5. Sleepy after eating. __________

Group 16- Lvr (T8 to T10) **Hepatic Herbs**

1. History of hepatitis, jaundice, or other liver disorders. __________
2. History of high blood pressure and/or medication. __________
3. Water retention, swelling and hands and feet. __________
4. Varicose veins and/or hemorrhoids. __________
5. Shoulder and neck stiffness and/or soreness. __________

SECTION FOUR

Group 17 SmI (T9 to L1) **Lactobacillus**

1. History of chronic or frequent yeast infections. __________
2. Foul odor to stool or urine. __________
3. Unusually large appetite i.e. cannot control urge to eat. __________
4. Frequent or prolonged use of antibiotics. __________
5. Constipation with hard, dry stool. __________

Group 18- Kdy (T10 to T11) **Kidney Herbal Tonic**

1. History of reactive hypoglycemia. __________
2. Suffer from airborne allergies. __________
3. Dark circles under the eyes. __________
4. Frequent nausea, vomiting or morning sickness. __________
5. Muscular lower back pain. __________

Group 19- Skn (T1 to L3) **Skin Herbal Tonic**

1. History of skin problems, such as acne. __________
2. Dermatitis, eczema, or psoriasis. __________
3. Have many warts or moles. __________
4. Frequent episodes of hives due to food allergies. __________
5. Excessive perspiration or lack of perspiration. __________

Group 20 LgI (L1 to L3) **Aperient Herbs**

1. History of constipation with infrequent bowel movements. __________
2. Frequent use of laxatives or enemas. __________
3. Hard, painful stools. __________
4. Lower abdominal gas. __________
5. Less than one bowel movement a day. __________

Group 21- IrB (L1 to L3) **Astringent Herbs**

1. History of colitis or other disorders of the large intestine. __________
2. Diarrhea with mucus or blood in the stool. __________
3. Frequent or soft bowel movements. __________
4. Left lower bowel pain. __________
5. Painful bowel movements. __________

Group 22- Mal (T10 to T11) **Male Herbal Tonic**

1. History of prostate disorders or medication. __________
2. Frequent night urination. __________
3. Dribbling. __________
4. Loss of sexual urge. __________
5. Pain radiating into groin or testes. __________

SECTION FOUR con't

Group 23-Fem (T10 to L1) **Female Herbal Tonic**
1. History of hysterectomy or estrogen replacement therapy. __________
2. Vaginal discharge. __________
3. Excessive menstruation flow. __________
4. Lack of menstruation, scanty flow, irregular periods. __________
5. Painful periods and/or symptoms of PMS. __________

SECTION FIVE con't

Group 24- UrT **Lithotriptic Nervines**
1. History of frequent bladder infections. __________
2. Frequent urination, urgency, or loss of control. __________
3. Pass small amounts of urine at each voiding. __________
4. Dry skin, flaking, and dandruff. __________
5. Pain or discomfort over the bladder. __________

Group 25- Para (S1 to S4) **Calcium Complex**
1. History of bone disorders, spurs, and/or osteoporosis. __________
2. Muscle soreness and weakness. __________
3. Loose teeth or poor fitting dentures. __________
4. Hyperirritability, insomnia, and/or restlessness. __________
5. Low back pain, weak joints or ligaments, fallen arches. __________

Group 26- CLM **Herbal Nervines**
1. History of injury to tailbone. __________
2. Restlessness or insomnia. __________
3. Inability to concentrate or frequent day dreaming. __________
4. Unresolved health problems. __________
5. Painful tailbones, hurts to sit down. __________

Group 27- MSCLR **Diaphoretic Herbs**
1. History of muscle soreness and pain after exercise. __________
2. Inability to tolerate potassium-rich foods such as molasses, olives, vegetable juices, bananas, oranges, etc. __________
3. Frequent writers cramp or stiffness, especially after rest. __________
4. Muscle soreness and pain after exercise. __________
5. Loss of joint range of motion, such as painful stretching. __________

Group 28- TRMA **Proteolytic Enzyme Complex**
1. History of deep bone or joint pain, painful weak teeth. __________

SECTION FIVE con't

2. Frequent anxiety (in need of tranquilizers). __________
3. Frequent infections (regular use of antibiotics). __________
4. Symptoms of edema, such as swelling of feet and ankles. __________
5. Recent acute traumatic incident/accident. __________

SECTION SIX

Group 29- Challenge **Herbal Parasiticide**

1. Always tired, i.e. unable to meet daily requirements. __________
2. Loss appetite or feel better if you don't eat. __________
3. Restless sleep, gnawing of teeth. __________
4. Thin and have difficulty gaining weight. __________
5. Itching around rectum or groin. __________

Group 30- DGST **Multiple Herbal Formula**

1. History of chronic depression. __________
2. Unusual fullness after eating. __________
3. Lower bowel gas. __________
4. Undigested food, capsules, or tablets found in the stool. __________
5. Frequent abdominal cramping after eating. __________

Group 31- ELXR **Multiple Herbal Formula**

1. Generalized malaise, i.e., lackadaisical attitude. __________
2. Frequent lack of motivation, unable to get started. __________
3. Fatigued easily tired. __________
4. Failure to meet ordinary requirements of daily activities. __________
5. Failure to respond to specific nutritional schedules. __________

Group 32- HCL **Herbal Stomachic**

1. History of pernicious anemia. __________
2. Loss of taste for meat. __________
3. Strong desire to eat when not hungry. __________
4. Indigestion, particularly 2 to 3 hours after eating. __________
5. Flatulence, lower bowel gas. __________

Group 33- SRB **Stabilized Rice Bran**

1. History of diabetes in your family. __________
2. Blood sugar problems, either hypoglycemia or diabetes. __________
3. Unable to control appetite. __________
4. Desire to lose weight. __________
5. Need a meal replacement. __________

SECTION SIX con't

Group 34-LAC **Lactase Enzyme Formula**

1. Painful gas. __________
2. Bloating after eating dairy. __________
3. Diarrhea after eating dairy. __________

Group 35-OSTEO **Organic Sulfur/Sulfate**

1. History of osteoarthritis or gout. __________
2. Musculoskeletal pain, difficulty walking, etc. __________
3. Bone and joint pain in spine, hips, knees, feet, or hands. __________
4. Inflammation, i.e. fever, redness, swelling, and/or pain. __________
5. Stiff joints/sore muscles or diagnosed with fibromyalgia. __________

Group 36-DERM/H3 **Epidermal Support**

1. History of chronic herpes-type skin eruptions, such as frequent canker sores, cold blisters, and boils. __________
2. Raises and red skin eruptions such as hives. __________
3. Strong reactions to mosquito or insect bites, certain foods, or chemicals. __________
4. Frequent allergic reactions such as sneezing attacks. __________
5. Painful skin irritations such as sunburn, diaper rash, and chapped lips. __________

Thank You!!

Thank you for taking the time to fill out this survey accurately and honestly. Your answers will assist us in making a more thorough examination of your health and enable us to make a more complete diagnosis of your health issues.

Ayurveda Mind Body Type Test

The following quiz is divided into three sections. For the first questions, which apply to Vata dosha, read each statement and mark, from 1 to 6, how well it applies to you.

1= Doesn't apply to me
3 =Applies to me somewhat (or some of the time)
6 =Applies to me very much (or nearly all of the time)

At the end of the section, write down your total Vata score. For example, if you mark a 6 for the first question, a 3 for the second, and a 2 for the third, your total up to that point would be 6+3+2=11. Total the entire section in this way, and you arrive at your total score. Proceed to the 20 questions for Pitta and those for Kapha.

When you are finished, you will have three separate scores. Comparing these will determine your body type.

For fairly objective physical traits, your choice will usually be obvious. For mental traits and behavior, which are more subjective, you should answer according to how you have felt and acted most of your life, or at least for the past few years.

SECTION 1-VATA

	Does Not Apply	Sometimes Applies	Applies Most
1.I perform activity very quickly	1**2**3**4**5**6		
2. I am not good at memorizing things and then remembering them later	1**2**3**4**5**6		
3. I am enthusiastic and vivacious by nature	1**2**3**4**5**6		
4. I have a thin physique –I don't gain weight easily	1**2**3**4**5**6		
5. I learn things easily	1**2**3**4**5**6		
6. My characteristic gait while walking is light and quick	1**2**3**4**5**6		
7. I tend to have difficulties making decisions	1**2**3**4**5**6		
8. I tend to develop gas or become constipated easily	1**2**3**4**5**6		
9. I tend to have cold hands and feet	1**2**3**4**5**6		
10. I become anxious or worried	1**2**3**4**5**6		
11. I don't tolerate cold weather as well as most people	1**2**3**4**5**6		
12. I speak quickly and my friends think I am talkative	1**2**3**4**5**6		
13. My moods change easily and I am somewhat emotional by nature	1**2**3**4**5**6		
14. I often have difficulty in falling asleep or have a sound night's sleep.	1**2**3**4**5**6		
15. My skin tends to be dry, especially in winter	1**2**3**4**5**6		
16. My mind is very active, sometimes restless, but also very imaginative	1**2**3**4**5**6		
17. My movements are quick and active; my energy tends to come in bursts.	1**2**3**4**5**6		
18. I am easily excitable	1**2**3**4**5**6		
19. Left on my own, my eating and sleeping habits tend to be irregular	1**2**3**4**5**6		
20. I learn quickly, but I also forget quickly	1**2**3**4**5**6		

VATA Score ______________

SECTION 2-PITTA

	Does Not Apply / Sometimes Applies / Applies Most
1. I consider myself to be very efficient	1**2**3**4**5**6
2. In my activities, I tend to be extremely precise and orderly	1**2**3**4**5**6
3. I am somewhat strong-minded and have a somewhat forceful manner	1**2**3**4**5**6
4. I feel uncomfortable or become easily fatigued in hot weather-more so than most other people	1**2**3**4**5**6
5. I tend to perspire easily	1**2**3**4**5**6
6. Even though I might not always show it, I become irritable or angry quite easily	1**2**3**4**5**6
7. If I skip a meal or a meal is delayed, I become uncomfortable	1**2**3**4**5**6
8. One or more of the following characteristics describe my hair: early graying or balding thin, fine, straight hair, blond, red, or sandy colored hair	1**2**3**4**5**6
9. I have a strong appetite; if I want to, I can eat quite a large quantity	1**2**3**4**5**6
10. Many people consider me stubborn	1**2**3**4**5**6
11. I am very regular in my bowel habits- it would be more common for me to have loose stools than to be constipated	1**2**3**4**5**6
12. I become impatient very easily	1**2**3**4**5**6
13. I tend to be a perfectionist about details	1**2**3**4**5**6
14. I get angry quite easily, but then quickly forget about it	1**2**3**4**5**6
15. I am very fond of cold foods like ice cream and also crave ice-cold drinks	1**2**3**4**5**6
16. I am more likely to feel that a room is too hot than too cold	1**2**3**4**5**6
17. I don't tolerate foods that are very hot and spicy	1**2**3**4**5**6
18. I am not very tolerant of disagreement	1**2**3**4**5**6
19. I enjoy challenges and when I want something, I am very determined in my efforts to get it	1**2**3**4**5**6
20. I tend to be critical of others and also of myself	1**2**3**4**5**6

PITTA Score _____________

SECTION 2-KAPHA

	Does Not Apply Sometimes Applies Applies Most
1. My natural tendency is to do things in slow and relaxed	1**2**3**4**5**6
2. I gain weight more easily than most people and lose it more slowly	1**2**3**4**5**6
3. I have a placid and calm disposition-I'm not easily ruffled.	1**2**3**4**5**6
4. I can skip meals easily without any significant discomfort	1**2**3**4**5**6
5. I have a tendency toward excess mucus, phlegm, chronic congestion, asthma, or sinus problems.	1**2**3**4**5**6
6. I must get at least eight hours of sleep in order to be comfortable the next day	1**2**3**4**5**6
7. I sleep very deeply	1**2**3**4**5**6
8. I am calm by nature and not easily angered	1**2**3**4**5**6
9. I don't learn as quickly as some people, but I have excellent retention and a long memory	1**2**3**4**5**6
10. I have a tendency toward becoming plump-I store extra fat easily	1**2**3**4**5**6
11. Weather that is cool and damp bothers me	1**2**3**4**5**6
12. My hair is thick, dark, and wavy	1**2**3**4**5**6
13. I have smooth, soft skin with a somewhat pale complexion	1**2**3**4**5**6
14. I have a large, solid body build	1**2**3**4**5**6
15. The following words describe me well: serene, sweet natured, affectionate, and forgiving	1**2**3**4**5**6
16. I have slow digestion, which makes me feel heavy after eating	1**2**3**4**5**6
17. I have very good stamina and physical endurance as well as steady level of energy	1**2**3**4**5**6
18. I generally walk with a slow, measured gait	1**2**3**4**5**6
19. I have a tendency toward oversleeping, grogginess upon awakening, and am generally slow to get going in the morning	1**2**3**4**5**6
20. I am a slow eater and am slow and methodical in my actions	1**2**3**4**5**6

KAPHA Score ____________

FINAL SCORE

Vata ___________ Pitta__________ Kapha__________

REQUISITION FORM
24-HOUR URINALYSIS ACCORDING TO LOOMIS

CLIA ID 38D0882508
Lita Lee, PhD.
5526 SE 70th Ave.
Portland, OR 97206
PH: 503-775-2251
Fax: 503-788-7974

This form must be completed in order to comply with CLIA regulations

Doctor: Elieth Ameni Harris **Patient Name: ___________________________**

Provider #CT0907 **Sex: M___ F ___ Age ____ Hgt. ____ Wgt. ____**

Phone # 203-452-0907 **24-Hr. Urine Vol. (cups, oz, ml, etc.) _________**

Fax # 203-268-9264 **Date Kit Sent _____________**

Date Received _____________

FOR FEMALES: When during your menstrual cycle was this urine test done? Count day one for first day of menses.
Day of cycle _______ Perimenopausal ________ Menopausal _______ Surgical Menopause ________

Please summarize your major health problems:

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____
____

List drugs or supplements taken DURING this test:

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____
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____

List drugs or supplements NOT taken during this test but otherwise used regularly:

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Instructions on how to do the Loomis 24-hour urinalysis test to determine nutritional stress

Please eat and drink as you normally do. For most accurate results discontinue over-the-counter medications, vitamins, mineral and herbal supplements the day before and the day of the collection process. We are a precision lab – the more representative your sample is of your lifestyle, the better your doctor can assist you with the results.

Ask your doctor if you should continue on any of your enzymes during the 24-hour urine collection. If you do take enzymes, please list them on the enclosed requisition form.

Collection of the specimen:

Freeze the blue ice bag contained in the urine kit PRIOR to shipping and include it with the urine sample.

Use a clean plastic gallon jug (preferably one that contained distilled water). Keep specimen refrigerated during the entire collection process. Measure each void in ounces or milliliters and add them up to give a total 24-hour volume. A 2-quart measuring cup is most convenient. Or, use the measuring scale on the left, holding the scale against the one gallon jug to determine your urine volume.

IMPORTANT: If you use a gallon jug to contain your urine, please hold this scale against the gallon jug to determine your 24-hour volume. Please circle the mark closest to the top of the fluid level.

Discard the first void of the day. Begin collecting the specimen with the second voiding of the day. Collect ALL urine for the next 24-hour period, including the entire first morning void of the second day.

Gently turn the urine container upside down several times to mix the contents of the entire sample and fill the urine sample bottle. BE SURE TO PUT THE URINE VOLUME ON THE SAMPLE BOTTLE AND ON THE URINE REQUISITION FORM.

Please place the urine kit into the sleeve for protection.

Mail via overnight or two-day Fed Ex, UPS or DHL. Some doctors may request you to ship via overnight express mail, preferably to arrive Tuesday through Friday. Our lab is open on Saturdays but please sign the signature waiver to insure a Saturday delivery if we are not at home.

We wish you the best of health!

Please Send To: CLIA ID 38D088250 Lita Lee, PhD., 5526 SE 70th Ave. Portland, OR 97206
PH: 503-775-2251