Dear New Patient:

Welcome to Cornerstone Progressive Health! Health is the most important thing you have and you have taken a serious step to improve yours. Congratulations! We look forward to being of service to you.

Our physicians are traditional Osteopathic physicians and Medical doctors. They specialize in osteopathic manipulative medicine, cranial osteopathy, nutritional medicine and heavy metal detoxification. We take a holistic approach to patient assessment and diagnosis, while utilizing natural therapeutics to treat health concerns. We also provide many other treatments in our facility to aid in your healing and for use on a maintenance basis to keep you healthy. Please refer to our website at www.CornerstoneProgressiveHealth.com for more detailed information on our medical facility.

The initial doctor's visit is 60 minutes, but please allow plenty of time (at least 1 to 2 hours) for discussing your plan of care and for any patient education on homeopathic, nutritional supplements, lab work and/or additional treatments that may be prescribed for you.

Please complete Office Policy, Consent Forms, and Questionnaires in this informational packet and bring them with you to your scheduled appointment. Please also bring any medications or supplements you are presently taking (we will be testing them) and any recent medical records or lab work (within 6 months) you might have available.

Again, we are excited that you have sought us out and we'll do everything in our power to help you reach your optimum health!!

~ Your Friends at Cornerstone Progressive Health

CPH Omaha Branch: 8031 West Center Road, #221, Omaha, NE 68124 • Office: 402-343-7963 • Fax 402-343-1330
www.CornerstoneProgressiveHealth.com

Office Policy & Consent

The following information is provided to facilitate a common understanding of rights, roles and responsibilities in this professional, therapeutic relationship. Please read this agreement thoroughly. If you have questions please ask for clarification.

- **Physician visits and treatments are by appointment only.** We attempt to provide emergency care when possible, but our office is not designed to handle acute emergency situations. In emergencies, your pediatrician, family practitioner or local emergency room is best suited to meet your needs.

- **Normal office hours are 9:00 AM to 5:00 PM, Monday – Thursday.**

- **We seek to adhere to our schedule, but please realize that the length of a treatment is determined by your medical need rather than the clock.** We strongly recommend that you arrive fifteen minutes prior to your appointment time. This will enable us to complete any pre-appointment treatments the doctors may recommend.

- **We are a cash basis office.** This means we require payment to CPH by cash, check or credit card (Visa or Master Card) at the time of your visit. We do not file insurance claims, however, a "Superbill" will be provided (a form detailing medical treatment, consultations, diagnosis, and fees) after each visit, which can be submitted to your insurance carrier. Natural, integrative, or alternative medical services may not be covered by your health insurance plan. It is your responsibility to know what your insurance covers. We cannot be responsible for unpaid claims by your insurance company, for services provided. Cornerstone Progressive Health **does not** accept insurance liens, assignment or any reimbursement from your insurance carrier. **Please indicate on your insurance claim form that any payments be sent directly to you.**

- **Medicare patients will be required to sign a Medicare Patient Contract which is a waiver to <u>not</u> bill Medicare, and pay on a cash basis instead.**

- **We are eager to care for you and understand that care may need to be given over the phone.** Please understand that our time is valuable. *Phone discussions regarding your medical care that are longer than five minutes will be invoiced for the professional services provided. Also, if research is required outside of your appointment time, charges will be invoiced for the services provided.*

- **We have a twenty-four hour cancellation policy.** If your appointment is missed without twenty-four hours prior notice, you will be charged a missed appointment fee of $300 for a new patient appointment and $150 for a missed follow-up office visit. You will be charged only if your appointment is missed without proper cancellation. We have a list of people waiting for appointments; if you need to cancel or reschedule, please do so as soon as possible to avoid any misunderstandings or missed appointment charges.

Initial_____

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Office Policy & Consent, continued

- **As a courtesy, our office <u>will endeavor</u> to confirm your appointment with the physician, nurse, or treatment specialist.**

- **Return Policy for Supplements:** Unopened supplements may be returned for credit, providing they have not been opened and they are returned within 30 days of purchase.

- **In signing this form, I understand that I am requesting evaluation, recommendations and treatment from Cornerstone Progressive Health.** I acknowledge that I accept responsibility for my own health and voluntarily request participation in the treatment plan and recommendations provided by the doctor.

- **Treatments with other physicians or healthcare providers do not need to be discontinued.** We endeavor to work with other practitioners to ensure the best comprehensive medical care. Please let the practitioners at our office know, if you are being treated by other healthcare providers (physicians, counselors, therapists, etc.). Consult your prescribing physician before discontinuing medications. It is your responsibility to disclose any changes in your condition, symptoms, contact information, medications, or treatments between visits.

- **If possible, please bring any family member(s) with you that will be involved in your treatment.** Lifestyle changes are often difficult and require family support. Your plan of care will be much easier to adhere to if all are educated about the process of treatment at Cornerstone Progressive Health.

Initial_____

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Patient _____Date _____

Statement of Informed Consent

The Patient (And Others Legally Responsible for The Patient): You have the right, as a patient, to be informed about your condition and how integrative and alternative medicine may be applied in a treatment plan. This disclosure is intended to provide an opportunity for you to make an informed decision so that you may give or withhold your consent to treatment that may be considered unconventional by physicians trained only in the United States. **Notice:** *Refusal to consent to the integrative and alternative procedure(s) shall not affect your right to future care or treatment.*

I voluntarily request that Martin Jan Pryor, D.O., M.P.H., and other affiliated health care personnel as he may deem necessary, treat my condition (or the condition of the person for whom I am responsible) as described below. I understand that some of, or all of, the following integrative and alternative treatments are planned for me (or the person for whom I am responsible), and I voluntarily consent and authorize the following: Administration of homeopathic remedies, herbal and nutritional therapies, off-label use of pharmaceuticals, Neural therapy, oxidative therapy, prolotherapy, prolozone, intravenous therapies including high dose Vitamin C, major auto-hemotherapy, Chelation therapy, and physical and/or quantum physical modalities (including osteopathy, light, laser, color, electromagnetic and magnetic therapies), Bio-identical hormone replacement therapy (BHRT) and extended neurological examination including neuromuscular and autonomic nervous system response as well as:

I understand that no warranty or guarantee has been made regarding the results of treatment. I realize that there may be risks and hazards in treating this present health condition, with or without conventional medicine, and there may also be risks and hazards related to the planned integrative treatment, including worsening of present symptoms, development of new symptoms (especially detox reactions and undesirable interactions between various treatments, both conventional and alternative as well as:

I have been given the opportunity to ask questions about the treatment of this health condition using conventional, integrative and alternative methods. I have had the opportunity to discuss the possible risks and hazards of treatment and non-treatment, and believe that I have sufficient information to give informed consent. I certify this form has been fully explained to me, that I have read it (or have had it read to me), that the blank spaces have been filled in, and that I understand its contents. I also certify that Martin Jan Pryor, D.O., M.P.H. has provided this Disclosure and Consent Form to me and fully explained the diagnostic and treatment options available, and has made no guarantees to me as to the success of this treatment.

For Patients Receiving Chelation / IV Therapy

We are happy to provide for your IV needs. Please read our requirements for receiving chelation. These are based on guidelines set by ACAM and the State Medical Board.

- You must be seen in our clinic by one of our practitioners for plan review and laboratory evaluation every twelve months.
- You must complete once a year or more frequent if the medical condition requires.
- You must have a yearly history and physical. This can be completed either at our office or at your primary care physician's office, but we will need a copy of the exam for your chart.
- Medicare does not cover chelation.

By signing below I acknowledge that I have read, understand and agree with the terms and conditions contained within this Office Policy & Consent form:

Signature of Patient of Other Legally Responsible Person Required Below:

Signed _____

PLEASE PRINT ONLY IF OTHER THAN LEGALLY RESPONSIBLE PERSON

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Medicare Contract

I acknowledge and agree that this agreement/contract has been entered into with Cornerstone Progressive Health to provide osteopathic manipulation and nutritional work; herein referred to as Osteopathic services. This is not an emergency or urgent health care situation.

I agree not to, submit a claim or request that Cornerstone Progressive Health submit a claim on my behalf under the Social Security Act, as amended (42 U.S.C. 1395a) for osteopathic services, even if such services are otherwise covered under Medicare part B.

I agree to be responsible for the payment of Cornerstone Progressive Health services. Medicare will not provide reimbursement for Cornerstone Progressive Health services and no Medicare fee limits will apply to charges for osteopathic services. I acknowledge that Medicare plans under 42 U.S.C. 1882 do not, and other supplemental insurance plans may not, make payments for osteopathic services.

As a Medicare beneficiary, I have the right to have the service provided by other physicians for whom a payment would be made under Medicare, 42 U.D.V. 1395a. Cornerstone Progressive Health is not excluded from participating in Medicare Part B under 42 U.S.C. 1128 but freely chooses not to do so.

I understand that by signing this contract I am forgoing my right to receive Medicare benefits for Cornerstone Progressive Health services, but I do not forfeit all Medicare benefits for other services.

Signed _____Date _____

Patient Name_____
PLEASE PRINT

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Patient History

Thank you for choosing us as part of your health care team. Please complete these pages as accurately and as completely as possible. This information helps us to provide the proper care and treatment for you. Please do not leave any information out, even if it seems insignificant. Every piece of information gives us clues in finding the underlying hindrances to healing. You can review our brochure, "The Seven Hindrances" at **www.CornerstoneProgressiveHealth.com**

Today's Date: _____/_____/_____

Name: _____ Gender: (CIRCLE ONE) Male Female

Date of Birth: _____/_____/_____ Current age: _____ Birthplace: _____

Height: _____ Weight: _____ Right handed: _____ Left handed: _____

Home address: _____

City: _____ State:_____ Zip Code:_____

Home phone: (____)_____ OK to leave message? **Yes** **No**

Work phone: (____)_____ OK to leave message? **Yes** **No**

Mobile phone: (____)_____ OK to leave message? **Yes** **No**

Fax: (____)_____

E-mail: _____ Receive newsletter? **Yes** **No**

Occupation: _____ Employer: _____

Education completed: _____

Circle One: Single / Married / Divorced

Spouse Name: _____ Phone: (____)_____

CHILDREN: Number of children (name & date of birth):

_____

_____

_____

_____

_____

Emergency Contact: _____ Phone: (____)_____

Who may we thank for referring you to our office?_____

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Present Health Concerns:

Please list your most important health concerns. If possible, please list them in order of importance to you. For example, #1 is the most important and #5 is least important. List month and year the problem began.

1) _____

_____

_____

2) _____

_____

_____

3) _____

_____

_____

4) _____

_____

_____

5) _____

_____

_____

Other Concerns:

Please tell us any additional concerns you have about your health:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Current Medications:

Please include both prescription and nonprescription medications. (e.g. Prozac, Atenolol, Tylenol, Advil, aspirin, etc.)

Name of Medication	DOSE: in milligrams or grams	FREQUENCY: times per day/ week/mo	DURATION: How long have you been taking this?

Allergies:

Please list all food, environmental, and/or medication allergies:

_____

_____

_____

_____

_____

Hospitalizations / Surgeries / Procedures:

Please list any previous medical procedures, surgeries, hospitalizations, and serious illnesses.

Approximate Date / Year	Surgery / Hospitalization / Procedure / Serious Illness / Injury

Please mark if you have had any of the following:

_____ Breast implants
_____ Other surgical implants
_____ Tummy Tuck
_____ Face lift
_____ Pacemaker
_____ Moles removed
_____ Body piercing
_____ Metal or plastic in your body (pins, plates, etc.)
_____ Other: _____

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Past Accidents or Physical Traumas:

Please list any accidents of physical traumas you may have suffered. Also, please list any scars you may have and their location:

_____

_____

_____

_____

_____

Personal Habits: *(note: this is strictly confidential information)*

DRUGS:

Do you currently use street drugs? (CIRCLE APPLICABLE) Marijuana Cocaine Heroin Uppers Downers

Others: _____ How often? _____

Have you used street drugs in the past? **Yes** **No**

If "Yes," which ones and for how long? _____

TOBACCO:

Do you currently smoke? **Yes** **No**

If yes, how much _____ packs per day for _____ years

Have you ever smoked? **Yes** **No**

Do you use any other tobacco products? (CIRCLE APPLICABLE) Chewing Tobacco Cigars

EXERCISE:

Do you exercise? **Yes** **No**

If so, how often and which activities? _____

_____

_____

Dental History:

Please check all of the following that apply to you:

Gum disease		Root canals	
Sensitive teeth		Crowns	
Bleeding gums		Bridges	
Amalgam (silver) fillings		Extractions	
Jaw pain		Orthodontics	

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Women only:

Please check all of the following that apply to you:

Pregnant		Menopause symptoms	
Breast-feeding		Hysterectomy	
Irregular periods		Premenstrual symptoms	

Date of last menstrual period? _____

Number of days of your menstrual flow? _____

Electromagnetic exposure:

How many hours do you spend daily:

Watching TV		Wearing a headset	
Working on a computer		Wearing a wrist watch	
Talking on a phone		Wearing a pager	
Talking on a cell phone		Near electrical equipment (copy machine, power lines, computer, etc)	
Sleeping next to plug-in alarm clock			

Toxic exposures:

Please check all of the following that apply to you:

_____I place lawn care chemicals on my lawn yearly.
_____I use cleaners such as chlorox, windex, kaboom, mildew removers in my house.
_____I eat mostly non-organic food.
_____I am very sensitive to perfumes, candles, air fresheners.
_____I eat tuna or other fish more than 2 times per week.
_____I have worked on a farm that uses pesticides, herbicides, and/or fertilizers.
_____Other possible exposures through work/home_____

Your Major Goals for the First Visit:

Please tell us what you would like to accomplish on the first visit.

1) _____

2) _____

3) _____

4) _____

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Your Questions:

What questions do you have for today's visit?

1) _____

2) _____

3) _____

4) _____

Supplement Information:

In order to help facilitate the visit between you and your practitioner, please fill in this form with any vitamin, mineral, amino acid, or other supplement that you may be taking.

Supplements (eg: Vitamin C)	**Manufacturer** (eg: Perque)	**Form** (eg: Powder)	**Dosage** (eg: 100mg)	**Frequency** (eg: 2/day)	**Duration** (eg: 3 mo's)

Comments:

_____

_____

_____

_____

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Family History:

Please mark all of the following that apply: (P=Paternal, M=Maternal, GP=Grandparents, S=Siblings)

ADHD		Cancer		Gluten sensitivities	
Addictions		Depression		Irritable bowel syn-	
Allergies		Diabetes		Ulcers	
ALS		Eczema		Kidney disease	
Alzheimers		Epilepsy		Liver disease	
Anxiety		Heart Disease		Multiple slerosis	
Arthritis		High blood pressure		Parkinson's	
Asthma		Hypoglycemia		Stroke	
Autism		Celiac disease		Thyroid	
Auto-immune disease		Colitis		Violence	
Bleeding Disorder		Crohn's		Yeast Problems	

Comments:

_____

_____

_____

_____

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Do You Have A Hormone Imbalance?

Possible Progesterone Insufficiency

SIGNS & SYMPTOMS	NEVER/NOT AN ISSUE				ALWAYS/VERY TRUE
1. My breasts are large or are getting larger	0	1	2	3	4
2. I'm nervous and agitated	0	1	2	3	4
3. I feel anxious	0	1	2	3	4
4. I sleep lightly and restlessly	0	1	2	3	4
5. I tend to have abdominal bloating	0	1	2	3	4
6. For men, I have male pattern baldness "M" shape	0	1	2	3	4
7. For women, I felt wonderful when I was pregnant	0	1	2	3	4
8. My joints ache	0	1	2	3	4

The following questions are for women who have not yet reached menopause, and menopausal women who are taking hormone replacement therapy (estrogen or estrogen and progesterone.)

9. My breasts are swollen and tender or painful before my period	0	1	2	3	4
10. I have fibrocystic breasts by exam or mammogram	0	1	2	3	4
11. My lower belly is swollen/bloated	0	1	2	3	4
12. I'm irritable and aggressive	0	1	2	3	4
13. I lose my self-control	0	1	2	3	4
14. I have heavy menstrual periods	0	1	2	3	4
15. I have spotting or breakthrough menstrual bleeding	0	1	2	3	4
16. My menses occur more often than every 28 days	0	1	2	3	4
17. Menstruation is continuously painful	0	1	2	3	4
18. I have been diagnosed with endometriosis	0	1	2	3	4
19. I have uterine fibroids	0	1	2	3	4

Possible Testosterone Insufficiency

SIGNS & SYMPTOMS (Men & Women)	NEVER/NOT AN ISSUE				ALWAYS/VERY TRUE
1. My face has gotten slack and more wrinkled	0	1	2	3	4
2. I've lost muscle tone and it's hard to build muscle mass	0	1	2	3	4
3. I don't seem to have much muscle power/endurance	0	1	2	3	4
4. My abdomen tends to get fat	0	1	2	3	4
5. I am constantly tired or lack interest in doing things	0	1	2	3	4
6. I feel like making love less often than I used to	0	1	2	3	4
7. I am more anxious and not as self confident	0	1	2	3	4
8. I have lost bone mineral density (osteopenia/osteoporosis)	0	1	2	3	4
9. I have reduced nipple and/or clitoral sensitivity	0	1	2	3	4
10. I have less interest in sex than usual. Reduced libido	0	1	2	3	4
11. The quality and quantity of my orgasms has lessened	0	1	2	3	4
12. I seem to have lowered pain threshold; more sensitive to pain	0	1	2	3	4
13. I have migraine/vascular headaches	0	1	2	3	4
14. I have joint aches or stiffness	0	1	2	3	4
SIGNS & SYMPTOMS (Men Only)					
15. My breasts are getting fatty	0	1	2	3	4
16. I feel less self-confident and more hesitant	0	1	2	3	4
17. I am crabby or often in a bad mood	0	1	2	3	4
18. My sexual performance is not as good as it used to be	0	1	2	3	4
19. The quality of my sleep has declined from when I was young	0	1	2	3	4
20. I have hot flashes and sweats	0	1	2	3	4
21. I tire easily with physical activity	0	1	2	3	4
22. My body hair is thinning	0	1	2	3	4
23. My skin is dry or not as oily as it used to be	0	1	2	3	4
24. My penis is less sensitive than it used to be	0	1	2	3	4

(continued)

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Possible Growth Hormone Insufficiency

SIGNS & SYMPTOMS	NEVER/NOT AN ISSUE				ALWAYS/VERY TRUE
1. My hair is thinning	0	1	2	3	4
2. My cheeks sag	0	1	2	3	4
3. My gums are receding	0	1	2	3	4
4. My abdomen is flabby/I've got a "spare tire" due to abdominal fat	0	1	2	3	4
5. My muscles are slack	0	1	2	3	4
6. My skin is thinning and/or tears easily and/or is dry	0	1	2	3	4
7. My skin bruises easily as though the blood vessels are fragile	0	1	2	3	4
8. It's hard to recover after physical activity	0	1	2	3	4
9. I feel exhausted	0	1	2	3	4
10. I don't feel like the world. I tend to isolate myself	0	1	2	3	4
11. I feel continuously anxious and worried	0	1	2	3	4

SIGNS & SYMPTOMS (Men Only)	NEVER/NOT AN ISSUE				ALWAYS/VERY TRUE
12. The size and firmness of my erections is reduced	0	1	2	3	4
13. My erections do not stay firm during sex	0	1	2	3	4
14. I am losing hair at the vertex/back of my head	0	1	2	3	4
15. I have a double chin (extra folds or tissue under my jawbone)	0	1	2	3	4

Possible DHEA Insufficiency

SIGNS & SYMPTOMS	NEVER/NOT AN ISSUE				ALWAYS/VERY TRUE
1. My hair is dry	0	1	2	3	4
2. My skin and eyes are dry	0	1	2	3	4
3. My muscles are flabby	0	1	2	3	4
4. My belly is getting fat	0	1	2	3	4
5. I don't have much hair under my arm	0	1	2	3	4
6. I don't have much hair in pubic area (0=plenty of hair/4=hairless)	0	1	2	3	4
7. I don't have much fatty tissue in the pubic area (flat "mound of venus" in women). (0=padded / 4=flat)	0	1	2	3	4
8. My body doesn't have much of a special scent during sexual arousal	0	1	2	3	4
9. I am not tolerant to noise	0	1	2	3	4
10. My sex drive/libido is low	0	1	2	3	4
11. I have medical consequences of low DHEA: diabetes, osteoporosis, high blood pressure, autoimmune disease, inflammation, etc.	0	1	2	3	4

Cortisol

SIGNS & SYMPTOMS	NEVER/NOT AN ISSUE				ALWAYS/VERY TRUE
1. Fatigue, especially in the morning	0	1	2	3	4
2. Do you have a hard time getting up in the morning?	0	1	2	3	4
3. Anxiety/nervousness	0	1	2	3	4
4. Poor stress tolerance	0	1	2	3	4
5. Environmental sensitivies	0	1	2	3	4
6. Frequent viral infections	0	1	2	3	4
7. Absent-mindedness/forgetfulness	0	1	2	3	4
8. Feeling spacey/confusion/poor concentration	0	1	2	3	4
9. Depression	0	1	2	3	4
10. Glaucoma	0	1	2	3	4
11. I get light-headedness upon standing up	0	1	2	3	4
12. My muscles are relatively thin and underdeveloped	0	1	2	3	4
13. My jaw is relatively narrow and I have a broad forehead	0	1	2	3	4
14. I have relatively underdeveloped shoulders and neck	0	1	2	3	4

(continued)

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Possible Estrogen Insufficiency (Females Only)

SIGNS & SYMPTOMS	NEVER/NOT AN ISSUE				ALWAYS/VERY TRUE
1. I am losing hair on top/front of my head	0	1	2	3	4
2. I'm getting thin, vertical wrinkles above my lips	0	1	2	3	4
3. My breasts are drooping or becoming flat/less full	0	1	2	3	4
4. I have facial hair	0	1	2	3	4
5. My eyes are dry and easily irritated	0	1	2	3	4
6. I have hot flashes	0	1	2	3	4
7. I feel tired constantly. Daytime sleepiness	0	1	2	3	4
8. I am depressed	0	1	2	3	4
9. My menstrual flow is light. (0=moderate/1-3=low/4=none)	0	1	2	3	4
10. If menstruating: My cycles are irregular, too short (<27 days), or too long (>31 days)	0	1	2	3	4
11. If not menstruating: I do not feel like making love anymore	0	1	2	3	4
12. Vaginal dryness or lack of lubrication	0	1	2	3	4
13. Urine leaks with coughing, jumping, running, laughing, etc.	0	1	2	3	4
14. Frequent urinary tract infections or blood cells on urinalysis	0	1	2	3	4
15. Reduced or lack of sexual desire/libido	0	1	2	3	4
16. Reduced concentration, memory, or mental clarity	0	1	2	3	4

Possible Estrogen Excess/Progesterone Insufficiency (Females Only)

(in premenopausal women, condition may be related to menstrual cycle)

SIGNS & SYMPTOMS	NEVER/NOT AN ISSUE				ALWAYS/VERY TRUE
1. Agitation	0	1	2	3	4
2. Anxiety, mood swings, depression	0	1	2	3	4
3. Weight gain	0	1	2	3	4
4. Water retention	0	1	2	3	4
5. Migraine/vascular headaches	0	1	2	3	4
6. Abdominal bloating or lower abdominal fat deposition	0	1	2	3	4
7. Poor sleep	0	1	2	3	4
8. Achy joints	0	1	2	3	4
9. Swollen, tender, or fibrocystic breasts	0	1	2	3	4
10. Spotting or breakthrough bleeding	0	1	2	3	4
11. Excessive or prolonged menstrual bleeding	0	1	2	3	4
12. Menses more frequent than every 28 days	0	1	2	3	4
13. Uterine fibroids	0	1	2	3	4
Males: Fatty enlarged breast tissue (not muscle)	0	1	2	3	4
Prostate enlargement (BPH) / night time urination, etc.	0	1	2	3	4

Do you have any causes of ESTROGEN DOMINANCE? (✓ all that apply)

- ❑ Problems with detoxification (lack of sulfur-containing amino acids and glutathione)
- ❑ Intestinal dysbiosis (overgrowth of unhealthful bacteria or yeast)
- ❑ Insulin resistance and abdominal obesity (loss of waist line; or waist is much larger than hips)
- ❑ Chronic stress (excess cortisol)
- ❑ Sleep deprivation
- ❑ Working nights under bright lights & then sleeping during day (melatonin effect)
- ❑ Environmental toxins: xenoestrogens, flouride, cadmium, tobacco, trans-fatty acid consumption, air pollution
- ❑ Mineral imbalances such as Zinc or Magnesium deficiency
- ❑ Hormone imbalances: testosterone, progesterone, or thyroid deficiency
- ❑ Sedentary lifestyle and/or inadequate exercise
- ❑ Inadequate anti-oxidants in your foods (fruits and vegetables) or they are not fresh and unprocessed
- ❑ Liver dysfunction (including medications that impair liver function)

(continued)

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Do you have any conditions that may be the consequence of ESTROGEN DOMINANCE? (✓ all that apply)

- ❑ Autoimmune diseases – Hashimoto's, SLE (lupus) – also due to heavy metals, IgG4 food allergies, parasites
- ❑ Cervical dysplasia and cervical cancer
- ❑ Endometriosis
- ❑ Gallbladder disease
- ❑ Cancers that may be dependent on hormones such as breast or uterine
- ❑ Fertility problems
- ❑ Menstrual irregularities
- ❑ Polycystic Ovary Syndrom or cysts on ovaries
- ❑ Prementrual Syndrome

Possible Thyroid Insufficiency

SIGNS & SYMPTOMS	NEVER/NOT AN ISSUE				ALWAYS/VERY TRUE
1. I am sensitive/intolerant to cold	0	1	2	3	4
2. My hands and feet are always cold	0	1	2	3	4
3. In the morning my face is puffy and my eyelids are swollen	0	1	2	3	4
4. I put on weight easily and find it hard to lose weight	0	1	2	3	4
5. When I gain weight, it mostly occurs on my thighs/upper legs	0	1	2	3	4
6. I have dry skin	0	1	2	3	4
7. I tend to be tired in the afternoons	0	1	2	3	4
8. I have trouble getting up in the morning	0	1	2	3	4
9. I feel more tired at rest than when I am active	0	1	2	3	4
10. I tend to be constipated	0	1	2	3	4
11. My joints are stiff in the morning	0	1	2	3	4
12. I feel like I am living in slow motion	0	1	2	3	4
13. My hips are less than 10" larger than my waist	0	1	2	3	4
14. FEMALES: My breasts are relatively small	0	1	2	3	4
15. MALES: Hair loss primarily at the vertex of my scalp	0	1	2	3	4
16. I have blunt short palms	0	1	2	3	4
17. My ankles are large and thick (not due to water retention)	0	1	2	3	4

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