

Adjunct to Symptom Survey

Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Cell Phone: _____ Sex: _____ Age: _____

CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE TAKING:

- Antacids
- Antibiotics/Antifungal
- Antidepressants
- Anti-diabetic/Insulin
- High Blood Pressure
- Chemotherapy
- Cortisone/Anti-inflammatory
- Diuretics
- Heart Medications
- Thyroid
- Hormones
- Laxatives
- Lithium
- Oral Contraceptives
- Relaxants/Sleeping Pills
- Recreational Drugs (specify below)
- Ulcer Medications
- Aspirin or Tylenol
- Other (specify below)

CIRCLE IF YOU EAT, DRINK, OR USE:

- Alcohol
- Candy or Refined Sugar
- Carbonated Beverages
- Chemical Exposure
- Cigarettes or Exposure To
- Coffee
- Vitamins & Minerals (specify below)
- Distilled Water
- Fluorinate/Chlorinated Water
- Frequent Fast Food Meals
- Luncheon Meat
- Margarine
- Tea
- Milk Products
- Refined (white) Flour
- Salt Food without Tasting
- Under Excessive Stress
- Sweeteners
- Tobacco (chewing)

PLEASE SPECIFY ANY DRUGS, VITAMINS, AND MINERALS:

1. _____
2. _____
3. _____
4. _____
5. _____