



Dear Patient,

Enclosed are several forms to help prepare you for your initial consultation at Synergy Natural Medicine Clinic. Please complete them to the best of your ability and contact us if you need assistance or have any questions or concerns prior to your appointment.

1. Adjunctive Medical Care for Cancer Patients – This briefly describes the kind of care we provide to cancer patients at Synergy Natural Medicine Clinic.

2. Medical Records Checklist – ***Please complete and bring with you.***

We need relevant information regarding your cancer diagnosis, including the pathology report, bloodwork, relevant diagnostic tests, the course of radiotherapy or chemotherapy prescribed by your oncologist (if applicable). We also need to know about any prescription drugs or food supplements you may be taking.

You may already have some/all of this information. For medical records that you are missing, either ask your oncologist for them or request them using our Cancer Records Release Form.

Please try to bring as much of this information as possible with you on your scheduled appointment date.

3. Cancer Records Release Form – Use this form to request medical records you do not have from your oncologist or facility providing your medical care.

4. 5-Day Diet Diary - ***Please complete and bring with you.*** This helps us to better understand your current eating habits and is very important to complete for at least 3 days (5 days preferred).

5. Nutritional Assessment Questionnaire – ***Please complete and bring with you.***

We look forward to working with you.

Sincerely,

Synergy Natural Medicine Clinic



Adjunctive Medical Care for Cancer Patients

Thank you for the opportunity to provide you with medical care in connection with your diagnosis of cancer. Prior to consultation and treatment, we want to inform you about the kind of care we provide to cancer patients at our Clinic.

Cancer is a serious disease in modern society. An estimated 40% of the US population will develop cancer at some point in their life. The standard methods for treating patients with cancer are surgery, radiotherapy and chemotherapy drugs. In combination with earlier detection, these methods have increased survival rates and length of survival from diagnosis. Despite these advances, about half of patients diagnosed with cancer will eventually die from cancer. In addition, most patients will suffer many significant side effects from the progression of the disease or from standard treatment methods (surgery/radiotherapy, chemotherapy). These side effects can inhibit the body's natural ability to fight cancer, cause serious pain and disability, and reduce a cancer patient's quality of life.

We provide adjunctive treatment plans for patients diagnosed with cancer. This means several important things that we want to clarify and make sure you understand before we provide care.

First, our care is adjunctive and should be used along with standard cancer treatment methods, not in place of them. We recommend that you strongly consider the advice of your Oncologist when making decisions about standard medical treatments for cancer. Please make sure you are well informed about the benefits, risks and side effects of treatment. Your course of standard therapy should be agreed upon by you and your Oncologist.

Second, the adjunctive treatment of cancer is an evolving field of medicine and is not standardized. The methods we use to treat patients with cancer are based on clinical evidence and research compiled through a variety of means including, but not limited to, research published in medical journals, research and advice from experts in both standard and adjunctive cancer treatment methods, and research provided by private companies. The standard of care we use when treating patients with cancer is in compliance with the requirements of a licensed Naturopathic Doctor in the state of California, but have not been evaluated or approved by the FDA for the treatment of cancer.

Third, we want to clarify that we are not directly treating cancer. Instead, we are treating patients who have cancer. The primary goals of our adjunctive cancer treatment plans include but are not limited to:

- (1) Improving survival rates and length of survival by strengthening the immune system and other bodily organ systems, improving the efficacy of standard cancer therapy, and addressing risk factors associated with poorer outcomes.
- (2) Improving quality of life measures by decreasing side effects associated with cancer progression and standard cancer therapy.

The Naturopathic Doctor will discuss the nature, purpose, benefits, major risks and likelihood of success of the proposed treatment plan, as well as the risks if you decide against treatment.

Fourth, in discussing your treatment plan, we may use the term "cytotoxic". We use this term to generally describe the body's ability to fight cancer by creating a more cytotoxic environment and less hospitable environment for cancer. We do not prescribe substances that are cytotoxic to cancer cells. For example, mistletoe injections have been shown to activate NK cells and T-cells, which are part of the immune system that is fighting against cancer. We do not support or make claims that substances we provide are cytotoxic to cancer.



Medical Records Checklist

- Pathology Report**
- Diagnostic Imaging Report (DIR)** – Most recent report
- Bloodwork** – Most recent CMP (Comprehensive Metabolic Panel) and CBC (Complete Blood Count)

- Radiotherapy/Chemotherapy Treatment Plan –**

- Prescription drugs prescribed by your Oncologist**

- Other prescription drugs you may be taking**

- Vitamins and nutritional supplements you current consume**



Synergy Natural Medicine Clinic
Dr. Jennifer Wicher ND | Dr. Laurel Kwon
698 West Foothill Blvd, Monrovia, CA 91016
Phone: (626) 303-3300 Fax: (626) 239-7380

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient name _____ Date of birth _____

I REQUEST AND AUTHORIZE _____ TO RELEASE HEALTHCARE
doctor/health care practitioner
INFORMATION FOR THE PATIENT NAMED ABOVE TO DR. JENNIFER WICHER, ND OR
DR. LAUREL KWON, ND AT SYNERGY NATURAL MEDICINE CLINIC.

Doctor's address _____

Doctor's phone & fax number _____

Medical Records Requested

This request and authorization applies to the following healthcare records between

_____ and _____
Start date End date

- All healthcare information
Healthcare information relating to the following treatment or condition
Laboratory test results
Diagnostic imaging reports

Additional Details _____

Confirmation of Request and Authorization

I authorize the release of my medical records. For the purpose of this request, records or files
shall include all confidential communicable disease-related information, confidential alcohol or
drug abuse-related information and confidential mental health diagnosis/ treatment information.

This authorization expires 90 days after it is signed.

PATIENT SIGNATURE _____ DATE SIGNED _____

Nutritional Assessment Questionnaire 1.5

Name: _____

Date: ____/____/____

Birth Date: _____

Gender: _____

Please list your five major health concerns in order of importance:

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

Notes:

PART I Read the following questions and circle the number that applies:

KEY: 0 = Do not consume or use 2 = Consume or use weekly
 1 = Consume or use 2 to 3 times monthly 3 = Consume or use daily

DIET 58

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|---|----------------------------------|---|
| 1. 0 1 2 3 Alcohol | 7. 0 1 2 3 Cigars/pipes | 14. 0 1 Radiation exposure (0=no, 1=yes) |
| 2. 0 1 2 3 Artificial sweeteners | 8. 0 1 2 3 Caffeinated beverages | 15. 0 1 2 3 Refined flour/baked goods |
| 3. 0 1 2 3 Candy, desserts, refined sugar | 9. 0 1 2 3 Fast foods | 16. 0 1 2 3 Vitamins and minerals |
| 4. 0 1 2 3 Carbonated beverages | 10. 0 1 2 3 Fried foods | 17. 0 1 2 3 Water, distilled |
| 5. 0 1 2 3 Chewing tobacco | 11. 0 1 2 3 Luncheon meats | 18. 0 1 2 3 Water, tap |
| 6. 0 1 2 3 Cigarettes | 12. 0 1 2 3 Margarine | 19. 0 1 2 3 Water, well |
| | 13. 0 1 2 3 Milk products | 20. 0 1 2 3 Diet often for weight control |

LIFESTYLE 12

21. 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
22. 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
23. 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
24. 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

MEDICATIONS Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes): 54

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|--|---|
| 25. 0 1 Antacids | 39. 0 1 Diuretics |
| 26. 0 1 Antianxiety medications | 40. 0 1 Estrogen or progesterone (pharmaceutical, prescription) |
| 27. 0 1 Antibiotics | 41. 0 1 Estrogen or progesterone (natural) |
| 28. 0 1 Anticonvulsants | 42. 0 1 Heart medications |
| 29. 0 1 Antidepressants | 43. 0 1 High blood pressure medications |
| 30. 0 1 Antifungals | 44. 0 1 Laxatives |
| 31. 0 1 Aspirin/Ibuprofen | 45. 0 1 Recreational drugs |
| 32. 0 1 Asthma inhalers | 46. 0 1 Relaxants/Sleeping pills |
| 33. 0 1 Beta blockers | 47. 0 1 Testosterone (natural or prescription) |
| 34. 0 1 Birth control pills/implant contraceptives | 48. 0 1 Thyroid medication |
| 35. 0 1 Chemotherapy | 49. 0 1 Acetaminophen (Tylenol) |
| 36. 0 1 Cholesterol lowering medications | 50. 0 1 Ulcer medications |
| 37. 0 1 Cortisone/steroids | 51. 0 1 Sildenafil citrate (Viagra) |
| 38. 0 1 Diabetic medications/insulin | |

PART II (See key at bottom of page)

Section 1 – Upper Gastrointestinal System 55

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|---|--|
| 52. 0 1 2 3 Belching or gas within one hour after eating | 61. 0 1 2 3 Feel like skipping breakfast |
| 53. 0 1 2 3 Heartburn or acid reflux | 62. 0 1 2 3 Feel better if you don't eat |
| 54. 0 1 2 3 Bloating within one hour after eating | 63. 0 1 2 3 Sleepy after meals |
| 55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes) | 64. 0 1 2 3 Fingernails chip, peel or break easily |
| 56. 0 1 2 3 Bad breath (halitosis) | 65. 0 1 2 3 Anemia unresponsive to iron |
| 57. 0 1 2 3 Loss of taste for meat | 66. 0 1 2 3 Stomach pains or cramps |
| 58. 0 1 2 3 Sweat has a strong odor | 67. 0 1 2 3 Diarrhea, chronic |
| 59. 0 1 2 3 Stomach upset by taking vitamins | 68. 0 1 2 3 Diarrhea shortly after meals |
| 60. 0 1 2 3 Sense of excess fullness after meals | 69. 0 1 2 3 Black or tarry colored stools |
| | 70. 0 1 2 3 Undigested food in stool |

KEY: 0=No, symptom does not occur 2=Moderate symptom, occurs occasionally (weekly)
 1=Yes, minor or mild symptom, rarely occurs (monthly) 3=Severe symptom, occurs frequently (daily)

Section 2 – Liver and Gallbladder

68

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|--|---|
| <p>71. 0 1 2 3 Pain between shoulder blades
72. 0 1 2 3 Stomach upset by greasy foods
73. 0 1 2 3 Greasy or shiny stools
74. 0 1 2 3 Nausea
75. 0 1 2 3 Sea, car, airplane or motion sickness
76. 0 1 History of morning sickness (0 = no, 1 = yes)
77. 0 1 2 3 Light or clay colored stools
78. 0 1 2 3 Dry skin, itchy feet or skin peels on feet
79. 0 1 2 3 Headache over eyes
80. 0 1 2 3 Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)
81. 0 1 Gallbladder removed (0=no, 1=yes)
82. 0 1 2 3 Bitter taste in mouth, especially after meals
83. 0 1 Become sick if you were to drink wine (0=no, 1=yes)
84. 0 1 Easily intoxicated if you were to drink wine (0=no, 1=yes)</p> | <p>85. 0 1 Easily hung over if you were to drink wine (0=no, 1=yes)
86. 0 1 2 3 Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14)
87. 0 1 Recovering alcoholic (0=no, 1=yes)
88. 0 1 History of drug or alcohol abuse (0=no, 1=yes)
89. 0 1 History of hepatitis (0=no, 1=yes)
90. 0 1 Long term use of prescription/recreational drugs (0=no, 1=yes)
91. 0 1 2 3 Sensitive to chemicals (perfume, cleaning agents, etc.)
92. 0 1 2 3 Sensitive to tobacco smoke
93. 0 1 2 3 Exposure to diesel fumes
94. 0 1 2 3 Pain under right side of rib cage
95. 0 1 2 3 Hemorrhoids or varicose veins
96. 0 1 2 3 Nutrasweet (aspartame) consumption
97. 0 1 2 3 Sensitive to Nutrasweet (aspartame)
98. 0 1 2 3 Chronic fatigue or Fibromyalgia</p> |
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Section 3 – Small Intestine

47

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| <p>99. 0 1 2 3 Food allergies
100. 0 1 2 3 Abdominal bloating 1 to 2 hours after eating
101. 0 1 Specific foods make you tired or bloated (0=no, 1=yes)
102. 0 1 2 3 Pulse speeds after eating
103. 0 1 2 3 Airborne allergies
104. 0 1 2 3 Experience hives
105. 0 1 2 3 Sinus congestion, "stuffy head"
106. 0 1 2 3 Crave bread or noodles
107. 0 1 2 3 Alternating constipation and diarrhea</p> | <p>108. 0 1 2 3 Crohn's disease (0 =no, 1=yes in the past, 2=currenty mild condition, 3=severe)
109. 0 1 2 3 Wheat or grain sensitivity
110. 0 1 2 3 Dairy sensitivity
111. 0 1 Are there foods you could not give up (0=no, 1=yes)
112. 0 1 2 3 Asthma, sinus infections, stuffy nose
113. 0 1 2 3 Bizarre vivid dreams, nightmares
114. 0 1 2 3 Use over-the-counter pain medications
115. 0 1 2 3 Feel spacey or unreal</p> |
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Section 4 – Large Intestine

58

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| <p>116. 0 1 2 3 Anus itches
117. 0 1 2 3 Coated tongue
118. 0 1 2 3 Feel worse in moldy or musty place
119. 0 1 2 3 Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months)
120. 0 1 2 3 Fungus or yeast infections
121. 0 1 2 3 Ring worm, "jock itch", "athletes foot", nail fungus
122. 0 1 2 3 Yeast symptoms increase with sugar, starch or alcohol
123. 0 1 2 3 Stools hard or difficult to pass
124. 0 1 History of parasites (0=no, 1=yes)
125. 0 1 2 3 Less than one bowel movement per day</p> | <p>126. 0 1 2 3 Stools have corners or edges, are flat or ribbon shaped
127. 0 1 2 3 Stools are not well formed (loose)
128. 0 1 2 3 Irritable bowel or mucus colitis
129. 0 1 2 3 Blood in stool
130. 0 1 2 3 Mucus in stool
131. 0 1 2 3 Excessive foul smelling lower bowel gas
132. 0 1 2 3 Bad breath or strong body odors
133. 0 1 2 3 Painful to press along outer sides of thighs (Iliotibial Band)
134. 0 1 2 3 Cramping in lower abdominal region
135. 0 1 2 3 Dark circles under eyes</p> |
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Section 5 – Mineral Needs

75

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| <p>136. 0 1 History of carpal tunnel syndrome (0=no, 1=yes)
137. 0 1 History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes)
138. 0 1 History of stress fracture (0=no, 1=yes)
139. 0 1 2 3 Bone loss (reduced density on bone scan)
140. 0 1 Are you shorter than you used to be? (0=no, 1=yes)
141. 0 1 2 3 Calf, foot or toe cramps at rest
142. 0 1 2 3 Cold sores, fever blisters or herpes lesions
143. 0 1 2 3 Frequent fevers
144. 0 1 2 3 Frequent skin rashes and/or hives
145. 0 1 Herniated disc (0=no, 1=yes)
146. 0 1 2 3 Excessively flexible joints, "double jointed"
147. 0 1 2 3 Joints pop or click
148. 0 1 2 3 Pain or swelling in joints
149. 0 1 2 3 Bursitis or tendonitis</p> | <p>150. 0 1 History of bone spurs (0=no, 1=yes)
151. 0 1 2 3 Morning stiffness
152. 0 1 2 3 Nausea with vomiting
153. 0 1 2 3 Crave chocolate
154. 0 1 2 3 Feet have a strong odor
155. 0 1 2 3 History of anemia
156. 0 1 2 3 Whites of eyes (sclera) blue tinted
157. 0 1 2 3 Hoarseness
158. 0 1 2 3 Difficulty swallowing
159. 0 1 2 3 Lump in throat
160. 0 1 2 3 Dry mouth, eyes and/or nose
161. 0 1 2 3 Gag easily
162. 0 1 2 3 White spots on fingernails
163. 0 1 2 3 Cuts heal slowly and/or scar easily
164. 0 1 2 3 Decreased sense of taste or smell</p> |
|---|--|

<p>KEY: 0=No, symptom does not occur 1=Yes, minor or mild symptom, rarely occurs (monthly)</p>	<p>2=Moderate symptom, occurs occasionally (weekly) 3=Severe symptom, occurs frequently (daily)</p>
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Section 6 – Essential Fatty Acids

22

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|------|---------|--|------|---------|--|
| 165. | 0 1 | Experience pain relief with aspirin (0=no, 1=yes) | 169. | 0 1 2 3 | Headaches when out in the hot sun |
| 166. | 0 1 2 3 | Crave fatty or greasy foods | 170. | 0 1 2 3 | Sunburn easily or suffer sun poisoning |
| 167. | 0 1 2 3 | Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=current) | 171. | 0 1 2 3 | Muscles easily fatigued |
| 168. | 0 1 2 3 | Tension headaches at base of skull | 172. | 0 1 2 3 | Dry flaky skin or dandruff |

Section 7 – Sugar Handling

39

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|------|---------|--|------|---------|--|
| 173. | 0 1 2 3 | Awaken a few hours after falling asleep, hard to get back to sleep | 180. | 0 1 2 3 | Headache if meals are skipped or delayed |
| 174. | 0 1 2 3 | Crave sweets | 181. | 0 1 2 3 | Irritable before meals |
| 175. | 0 1 2 3 | Binge or uncontrolled eating | 182. | 0 1 2 3 | Shaky if meals delayed |
| 176. | 0 1 2 3 | Excessive appetite | 183. | 0 1 2 3 | Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4) |
| 177. | 0 1 2 3 | Crave coffee or sugar in the afternoon | 184. | 0 1 2 3 | Frequent thirst |
| 178. | 0 1 2 3 | Sleepy in afternoon | 185. | 0 1 2 3 | Frequent urination |
| 179. | 0 1 2 3 | Fatigue that is relieved by eating | | | |

Section 8 – Vitamin Need

81

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|------|---------|---|------|---------|--|
| 186. | 0 1 2 3 | Muscles become easily fatigued | 200. | 0 1 2 3 | Can hear heart beat on pillow at night |
| 187. | 0 1 2 3 | Feel exhausted or sore after moderate exercise | 201. | 0 1 2 3 | Whole body or limb jerk as falling asleep |
| 188. | 0 1 2 3 | Vulnerable to insect bites | 202. | 0 1 2 3 | Night sweats |
| 189. | 0 1 2 3 | Loss of muscle tone, heaviness in arms/legs | 203. | 0 1 2 3 | Restless leg syndrome |
| 190. | 0 1 2 3 | Enlarged heart or congestive heart failure | 204. | 0 1 2 3 | Cracks at corner of mouth (Cheilosis) |
| 191. | 0 1 2 3 | Pulse below 65 per minute (0=no, 1=yes) | 205. | 0 1 2 3 | Fragile skin, easily chaffed, as in shaving |
| 192. | 0 1 2 3 | ringing in the ears (Tinnitus) | 206. | 0 1 2 3 | Polyps or warts |
| 193. | 0 1 2 3 | Numbness, tingling or itching in hands and feet | 207. | 0 1 2 3 | MSG sensitivity |
| 194. | 0 1 2 3 | Depressed | 208. | 0 1 2 3 | Wake up without remembering dreams |
| 195. | 0 1 2 3 | Fear of impending doom | 209. | 0 1 2 3 | Small bumps on back of arms |
| 196. | 0 1 2 3 | Worrier, apprehensive, anxious | 210. | 0 1 2 3 | Strong light at night irritates eyes |
| 197. | 0 1 2 3 | Nervous or agitated | 211. | 0 1 2 3 | Nose bleeds and/or tend to bruise easily |
| 198. | 0 1 2 3 | Feelings of insecurity | 212. | 0 1 2 3 | Bleeding gums especially when brushing teeth |
| 199. | 0 1 2 3 | Heart races | | | |

Section 9 – Adrenal

78

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|------|---------|--|------|---------|--|
| 213. | 0 1 2 3 | Tend to be a "night person" | 226. | 0 1 2 3 | Arthritic tendencies |
| 214. | 0 1 2 3 | Difficulty falling asleep | 227. | 0 1 2 3 | Crave salty foods |
| 215. | 0 1 2 3 | Slow starter in the morning | 228. | 0 1 2 3 | Salt foods before tasting |
| 216. | 0 1 2 3 | Tend to be keyed up, trouble calming down | 229. | 0 1 2 3 | Perspire easily |
| 217. | 0 1 2 3 | Blood pressure above 120/80 | 230. | 0 1 2 3 | Chronic fatigue, or get drowsy often |
| 218. | 0 1 2 3 | Headache after exercising | 231. | 0 1 2 3 | Afternoon yawning |
| 219. | 0 1 2 3 | Feeling wired or jittery after drinking coffee | 232. | 0 1 2 3 | Afternoon headache |
| 220. | 0 1 2 3 | Clench or grind teeth | 233. | 0 1 2 3 | Asthma, wheezing or difficulty breathing |
| 221. | 0 1 2 3 | Calm on the outside, troubled on the inside | 234. | 0 1 2 3 | Pain on the medial or inner side of the knee |
| 222. | 0 1 2 3 | Chronic low back pain, worse with fatigue | 235. | 0 1 2 3 | Tendency to sprain ankles or "shin splints" |
| 223. | 0 1 2 3 | Become dizzy when standing up suddenly | 236. | 0 1 2 3 | Tendency to need sunglasses |
| 224. | 0 1 2 3 | Difficulty maintaining manipulative correction | 237. | 0 1 2 3 | Allergies and/or hives |
| 225. | 0 1 2 3 | Pain after manipulative correction | 238. | 0 1 2 3 | Weakness, dizziness |

Section 10 – Pituitary

29

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|------|---------|---|------|---------|---|
| 239. | 0 1 | Height over 6' 6" (0=no, 1=yes) | 245. | 0 1 | Height under 4' 10" (0=no, 1=yes) |
| 240. | 0 1 | Early sexual development (before age 10) (0=no, 1=yes) | 246. | 0 1 2 3 | Decreased libido |
| 241. | 0 1 2 3 | Increased libido | 247. | 0 1 2 3 | Excessive thirst |
| 242. | 0 1 2 3 | Splitting type headache | 248. | 0 1 2 3 | Weight gain around hips or waist |
| 243. | 0 1 2 3 | Memory failing | 249. | 0 1 2 3 | Menstrual disorders |
| 244. | 0 1 | Tolerate sugar, feel fine when eating sugar (0=no, 1=yes) | 250. | 0 1 | Delayed sexual development (after age 13) (0=no, 1=yes) |
| | | | 251. | 0 1 2 3 | Tendency to ulcers or colitis |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

Section 11 – Thyroid

48

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|---|---|
| 252. 0 1 2 3 Sensitive/allergic to iodine | 260. 0 1 2 3 Mentally sluggish, reduced initiative |
| 253. 0 1 2 3 Difficulty gaining weight, even with large appetite | 261. 0 1 2 3 Easily fatigued, sleepy during the day |
| 254. 0 1 2 3 Nervous, emotional, can't work under pressure | 262. 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet) |
| 255. 0 1 2 3 Inward trembling | 263. 0 1 2 3 Constipation, chronic |
| 256. 0 1 2 3 Flush easily | 264. 0 1 2 3 Excessive hair loss and/or coarse hair |
| 257. 0 1 2 3 Fast pulse at rest | 265. 0 1 2 3 Morning headaches, wear off during the day |
| 258. 0 1 2 3 Intolerance to high temperatures | 266. 0 1 2 3 Loss of lateral 1/3 of eyebrow |
| 259. 0 1 2 3 Difficulty losing weight | 267. 0 1 2 3 Seasonal sadness |

Section 12 – Men Only

27

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|--|---|
| 268. 0 1 2 3 Prostate problems | 272. 0 1 2 3 Waking to urinate at night |
| 269. 0 1 2 3 Difficulty with urination, dribbling | 273. 0 1 2 3 Interruption of stream during urination |
| 270. 0 1 2 3 Difficult to start and stop urine stream | 274. 0 1 2 3 Pain on inside of legs or heels |
| 271. 0 1 2 3 Pain or burning with urination | 275. 0 1 2 3 Feeling of incomplete bowel evacuation |
| | 276. 0 1 2 3 Decreased sexual function |

Section 13 – Women Only

60

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|---|--|
| 277. 0 1 2 3 Depression during periods | 287. 0 1 2 3 Breast fibroids, benign masses |
| 278. 0 1 2 3 Mood swings associated with periods (PMS) | 288. 0 1 2 3 Painful intercourse (dysparenia) |
| 279. 0 1 2 3 Crave chocolate around periods | 289. 0 1 2 3 Vaginal discharge |
| 280. 0 1 2 3 Breast tenderness associated with cycle | 290. 0 1 2 3 Vaginal dryness |
| 281. 0 1 2 3 Excessive menstrual flow | 291. 0 1 2 3 Vaginal itchiness |
| 282. 0 1 2 3 Scanty blood flow during periods | 292. 0 1 2 3 Gain weight around hips, thighs and buttocks |
| 283. 0 1 2 3 Occasional skipped periods | 293. 0 1 2 3 Excess facial or body hair |
| 284. 0 1 2 3 Variations in menstrual cycles | 294. 0 1 2 3 Hot flashes |
| 285. 0 1 2 3 Endometriosis | 295. 0 1 2 3 Night sweats (in menopausal females) |
| 286. 0 1 2 3 Uterine fibroids | 296. 0 1 2 3 Thinning skin |

Section 14 – Cardiovascular

30

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| 297. 0 1 2 3 Aware of heavy and/or irregular breathing | 302. 0 1 2 3 Ankles swell, especially at end of day |
| 298. 0 1 2 3 Discomfort at high altitudes | 303. 0 1 2 3 Cough at night |
| 299. 0 1 2 3 "Air hunger" or sigh frequently | 304. 0 1 2 3 Blush or face turns red for no reason |
| 300. 0 1 2 3 Compelled to open windows in a closed room | 305. 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion |
| 301. 0 1 2 3 Shortness of breath with moderate exertion | 306. 0 1 2 3 Muscle cramps with exertion |

Section 15 – Kidney and Bladder

13

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| 307. 0 1 2 3 Pain in mid-back region | 310. 0 1 2 3 Cloudy, bloody or darkened urine |
| 308. 0 1 2 3 Puffy around the eyes, dark circles under eyes | 311. 0 1 2 3 Urine has a strong odor |
| 309. 0 1 History of kidney stones (0=no, 1=yes) | |

Section 16 – Immune system

30

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|---|--|
| 312. 0 1 2 3 Runny or drippy nose | 317. 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years) |
| 313. 0 1 2 3 Catch colds at the beginning of winter | 318. 0 1 2 3 Acne (adult) |
| 314. 0 1 2 3 Mucus producing cough | 319. 0 1 2 3 Itchy skin (Dermatitis) |
| 315. 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year) | 320. 0 1 2 3 Cysts, boils, rashes |
| 316. 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year) | 321. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe) |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

Synergy's 5-Day Diet Diary

Use this chart to record all foods, beverages and dietary supplements you consume for 3-5 days.



	Day 1	Day 2	Day 3	Day 4	Day 5
Breakfast					
Lunch					
Dinner					
Other Snacks and Beverages (and when)					