DIGESTIVE HEALTH CENTER
650.856.3151

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WELCOME TO THE OFFICE OF CHRISTINE ROSCHE, M.P.H. C.N.S

Digestive Health Expert B.C.I.A. Cert. Biofeedback Therapist
Nutrition Consultant/Specialist

Date: _____

Name:			
Address:	City:	State:	Zip:
Telephone #:	E-mail:		
Social Security Number:	Driver's Licence #:		
Age:	Date of Birth:	No. of Children:	
Marital Status:	Occupation:		
Employer:			
Address:	City:	State:	Zip:
Telephone #:	E-mail:		
Spouse's Name:	Occupation:		
Who referred you to this office?			
Have you ever seen a counsellor or psychotherapist?	Date:		
Family Physician:			
Address:	City:	State:	Zip:
In case of Emergency, please notify:			
Telephone #:			

FINANCIAL POLICY OF THIS OFFICE: We ask our clients to pay at the end of each visit, unless other specific payment arrangements are made.

CANCELLATION POLICY: The time of your appointment is reserved for you. Please give us 48 hours' notice if you are unable to keep your appointment. Appointments cancelled less than 48 hours will be charged for.

☐ I have read the Financial Policy of the office and the Cancellation Policy and agree to the Terms stated above

_____ _____
Signature Date

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INITIAL CONSULTAION QUESTIONNAIRE	
Name:	Date:
What type of digestive issues do you have?	
Please described what types of medical/treatment programs you have done?	
What did you like about what you have done before?	
What did you dislike about it and what did not work?	
If you could design your own program, what would be the most important elements in it?	
What are your most important goals for your health? What behavioural patterns do you want to change?	

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THE QUICK SYMPTOM QUESTIONNAIRE

(Adapted from: **The Diet Cure** by Julia Ross pgs. XXV - XXIX)

Check the number nest to any symptom that applies to you and follow the directions at the end of each section to calculate your score. If you are uncertain about whether you might have a particular imbalance, please turn to the more complete symptom lists found in the corresponding chapters.

1. Is depleted brain chemistry the problem?

- ☐ 4 Sensitivity to emotional (or physical) pain; cry easily
- ☐ 4 Eat as a reward or for pleasure, comfort, or numbness
- ☐ 4 Worry, anxiety, phobia, or panic
- ☐ 4 Difficulty getting to sleep or staying asleep
- ☐ 3 Difficulty with focus, attention deficits
- ☐ 2 Low energy, drive, and arousal
- ☐ 4 Obsessive thinking or behaviour
- ☐ 4 Inability to relax after tension, stress
- ☐ 3 Depression, negativity
- ☐ 4 Low self-esteem, lack of confidence
- ☐ 4 More mood and eating problems in winter or at the end of the day
- ☐ 3 Irritability, anger
- ☐ 4 Use alcohol or drugs to improve mood

Total Score _____ If your score is over 10, please turn to chapters 1 and 9.

2. Are you suffering because of low-calorie dieting?

- ☐ 4 Increased cravings for and focus on food; overeating
- ☐ 4 Regain weight after dieting, more than was lost
- ☐ 3 Increased moodiness, irritability, anxiety, or depression
- ☐ 3 Less energy and endurance
- ☐ 3 Usually eat less than 2,100 calories a day
- ☐ 3 Skip meals, especially breakfast
- ☐ 3 Eat mostly low-fat carbohydrates (bagels, pasta, frozen yogurt, and others)
- ☐ 2 Constantly think about weight
- ☐ 2 Use aspartame (NutraSweet) daily
- ☐ 2 Take Prozac or similar serotonin-boosting drugs
- ☐ 2 have become vegetarian
- ☐ 3 Increased self-esteem
- ☐ 4 Have become bulimic or anorectic

Total Score _____ If your score is over 12, please turn to chapters 2 and 10.

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3. Are you struggling with blood sugar instability or high stress?

- ☐ 4 Crave a lift from sweets or alcohol, but later experience a drop-in energy and mood after ingesting them
- ☐ 4 Family history of diabetes, hypoglycaemia, or alcoholism
- ☐ 3 Nervous, jittery, irritable, headachy, weak, or teary on and off throughout the day; maybe calmer after meals
- ☐ 3 Frequent infections, allergies, or asthma, especially when weather changes
- ☐ 3 Mental confusion, decreased memory, hard to focus or get organized
- ☐ 4 Frequent thirst
- ☐ 3 Night sweats (not menopausal)
- ☐ 5 Light-headed, especially on standing up
- ☐ 4 Crave salty foods or licorice
- ☐ 4 Often feel stressed, overwhelmed, and exhausted
- ☐ 4 Dark circles under eyes or eyes sensitive to bright light
- ☐ 4 More awake at night

Total Score _____ If your score is over 12, please turn to chapters 3 and 11.

4. Do you have unrecognized low thyroid function?

- ☐ 4 Low energy
- ☐ 4 Easily chilled (especially hands and feet)
- ☐ 4 Other family members have thyroid problems
- ☐ 4 Can gain weight without overeating; hard to lose excess weight
- ☐ 3 Have to force yourself to do even moderate exercise
- ☐ 4 Find it hard to get going in the morning
- ☐ 3 High cholesterol
- ☐ 3 Low blood pressures
- ☐ 4 Weight gain began near the start of menses, a pregnancy, or menopause
- ☐ 3 Chronic headaches
- ☐ 3 Use food, caffeine, tobacco, and/or other stimulants to get going

Total Score _____ If your score is over 15, please turn to chapters 4 and 12.

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5. Are you addicted to foods you are actually allergic to?

- ☐ 3 Crave milk, ice cream, yogurt, cheese, or doughy foods (pasta, bread, cookies, among others) and eat them frequently
- ☐ 3 Experience bloating after meals
- ☐ 4 Gas, frequent belching
- ☐ 3 Digestive discomfort of any kind'
- ☐ 3 Chronic constipation and/or diarrhea
- ☐ 4. Respiratory problems, such as asthma, postnasal drip, Congestion
- ☐ 3 Low energy or drowsiness, especially after meals
- ☐ 4 Allergic to milk products or other common foods
- ☐ 3 Under eat or often prefer beverages to solid food
- ☐ 3 Avoid food or throw up food because bloating after eating makes you feel fat or tired
- ☐ 4 Can't gain weight
- ☐ 3 Hyperactivity or manic-depression
- ☐ 3 Severe headaches, migraines
- ☐ 4 Food Allergies in family

Total Score _____ If your score is over 12, please turn to chapters 5 and 13.

6. Are your hormones unbalanced?

- ☐ 4 Premenstrual mood swings
- ☐ 4 Premenstrual or menopausal food cravings
- ☐ 4 Irregular periods or migraines
- ☐ 3 Experienced a miscarriage, an abortion, or infertility
- ☐ 4 Use(d) birth control pills or another hormone medication
- ☐ 3 Uncomfortable periods - cramps, lengthy or heavy bleeding, or sore breasts
- ☐ 4 Peri- or postmenopausal discomfort (e.g., hot flashes, weight gains, sweats, insomnia, or mental dullness) 3 Skin eruptions with period

Total Score _____ If your score is over 6, please turn to chapters 6 and 14.

Note: Some men experience "male menopause" as a result of hormonal imbalance. Men, please see the box on page 79 if you are experiencing weight gain and emotional stress.

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7. **Do you have yeast overgrowth triggered by antibiotics, cortisone, or birth control pills?**

- ☐ 4 Often bloated, abdominal distention
- ☐ 3 Foggy-headed
- ☐ 2 Dressed
- ☐ 4 Have chronic fungus on nails or skin or athlete's foot
- ☐ 3 Recurring sinus or ear infections as an adult or child
- ☐ 3 Achy muscles and joints
- ☐ 4 Rashes
- ☐ 3 Stool unusual in color, shape or consistency

Total Score _____ If your score is over 13, please turn to chapters 7 and 15.

8. **Do you have fatty acid deficiency?**

- ☐ 4 Crave chips, cheese, and other rich foods more than, or in addition to, sweets and starches
- ☐ 4 Have ancestry that includes Irish, Scottish, Welsh, Scandinavian, or coastal Native American
- ☐ 3 Alcoholism and depression in the family history
- ☐ 3 High cholesterol, low HDL levels
- ☐ 4 Feel heavy, uncomfortable, and “clogged up” after eating fatty foods
- ☐ 4 History of hepatitis or other liver or gallbladder problems 4 Light-colored stool
- ☐ 4 Hard or foul-smelling stool
- ☐ 4 Pain on right side under your rib cage

Total Score _____ If your score is over 12, please turn to chapters 8 and 16.

Clear **Save** **Print**