FDN® INTAKE FORM

Functional Diagnostic Nutrition®

The following questions will be used as valuable information to assess your current state of health. Please answer the questions to the best of your ability.

Question	Yes	No
1. Intake Questions		
Do you experience problems falling asleep?	☐	☐
Do you experience problems staying asleep?	☐	☐
What time do you normally go to bed?	☐	☐
What time do you normally awaken?	☐	☐
Do you feel rested upon awakening?	☐	☐
Do you awaken regularly between 2-3 A.M.?	☐	☐
Do you recall your dreams?	☐	☐
Do you frequently have nightmares?	☐	☐
Is your energy good all day?	☐	☐
If No, what time of day is your energy best?	Time:	
What time is the lowest?	Time:	
Do you feel tired all the time?	☐	☐
If yes, how long have you felt this way?		
Do you suffer from depression?	☐	☐
If yes, please describe:		
Do you suffer from pain?	☐	☐
If yes, please explain:		
Are you mentally and emotionally exceptionally stressed?	☐	☐
If yes, how long have you felt this way?		
Do you suffer from low blood sugar?	☐	☐
If yes, please explain		
How many meals (including snacks) do you eat a day?	Meals:	

Question	Yes	No
How much time between meals/snack?	Time:	
Do you eat within 1 hour of awakening?	☐	☐
If yes, please describe a typical breakfast:		
If no, how long after awakening until you eat your first meal of the day?	Time:	
Please describe the typical meal:		
Do you have a bedtime snack?	☐	☐
If yes, please describe		
If no, how many hours between dinner and bedtime?	Time:	
Please describe a typical day's meals and snacks from awakening until bedtime (ending your day)		
Breakfast: (time)		
Lunch: (time)		
Dinner/supper: (time)		
Snack: (time)		
Snack: (time)		
Snack: (time)		
Do you frequently skip meals?	☐	☐
Do you need caffeine (Coffee, tea, etc.) to get going in the morning?	☐	☐
Do loud noises (sounds) bother you?	☐	☐
Are you startled easily?	☐	☐
Do you suffer from allergies?	☐	☐
Do you suffer from recurrent/chronic infections?	☐	☐
(Describe)		
Do you take thyroid hormones?	☐	☐
If yes, please list type, dosage, and how long have you been taking them:		
Do you suffer mental confusion?	☐	☐
Do you suffer from chronic headaches?	☐	☐

Question	Yes	No
Have you ever fainted?	☐	☐
Are you easily upset?	☐	☐
Are you taking any sleeping medication?	☐	☐
If yes, please list:		
Are you taking any anti-depressants?	☐	☐
If yes, please list type and dosage:		
Do you exercise?	☐	☐
If yes, what type, time of day, how long, how often?		
If no, is there any reason you cannot exercise?	☐	☐
If yes, please explain:		
Do you feel better or worse after exercise?	Better: ☐	Worse: ☐
Do you frequently experience a second wind (high energy) late at night?	☐	☐
What is your daytime light source? (i.e. indoor/outdoor, fluorescent, full spectrum, etc.)	Type:	
How much time do you get outdoor light (direct or indirect) daily?	Amount:	
Do you wear sunglasses when you are outdoors?	☐	☐
Does sunlight bother your eyes?	☐	☐
Do you have high blood pressure?	☐	☐
If yes, are you taking any medication?	☐	☐
If yes, please list type and dosage:		
Do you have low blood pressure?	☐	☐
Do you feel nauseous?	☐	☐
Do you have bloating?	☐	☐
Do you have heartburn?	☐	☐
Do you have constipation?	☐	☐
Do you have gas?	☐	☐

Question	Yes	No
Do you belch following meals?	☐	☐
Do your bowel movements alternate between constipation and diarrhea?	☐	☐
Do you have abdominal/intestinal pain?	☐	☐
Do you get bet bloated after meals?	☐	☐
Do you have diarrhea?	☐	☐
Do you travel outside of the U.S.?	☐	☐
Are your stools compact/hard to pass?	☐	☐
Do you have gurgles in your stomach?	☐	☐
Do you have any known food allergies?	☐	☐
What is your heritage? (e.g. Irish, German, Spanish, Asian, etc.)		
Have you had any root canals?	☐	☐
If yes, how many and when?		
Have you had any teeth extracted, including wisdom teeth?	☐	☐
If yes, when?		
Do you have a dental bridge in your mouth?	☐	☐
If yes, what is the material used?		
Do you have fillings?	☐	☐
If yes, how many and what materials were used?		
Do you have braces?	☐	☐
If yes, what is the material used?		
Do you have TMJ (jaw problems)	☐	☐
If yes, please describe:		
Describe any believed exposure(s) to environmental and/or chemical toxins:		

Question	Yes	No
Describe your hobbies and forms of recreation:		
Are you currently taking nutritional supplements?	☐	☐
If yes, please list all products and daily dosages:		
Have you ever had any head, neck, or back injuries?	☐	☐
If yes, please describe:		
How long has it been since you have felt your best?		
Please list your main health complaints, the one(s) you would most like to get rid of:		
2. Patient Health Survey:	**Yes**	**No**
Estrogen Deficiency	☐	☐
Hot flashes	☐	☐
Night Sweats	☐	☐
Vaginal Dryness	☐	☐
Foggy Thinking	☐	☐
Memory Lapses	☐	☐
Incontinence	☐	☐
Tearful	☐	☐
Depressed	☐	☐
Sleep Disturbances	☐	☐
Estrogen Excess	☐	☐
Mood Swings (PMS)	☐	☐
Tender Breasts	☐	☐
Water Retention	☐	☐
Nervousness	☐	☐
Irritability	☐	☐
Anxiousness	☐	☐

Question	Yes	No
Fibrocystic Breasts	☐	☐
Uterine Fibroids	☐	☐
Weight gain in hips	☐	☐
Bleeding changes	☐	☐
Progesterone Deficiency		
Hot Flashes	☐	☐
Night Sweats	☐	☐
Vaginal Dryness	☐	☐
Foggy Thinking	☐	☐
Memory Lapses	☐	☐
Bone Loss	☐	☐
Incontinence	☐	☐
Tearful	☐	☐
Depressed	☐	☐
Sleep Disturbances	☐	☐
Heart Palpitation	☐	☐
Progesterone Excess		
Sleepiness	☐	☐
Breast swelling/tenderness	☐	☐
Decreased libido	☐	☐
Mild Depression	☐	☐
Candida infections	☐	☐
Androgen Deficiency (Testosterone)		
Low libido	☐	☐
Vaginal Dryness	☐	☐
Foggy Thinking	☐	☐
Fatigue	☐	☐
Aches/pains	☐	☐
Memory lapses	☐	☐
Incontinence	☐	☐
Depressed	☐	☐
Sleep disturbances	☐	☐
Androgen Excess (Testosterone)		
Excessive facial/body hair	☐	☐
Loss of scalp hair	☐	☐
Increased acne	☐	☐
Voice change	☐	☐
Oily skin	☐	☐
Irritability	☐	☐

Question	Yes	No
Cortisol Deficiency (Adrenal)		
Fatigue	☐	☐
Sugar Craving	☐	☐
Allergies	☐	☐
Chemical sensitivity	☐	☐
Stress	☐	☐
Cold body temperature	☐	☐
Heart Palpitations	☐	☐
Cortisol Excess (Adrenal)		
Sleep disturbances	☐	☐
Bone Loss	☐	☐
Fatigue	☐	☐
Weight gain in waist	☐	☐
Loss of muscle mass	☐	☐
Thinning skin	☐	☐
3. Bivins-HormonalSymptoms[1] List for Women and Men		
A) Physical complaints		
headaches	☐	☐
low back pain	☐	☐
mid back pain	☐	☐
migraines	☐	☐
neck pain	☐	☐
neurological symptoms	☐	☐
wellness care	☐	☐
other pain:	☐	☐
B) Rule Out Parasites: *(401H, 410 stool)*		
bloating	☐	☐
constipation	☐	☐
diarrhea	☐	☐
various GI symptoms	☐	☐
rectal itching	☐	☐
no symptoms	☐	☐
C) Rule Out H. Pylori: *(401H & 418 stool)*		
acid reflux	☐	☐
acne	☐	☐
bad breath	☐	☐
belching	☐	☐
burping	☐	☐
cancer	☐	☐

Adopted from the Patient and Significant Others Health Survey© with permission.

Question	Yes	No
constipation	☐	☐
depression	☐	☐
fatigue	☐	☐
gastritis	☐	☐
headaches	☐	☐
heartburn	☐	☐
indigestion or nausea	☐	☐
intense hunger	☐	☐
malabsorption	☐	☐
migraines	☐	☐
morning, painful, or fowl smelling gas	☐	☐
overweight/cannot lose weight	☐	☐
poor sleep	☐	☐
rosacea	☐	☐
ulcers	☐	☐
upper abdominal pain	☐	☐
D) Rule Out Gluten Intolerance: *(Cyrex)*		
ADD/ADHD	☐	☐
Addison's Disease	☐	☐
Alternating diarrhea/constipation	☐	☐
asthma	☐	☐
autism	☐	☐
autoimmune growth retardation	☐	☐
bone diseases	☐	☐
celiac disease	☐	☐
Crohn's Disease	☐	☐
colitis	☐	☐
dark circles under eyes	☐	☐
dental enamel lesions	☐	☐
depression	☐	☐
Down's Syndrome	☐	☐
dyslexia	☐	☐
epilepsy	☐	☐
esophageal symptoms	☐	☐
failure to thrive	☐	☐
fatigue	☐	☐
fibromyalgia	☐	☐
food sensitivity (ex: soymilk, cow's milk)	☐	☐
gynecological disorders	☐	☐
headaches	☐	☐
IBS	☐	☐
infertility	☐	☐
learning disabilities	☐	☐
liver disorders	☐	☐

Question	Yes	No
malabsorption	☐	☐
nausea	☐	☐
otitis media	☐	☐
pernicious anemia	☐	☐
postpartum depression	☐	☐
psychiatric & brain disorders	☐	☐
RA	☐	☐
skin diseases	☐	☐
sleep & behavior disorders	☐	☐
suicidal thoughts (or attempts)	☐	☐
thyroid & eating disorders	☐	☐
undigested food in stool	☐	☐
vitamin & mineral deficiencies	☐	☐
vomiting	☐	☐
weight loss	☐	☐
E) Low Adrenal Function: *(201, 205 saliva)*		
allergies	☐	☐
bacterial, fungus or mold infection	☐	☐
blood sugar imbalance	☐	☐
chronic illness	☐	☐
depression	☐	☐
digestive disorder	☐	☐
dizziness upon standing	☐	☐
dry or thin skin	☐	☐
excessive hunger	☐	☐
hair loss	☐	☐
headaches	☐	☐
heart palpitations	☐	☐
immune deficiency	☐	☐
inflammation	☐	☐
liver disorders	☐	☐
low blood pressure	☐	☐
low body temperature	☐	☐
low sex drive	☐	☐
mood swings	☐	☐
parasite infection	☐	☐
PMS	☐	☐
poor concentration	☐	☐
poor memory	☐	☐
shoulder pain	☐	☐
sleep disorder	☐	☐
sweet craving	☐	☐
thyroid disorder	☐	☐
weakness	☐	☐

Question	Yes	No
weight gain/loss	☐	☐
F) High Estrogens: *(205, 208 saliva)*		
blood sugar imbalance	☐	☐
bone repair-interference	☐	☐
depression	☐	☐
endometriosis	☐	☐
excessive blood clotting	☐	☐
headaches	☐	☐
increased risk for breast cancer	☐	☐
increased body fat	☐	☐
infertility	☐	☐
interference with thyroid hormone	☐	☐
loss of zinc retention of copper	☐	☐
low sex drive	☐	☐
reduced vascular tone	☐	☐
reduced oxygen in all cells	☐	☐
risk for endometrial cancer	☐	☐
salt & fluid retention	☐	☐
uterine cramping	☐	☐
G) Low Estrogens: *(205, 208 saliva)*		
accelerated aging	☐	☐
depression	☐	☐
dry hair, skin, and nails	☐	☐
fear	☐	☐
headaches	☐	☐
heart palpitations	☐	☐
hot flashes	☐	☐
mental fogginess	☐	☐
migraines	☐	☐
poor sleep	☐	☐
vaginal dryness	☐	☐
worry	☐	☐
H) Immunity *(Genova, Cyrex)*		
_____		
_____		
_____		
_____		
_____		
_____		

Question	Yes	No
I) Toxic Liver		
abdominal pain	☐	☐
altered smell or taste	☐	☐
ascites (fluid that fills and distends the abdomen)	☐	☐
autoimmune disorders	☐	☐
aversion to certain foods	☐	☐
dark circles under eyes	☐	☐
fatigue	☐	☐
fever	☐	☐
hemochromatosis (too much iron)	☐	☐
infections (especially viral)	☐	☐
itching of the skin	☐	☐
jaundice (yellowness of skin and whites of eyes)	☐	☐
loss of appetite	☐	☐
muscles aches	☐	☐
nausea	☐	☐
progressive weight loss	☐	☐
weakness headache	☐	☐
Wilson' Disease	☐	☐
J) Low Progesterone: *(205, 208 saliva)*		
anxiety, can't shut down	☐	☐
endometriosis and uterine fibroids	☐	☐
heavy menstrual bleeding	☐	☐
irregular menstrual cycles	☐	☐
irritability and mood swings	☐	☐
poor sleep	☐	☐
tender breasts	☐	☐
unable to get pregnant	☐	☐
unable to maintain a pregnancy	☐	☐
K) High Progesterone: *(205, 208 saliva)*		
bloating	☐	☐
breast tenderness	☐	☐
decreasing insulin sensitivity	☐	☐
depression	☐	☐
raising insulin levels	☐	☐
reducing libido	☐	☐
weight gain	☐	☐
L) Hypothyroid: *(Pharmasan serum)*		
abnormal menstrual cycles	☐	☐
depression	☐	☐

Question	Yes	No
dry & coarse skin and hair	☐	☐
fatigue	☐	☐
forgetfulness	☐	☐
high cholesterol	☐	☐
iodine deficiency	☐	☐
iodine increase	☐	☐
weight gain	☐	☐
M) Hyperthyroid: *(Pharmasan serum)*		
breathlessness	☐	☐
budging eyes, "spacy gaze"	☐	☐
chest pain	☐	☐
diarrhea or GI upset	☐	☐
feeling of being too warm all the time	☐	☐
hair loss	☐	☐
heart palpitations/ accelerated heart rate	☐	☐
heightened anxiety, irritability, moodiness or depression	☐	☐
increased appetite	☐	☐
light or absent menstrual periods, infertility	☐	☐
muscle deterioration	☐	☐
nervousness or trembling	☐	☐
poor sleep yet exhausted	☐	☐
vision problems or eye irritation	☐	☐
warm or moist skin	☐	☐
weight loss	☐	☐
4. FACTOR Check Sheet		
Predisposing Factors		
I have experienced long periods of stress that have affected my well-being.	☐	☐
I have had one or more severely stressful events that have affected my well-being.	☐	☐
I have driven myself to exhaustion.	☐	☐
I overwork with little play or relaxation for extended periods.	☐	☐
I have had extended, severe or recurring respiratory infections.	☐	☐
I have taken long term or intense steroid therapy (corticosteroids).	☐	☐
I tend to gain weight, especially around the middle (spare tire).	☐	☐
I have a history or alcoholism and/or drug abuse.	☐	☐
I have environmental sensitivities.	☐	☐
I have diabetes (type II, adult onset, NIDDM).	☐	☐
I suffer from post-traumatic distress syndrome.	☐	☐
I suffer from anorexia.	☐	☐
I have one or more other chronic illnesses or diseases.	☐	☐
Key Signs and Symptoms		

Question	Yes	No
My ability to handle stress and pressure has decreased.	☐	☐
I am less productive at work.	☐	☐
I seem to have decreased in cognitive ability. I don't think as clearly as I used to.	☐	☐
My thinking is confused when hurried or under pressure.	☐	☐
I tend to avoid emotional situations.	☐	☐
I tend to shake or am nervous when under pressure.	☐	☐
I suffer from nervous stomach indigestions when tense.	☐	☐
I have many unexplained fears/anxieties.	☐	☐
My sex drive is noticeably less than it used to be.	☐	☐
I get lightheaded or dizzy when rising rapidly from a sitting or lying position.	☐	☐
I have feelings of graying out or blacking out/	☐	☐
I am chronically fatigued; a tiredness that is not usually relieved by sleep.	☐	☐
I feel unwell most of the time.	☐	☐
I notice that my ankles are sometimes swollen - the swelling worse in the evening.	☐	☐
I usually need to lie down or rest after sessions of psychological or emotional pressure/stress.	☐	☐
My muscles sometimes feel weaker than they should.	☐	☐
My hands and legs get restless - experience meaningless body movements.	☐	☐
I have become allergic or have increased frequency/severity of allergic reactions.	☐	☐
When I scratch my skin a white line remains for a minute or more.	☐	☐
Small irregular dark brown spots have appeared on my forehead, face, neck, and shoulders.	☐	☐
I sometimes feel weak all over.	☐	☐
I have unexplained and frequent headaches.	☐	☐
I am frequently cold.	☐	☐
I have decreased tolerance for cold.	☐	☐
I have low blood pressure.	☐	☐
I often become hungry, confused, shaky, or somewhat paralyzed under stress.	☐	☐
I have lost weight without reason while feeling very tired and listless.	☐	☐
I have feelings of hopelessness and despair.	☐	☐
I have decreased tolerance. People irritate me more.	☐	☐
The lymph nodes in my back are frequently swollen. (I get swollen glands on my neck).	☐	☐
I have times of nausea and vomiting for no apparent reason.	☐	☐
Energy Patterns	**Past**	**Now**
I often have to force myself in order to keep going. Everything seems like a chore.	☐	☐
I am easily fatigued.	☐	☐
I have difficulty getting up in the morning (don't really wake up until after 10:00 A.M.)	☐	☐
I suddenly run out of energy.	☐	☐
I usually feel much better and fully awake after the noon meal.	☐	☐
I often have an afternoon low between 3:00-5:00 P.M.	☐	☐

Question	Yes	No
I get low energy, moody, foggy if I do not eat regularly.	☐	☐
I usually feel my best after 6:00 P.M.	☐	☐
I am often tired at 9:00-10:00 P.M., but resist going to bed.	☐	☐
I like to sleep late in the morning.	☐	☐
My best, most refreshing sleep often comes between 7:00-9:00 A.M.	☐	☐
I often do my best work late at night (early in the morning).	☐	☐
If I don't go to bed by 11:00 P.M. I get a second burst of energy, often lasting until 1:00-2:00 A.M.	☐	☐
Frequently Observed Events		
I get coughs/colds that stay around for several weeks.	☐	☐
I have frequent or recurring bronchitis, pneumonia or other respiratory infections.	☐	☐
I get asthma, colds and other respiratory involvements two or more times per year.	☐	☐
I frequently get rashes, dermatitis or other skin conditions.	☐	☐
I have rheumatoid arthritis.	☐	☐
I have allergies to several things in the environment.	☐	☐
I have multiple chemical sensitivities.	☐	☐
I have chronic fatigue syndrome.	☐	☐
I get pain in the muscles of my upper back and lower neck for no apparent reason.	☐	☐
I get pain in the muscles on the sides of my neck.	☐	☐
I have insomnia or difficulty sleeping.	☐	☐
I have fibromyalgia.	☐	☐
I suffer from asthma.	☐	☐
I suffer from hay fever.	☐	☐
I suffer from nervous breakdowns.	☐	☐
My allergies are becoming worse (more severe/frequent/diverse)	☐	☐
The fat pads on my palms of my hands and/or tips of my fingers are often red.	☐	☐
I bruise more easily than I used to.	☐	☐
I have tenderness in my back near my spine at the bottom of my rib cage when pressed.	☐	☐
I have a swelling under my eyes upon rising that goes away after I have been up for a couple of hours	☐	☐
The next two questions are for women only	☐	☐
· I have increasing symptoms of PMS such as cramps, bloating, moodiness, irritability, emotional instability,	☐	☐
headaches, tiredness and/or intolerance before my period (only some of these need be present)	☐	☐
· My periods are generally heavy but they often stop, or almost stop, on the fourth day, only to start up profusely on the 5th or 6th day	☐	☐
Food Patterns		
I need coffee or some other stimulant to get going in the morning.	☐	☐
I often crave food high in fat and feel better with high fat foods.	☐	☐

Question	Yes	No
I use high fat foods to drive myself.	☐	☐
I often use high fat foods and caffeine containing drinks (coffees, colas, chocolate) to drive myself.	☐	☐
I often crave salt and/or foods high in salt. I like salty foods.	☐	☐
I feel worse if I eat high potassium foods (like bananas, figs, raw potatoes), especially if I eat them in the morning	☐	☐
I crave high protein foods (meats, cheeses).	☐	☐
I crave sweet foods (pies, cakes, pastries, doughnuts, dried fruits, candies or desserts).	☐	☐
I feel worse if I miss or skip a meal.	☐	☐
Aggravating Factors		
I have constant stress in my life or work.	☐	☐
My dietary habits tend to be sporadic and unplanned.	☐	☐
My relationships at work and/or home are unhappy.	☐	☐
I do not exercise regularly.	☐	☐
I eat lots of fruit.	☐	☐
My life contains insufficient enjoyable activities.	☐	☐
I have little control over how I spend my time/	☐	☐
I restrict my salt intake.	☐	☐
I have gum and/or tooth infections and abscesses.	☐	☐
I have meals at irregular times	☐	☐
Relieving Factors		
I feel better almost right away once a stressful situation is resolved.	☐	☐
Regular meals decrease the severity of my symptoms.	☐	☐
I often feel better after spending a night out with my friends.	☐	☐
I often feel better if I lie down.	☐	☐
Other relieving factors:	☐	☐