YEH CENTER OF NATURAL MEDICINE, INC.
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PERSONALIZED FOOD CONSULTATION - FORM A

(Please Print)

PERSONAL INFORMATION:

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: ____ /____/____ Sex: M / F Age: ___ Height: ___'___" Weight: _____
Who may we thank for referring this Food Medicine book to you? _____
What is your goal and objective for health, with help from this book? _____
_____

Which statement best describes your outlook?

- o If the information benefits my health, I am willing to make changes right away.
- o If the information benefits my health, I will make slow and gradual changes.
- o I just want to be informed about nutrition and diet.
- o I am not willing to make dietary changes or give up my favorite foods.

MEDICAL HISTORY:

Primary Illness: _____ Duration of Illness: _____
Secondary Illness: _____ Duration of Illness: _____
Medical History: _____
_____
_____

Surgeries:	Procedure (Please be Specific):	Date:
	_____	_____
	_____	_____
	_____	_____
	_____	_____

MEDICATIONS AND SUPPLEMENTS:

Drug Medications:

Drug Name:	Dosage:	Frequency Per Day:		Starting Day:
_____	_____	_____	__	_____
_____	_____	_____	__	_____
_____	_____	_____	__	_____
_____	_____	_____	__	_____

Natural Nutritional and Herbal Supplements:

Supplement:	Dosage:	Frequency Per Day:		Starting Day:
_____	_____	_____	__	_____
_____	_____	_____	__	_____
_____	_____	_____	__	_____
_____	_____	_____	__	_____

BIOLOGICAL EVALUATION:

1. Do you have high blood pressure? o yes o no high cholesterol? o yes o no
   If yes, please explain: _____

2. Do you suffer from headaches, migraines or head pain? o yes o no
   If yes, please explain: _____

3. Do you suffer from dizziness or vertigo? Do you faint? o yes o no
   If yes, please explain: _____

4. Do you suffer from chest pains or shortness of breath? o yes o no
   If yes, please explain: _____

5. Date of EKG or stress test for the heart?_____
   What were the findings?_____

6. Do you suffer from pain of the hypochondriac region or rib cage? o yes o no
   If yes, please explain: _____

7. Do you suffer from upper or lower abdominal pain? o yes o no
   If yes, please explain: _____

8. Do you experience loss of appetite, nausea or vomiting? o yes o no
   If yes, please explain: _____

9. Do you suffer from anorexia, bulimia or compulsive eating? o yes o no
   If yes, please explain: _____

10. Do you have bodily aches and pains? o yes o no
    If yes, please explain: _____

11. How many times per year do you catch a cold or flu? _____
    How many days does it usually last? _____

12. Do you suffer from respiratory infections? o yes o no
    If yes, please explain: _____

13. Do you suffer from any of the following? Please circle all that apply:

chronic cough	runny nose	sneezing	asthma
phlegm	post nasal drip	rhinitis	hay fever
bronchitis	pneumonia	sinusitis	allergies

The color of my phlegm/mucous is usually: (Please circle all that apply.)

Clear
Yellow
Orange
Green
Brown
With Blood

Comments: _____

14. Do you suffer from food allergies? o yes o no
    If yes, please list foods that you are allergic to: _____
    _____

15. Do you have normal bowel movements, 2-3 times daily? o yes o no
    If no, please explain:_____

16. Do you suffer from diarrhea, dysentery or constipation? o yes o no
    If yes, please explain: _____

17. Is your urine color light yellow or dark yellow? _____

18. Do you have blood in the urine and painful or burning urination? o yes o no
    If yes, please explain: _____

19. How many glasses of water do you consume daily? _____ How many ounces? _____

20. Please explain your exercise routine:

21. Please explain how you relax and cope with stress:

22. How many hours do you sleep each night? _____
I sleep from ____ a.m. / p.m. to ____ a.m. / p.m.
I nap from ____ a.m. / p.m. to ____ a.m. / p.m.
Is your sleep disturbed? Please explain: _____

23. Do your hands and feet feel cold, numb or tingly? o yes o no
If yes, please explain: _____

24. Do you suffer from uncontrolled movement(s) or seizures? o yes o no
If yes, please explain: _____

25. Do you suffer from mood swings, anxiety, anger or depression? o yes o no
If yes, please explain: _____

26. Have you been diagnosed with cancer, tumors or cysts? o yes o no
If yes, please explain: _____

27. Do you smoke cigarettes, drink alcohol or take drugs? o yes o no
If yes, please explain: _____

28. Do you have hair loss or gray hair? o yes o no
If yes, please explain: _____

29. Do you have wrinkles, dry skin, skin flaws and/or blemishes? o yes o no
If yes, please explain: _____

30. Do you suffer from hypoglycemia or hyperglycemia? o yes o no
If yes, please explain: _____

31. Do you suffer from hypothyroidism or hyperthyroidism? o yes o no
If yes, please explain: _____

32. Do you have tendinitis, bursitis, arthritis or osteoarthritis? o yes o no
If yes, please explain: _____

33. I have a tendency to feel (cool, cold, warm, hot)? (please circle one)
I enjoy (spring, summer, autumn, winter) the most? (please circle one)

34. Please circle all that apply to your personality:

Aggressive	Loud	Talkative	Fun-Loving
Friendly	Social	Organized	Picky/Choosy
Quiet	Shy	Passive	Generous

35. Please circle all that apply to your lifestyle:
Prefer Outdoor Athletic Active Prefer Indoor Sedentary

36. Please circle the emotion that most applies to you:
Anger Sadness Fear Joy Worry

37. How many hours a day do you engage in … (24 hours total)?
studying? ____ working? ____ sleeping/napping? ____
playing? ____ exercising? ____ resting/relaxing? ____

WOMEN ONLY:

Do you have reoccurring yeast, bladder or urinary tract infections? o yes o no
If yes, please explain: _____

Have you ever been pregnant? o yes o no
If yes, please explain any difficult pregnancies or complications during childbirth:
_____
Number of total pregnancies: ____ Number of children: ____

MENSTRATING WOMEN ONLY:

Are you currently pregnant? o yes o no
If yes, how many months: _____

Do you suffer from abnormal menstrual cycles? o yes o no
If yes, please explain: _____

During menstruation, do you have cramps? o yes o no
If yes, please explain: _____

Do you suffer from PMS? o yes o no
If yes, please explain: _____

Are you on birth control pills? o yes o no
If yes, for how long? _____ Please explain: _____

MENOPAUSE WOMEN ONLY:

Are you undergoing hormone replacement therapy? o yes o no
If yes, please explain: _____
_____

How long have you experienced absence of menstruation? _____

Do you suffer from menopause symptoms? o yes o no
If yes, please explain: _____
_____

HYSTERECTOMY PATIENTS ONLY:

What were the reasons for the hysterectomy?_____

Was it a partial or complete hysterectomy? _____

When did you have the hysterectomy? _____

Are you undergoing hormone replacement therapy? o yes o no

If yes, please explain: _____

_____

MEN ONLY

Do you have prostatitis or prostate enlargement? o yes o no

If yes, please explain: _____

Have you had a vasectomy? o yes o no

If yes, please explain: _____

Do you suffer from impotence or sterility? o yes o no

If yes, please explain: _____

Do you have nocturnal emissions? o yes o no

If yes, please explain: _____

Do you have painful ejaculation or premature ejaculation? o yes o no

If yes, please explain: _____

I Would Like More Information On: _____

Additional Comments: _____

_____

_____

After completing this form, please return it to the receptionist office.
Thank you.

The information I have provided is true and accurate to the best of my knowledge. I understand that this information will be held in strict confidentiality between the medical staff at Yeh Center of Natural Medicine, Inc. and myself.

The purpose of "Food Consultation" is to familiarize the patient with food medicine, nutrition, and diet on an individualized basis. The manual does not make any health claims, and the information introduced does not take the place of physician's care, medical procedures, lab tests, or any necessary medication.

Yeh Center of Natural Medicine, Inc. also does not in any way encourage any person to try to heal themselves or to stop their current medical care and supervision, as all medical treatment requires the knowledge and skill of a trained professional. Due to the personalized nature of this food medicine program, long hours are spent putting it together. Therefore, there is no exchange or refund for this book. I have read and understand the above statements.

Print Name: _____ Signature: _____ Date: _____

Food Medicine for Your Health and Wellness!

Food Consultation on a schedule time we agree
$250
This amount includes the digital tongue diagnosis and
ALL of the following books - 5 books total!

1. FOODS OF FOOD MEDICINE ™

It is a unique food encyclopedia with knowledge of food biology, chemistry, and physics.
This book also provides food effects for health.

2. SEASONAL FOOD MEDICINE ™

Specific foods required by the body and vital organ systems during the changing seasons.
This is your guide through spring, summer, autumn and winter foods and related systems.

3. BALANCED FOOD MEDICINE ™

It takes an in-depth look at the importance of food, the major determinants of health,
the balance of chemistry, physics and biology, and special care for specific illnesses.
It is a comprehensive guide for your health and wellness.

4. NATURAL MEDICINE WORKS

It is the complete collection of inspirational recoveries and patient testimonials
that will touch your heart, mind and soul.
This book also includes history, theory and use of natural medicine.

5. TAI CHI EXERCISES

Classical Tai Chi exercises from China to benefit the mind and body.
Tai Chi is good for the nervous, cardiovascular, digestive, metabolic,
respiratory systems as well as skeletal, muscle and joint activities.
This book illustrates and explains 24 forms and 174 movements carefully and precisely.