Patient Medical History

The health information you provide in this Starter Booklet will never be disclosed to outside parties, nor will it be used for marketing purposes. It will be used to assist your LEAP Dietitian with your Dietary Treatment Program. The contact information you provide will help your LEAP Dietitian to contact you to schedule your Dietary Consultations.

Primary Care Doctor Name: _____Phone:_____ Fax:_____

Specialist Doctor Name: _____Phone:_____Fax:_____

Patient First Name: _____ Last Name:_____

Street Address: _____City: _____ State: ____

Zip: _____ Email Address: _____

Preferred Contact Phone: (_____)_____ Best Hours To Call: _____

Alternate Phone 1: (_____)_____ Best Hours To Call: _____

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The LEAP Program will change your life and could be one of the most important steps you've ever taken to improve your day-to-day health and well-being. If you have any questions about the LEAP Program speak with your Healthcare Provider or call LEAP Client Support at 1-561-848-7111 or toll free 888-NOW-LEAP.

Medical History

What you eat and how you eat is one of the pillars that can either strengthen your body helping you live healthier happier lives, or it can give rise to unwanted symptoms, illness, and a decreased quality of life. Migraines, headaches, irritable bowel syndrome, chronic digestive problems, and many other symptoms can often be caused by reactions to foods and additives in your diet. Many times these reactions are delayed or hidden.

A thorough history and prompt intervention quickly uncover the foods and additives responsible for symptoms and provides personalized Dietitian support to help you overcome diet related health problems.

Step-By-Step Instructions:

1. Follow the instructions and provide complete and accurate information. The information you provide will be used by your dietitian to tailor your plan to give you the best chances of success on the program.

2. Bring the starter book and a diet history with you to your first appointment

3. Take your specimen kit to your draw site (check with your dietitian)

4. Schedule an appointment with your dietitian to receive the results of your test. It usually takes 7 – 10 working days for your dietitian to receive the test results from the date your blood sample was taken.

Symptom Survey

Date:	Patient Name:	Patient Signature:

Please fill in the following form completely. Score every symptom based on your experience over the last 30 days. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for EVERY symptom listed.

SCALE OF SYMPTOM POINTS:

●○○○○ = 0 = Did Not Suffer From This Ever or Almost Ever
○●○○○ = 1 = Suffered OCCASSIONALLY (less than 2 times per week), symptom **wasn't severe**
○○●○○ = 2 = Suffered FREQUENTLY (2 or more times per week), symptom **wasn't severe**
○○○●○ = 3 = Suffered OCCASSIONALLY and symptom **was severe**
○○○○● **= 4 =** Suffered FREQUENTLY and symptom **was severe**

CONSTITUTIONAL
○○○○○ Fatigue (sluggish, tired)
○○○○○ Hyperactive (nervous energy)
○○○○○ Restless (can't relax/sit still)
○○○○○ Sleepiness During Day
○○○○○ Insomnia at Night
○○○○○ Malaise (Feel Lousy)
_____ TOTAL (0-24)

EMOTIONAL/MENTAL
○○○○○ Depression
○○○○○ Anxiety
○○○○○ Mood Swings
○○○○○ Irritability
○○○○○ Forgetfulness
○○○○○ Lack of concentration/focus
_____ TOTAL (0-24)

HEAD/EARS
○○○○○ Headache (any kind)
○○○○○ Earache
○○○○○ Ear Infection
○○○○○ Ringing in Ear
○○○○○ Itchy Ears
○○○○○ Discharge From Ears
_____ TOTAL (0-24)

SKIN
○○○○○ Blemishes, Acne
○○○○○ Rashes, Hives
○○○○○ Eczema
○○○○○ "Rosy" Cheeks
_____ TOTAL (0-16)

NASAL/SINUS
○○○○○ Post Nasal Drip
○○○○○ Sinus Pain
○○○○○ Runny Nose
○○○○○ Stuffy Nose
○○○○○ Sneezing
_____ TOTAL (0-20)

MOUTH/THROAT
○○○○○ Sore Throat
○○○○○ Swollen Throat
○○○○○ Swelling of Lips/Tongue
○○○○○ Gagging/Throat Clearing
○○○○○ Canker Sores
_____ TOTAL (0-20)

LUNGS
○○○○○ Wheezing
○○○○○ Chest Congestion
○○○○○ Dry Cough
○○○○○ Wet Cough
_____ TOTAL (0-16)

EYES
○○○○○ Red or Swollen Eyes
○○○○○ Watery Eyes
○○○○○ Itchy Eyes
○○○○○ Dark Circles" or "Bags"
_____ TOTAL (0-16)

GENITOURINARY
○○○○○ Increased Urinary Frequency
○○○○○ Painful Urination
_____ TOTAL (0-8)

MUSCULOSKELETAL
○○○○○ Joint Pains/Aching
○○○○○ Stiff Joints
○○○○○ Muscle Aches
○○○○○ Stiff Muscles
_____ TOTAL (0-16)

CARDIOVASCULAR
○○○○○ Irregular Heartbeat
○○○○○ High Blood Pressure
_____ TOTAL (0-8)

DIGESTIVE
○○○○○ Heartburn/Reflux
○○○○○ Stomach Pains/Cramps
○○○○○ Intestinal Pains/Cramps
○○○○○ Constipation
○○○○○ Diarrhea
○○○○○ Bloating Sensation
○○○○○ Gas (of Any Kind)
○○○○○ Nausea, Vomiting
○○○○○ Painful Elimination
_____ TOTAL (0-36)

WEIGHT MANAGEMENT
_____ **Record Actual Weight**
○○○○○ Fluctuating Weight
○○○○○ Food Cravings
○○○○○ Water Retention
○○○○○ Binge Eating or Drinking
○○○○○ Purging (all methods)
_____ TOTAL (0-20)

Signet Diagnostic Corporation ✦ 3555 Fiscal Court, Suite 9 Riviera Beach FL 33404 ✦ Ph. 561-848-7111 Fax 561-848-6655
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Health History Questionnaire

The Health History Questionnaire section supplements information obtained in your Symptom Survey with past medical problems and treatments. This information is vital for the LEAP Treatment Staff in identifying dietary considerations apart from your food sensitivity test results. Please answer all questions completely and accurately.

Name:	Date of Birth:		
Sex: [ ] Male [ ] Female	Height:	Weight:	Blood Pressure: /
Marital Status:	Occupation:		

List Your Main Health Complaints (In order of importance)	Duration of Problem
1.	
2.	
3.	
4.	

Surgical History (Please list all surgeries)

1.	2.	3.

Circle (Or Write In) All Medical Conditions You Have Been Previously Diagnosed With

Arthritis, Rheumatoid	Crohn's Disease	Hypoglycemia	Fructose Intolerance
Arthritis, Osteo	Depression	Interstitial Cystitis	Other:
Asthma	Diabetes	Irritable Bowel Syndrome	Other:
Attention Deficit Disorder	Eczema	Lactose Intolerance	Other:
Celiac Disease	Gastroesophageal Reflux	Migraine	Other:
Chronic Fatigue Syndrome	Hives	Rhinitis	Other:
Colitis	Hypertension	Ulcerative Colitis	Other:

List All Medications You Currently Take Regularly OR As Needed (Prescription & OTC)

Drug	Dosage	# Times Per Day	Start Date

Allergy History

Does Anyone In Your Family Have Allergies? [ ] Yes [ ] No
If Yes: [ ] Parent [ ] Sibling [ ] Other Blood Relative:
If Yes, What Are They Allergic To? [ ] Food [ ] Medication [ ] Pollen [ ] Dust [ ] Other:
Do you Have Any Known Allergies? [ ] Yes [ ] No
List All Foods, Additives, and Medications That You KNOW OR SUSPECT You Are Allergic To:

List All Vitamins & Herbs Taken On A Regular Basis

Diet History

# of times you typically skip Breakfast each week:	How many snacks do you typically eat per day?					
# of times you typically skip Lunch each week:	***Circle below all snacks you typically eat***					
# of times you typically skip Dinner each week:	Chips	Cookies	Candy	Fruit	Veggies	Other

Place a letter next to each beverage indicating how often you consume it using the following scale:
D = Daily, W = Weekly, M = Monthly 0 = Never or almost never.

____Water ____Coffee ____Tea ____Soda ____Milk ____Juice ____Wine ____Beer ____Other:

How many times do you typically eat out each week?

How many times per week do you eat at a "Fast Food" restaurant?

LEAP Program Goals

The positive benefits experienced by changing your diet and lifestyle can be tremendous. What Health Goals do you want to accomplish? Whether your aim is to decrease the frequency or severity of specific symptoms, or to increase energy and general wellness, your LEAP Dietitian will work with you to design a plan that will help you achieve those goals. The first step is to write down your goals and then discuss them with your Dietitian to develop your personalized plan.

1.	4.
2.	5.
3.	6.

Food Avoidance Form

Patient Name:

Referring Doctor:

INSTRUCTIONS: FILL-IN the box completely next to every food you DO NOT WANT included in your diet. This should include all foods that you do not want to eat **AND** any foods that you know you are intolerant or allergic to, in every food category listed. BUT, the more foods you leave unchecked, the more variety you'll have in your diet. So only check off the foods you absolutely do not want included in your diet, not just those you are unfamiliar with.

PROTEINS

MEATS:
- ❑ ALL MEATS
- ❑ BEEF
- ❑ LAMB
- ❑ PORK

POULTRY:
- ❑ ALL POULTRY
- ❑ CHICKEN
- ❑ DUCK
- ❑ EGG (CHICKEN)
- ❑ TURKEY

SEAFOOD:
- ❑ ALL SEAFOOD
- ❑ ALL FISH
- ❑ ALL SHELLFISH
- ❑ CLAM
- ❑ CODFISH
- ❑ CRAB
- ❑ RED SNAPPER
- ❑ SALMON
- ❑ SCALLOP
- ❑ SHRIMP
- ❑ SOLE
- ❑ TROUT
- ❑ TUNA

OTHER PROTEINS:
- ❑ GARBANZO BEAN
- ❑ LENTIL
- ❑ PINTO BEAN
- ❑ SOY BEAN

DAIRY/MISC.

- ❑ ALL DAIRY
- ❑ AMERICAN CHEESE
- ❑ BLEU CHEESE
- ❑ COFFEE
- ❑ COTTAGE CHEESE
- ❑ COW'S MILK
- ❑ GOAT'S MILK
- ❑ SWISS CHEESE
- ❑ TEA
- ❑ YEAST
- ❑ YOGURT

STARCHES

GRAINS:
- ❑ ALL GLUTEN GRAINS (WHEAT, SPELT, KAMUT,RYE, BARLEY)
- ❑ AMARANTH
- ❑ BARLEY
- ❑ CORN
- ❑ KAMUT
- ❑ MILLET
- ❑ OAT
- ❑ QUINOA
- ❑ RICE
- ❑ RYE
- ❑ SPELT
- ❑ WHEAT

STARCHY VEGETABLES:
- ❑ SWEET POTATO
- ❑ WHITE POTATO

FRUITS

- ❑ APPLE
- ❑ APRICOT
- ❑ AVOCADO
- ❑ BANANA
- ❑ BLUEBERRY
- ❑ CANTALOUPE
- ❑ CHERRY
- ❑ CRANBERRY
- ❑ GRAPE
- ❑ GRAPEFRUIT
- ❑ HONEYDEW
- ❑ MANGO
- ❑ OLIVE
- ❑ ORANGE
- ❑ PAPAYA
- ❑ PEACH
- ❑ PEAR
- ❑ PINEAPPLE
- ❑ PLUM
- ❑ RASPBERRY
- ❑ STRAWBERRY
- ❑ WATERMELON

VEGETABLES

- ❑ ALL GAS PRODUCING VEGETABLES (BROCCOLI, CAULIFLOWER, CABBAGE)
- ❑ ALL NIGHTSHADE VEGETABLES (ALL PEPPERS, EGGPLANT, TOMATO, WHITE POTATO)
- ❑ ASPARAGUS
- ❑ BEET
- ❑ BROCCOLI
- ❑ CABBAGE
- ❑ CARROT
- ❑ CAULIFLOWER
- ❑ CELERY
- ❑ CUCUMBER
- ❑ EGGPLANT
- ❑ GREEN PEA
- ❑ GREEN PEPPER
- ❑ LETTUCE
- ❑ LIMA BEAN
- ❑ MUSHROOM
- ❑ ONION
- ❑ PUMPKIN
- ❑ SPINACH
- ❑ STRING BEAN
- ❑ TOMATO
- ❑ YELLOW SQUASH
- ❑ ZUCCHINI

FLAVOR ENHANCERS

- ❑ BASIL
- ❑ BAY LEAF
- ❑ BLACK PEPPER
- ❑ CANE SUGAR
- ❑ CAYENNE PEPPER
- ❑ CINNAMON
- ❑ COCOA
- ❑ COCONUT
- ❑ CUMIN
- ❑ DILL
- ❑ GARLIC
- ❑ GINGER
- ❑ HONEY
- ❑ LEEK
- ❑ LEMON
- ❑ MINT
- ❑ MUSTARD
- ❑ NUTMEG
- ❑ OREGANO
- ❑ PAPRIKA
- ❑ PARSLEY
- ❑ POPPY SEED
- ❑ SESAME
- ❑ TURMERIC
- ❑ VANILLA

NUTS/SEEDS/OILS

- ❑ ALL NUTS
- ❑ ALMOND
- ❑ CASHEW
- ❑ CORN OIL
- ❑ HAZELNUT
- ❑ OLIVE OIL
- ❑ PEANUT
- ❑ PEANUT OIL
- ❑ PECAN
- ❑ PISTACHIO
- ❑ POPPY SEED
- ❑ SESAME
- ❑ SESAME OIL
- ❑ SOYBEAN OIL
- ❑ SUNFLOWER SEED
- ❑ WALNUT

Standard Form – 36 (SF-36)

Patient Name:	Date:

Standard Form 36 Survey: The SF-36 Form is one of many outcomes assessments designed by the Medical Outcomes Trust in Boston, MA. It is designed to approximate the improvement in health status from a medical intervention.

INSTRUCTIONS: This survey asks for views about your health. This information will help keep track of how you feel and how well you are able to do your usual daily activities. Answer every question marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is: (Circle One)	1. Excellent 2. Very Good 3. Good **4.** Fair **5.** Poor

2. Compared to one year ago, how would you rate your health in general at this time? (Circle One)	1. Much better now than one year ago 2. Somewhat better now than one year ago 3. About the same as one year ago **4.** Somewhat worse that one year ago **5.** Much worse now than one year ago

3. The following items are about activities you might do during a typical day. Does your health now <u>limit you</u> in these activities? If so, how much? (Circle the appropriate number for each question)

Activities	Yes, limited a lot	Yes, limited a little	No, not limited
a. Vigorous activities, such as running, lifting heavy Objects, or participation in strenuous sports	1	2	3
b. Moderate activities, such as moving a table, Vacuuming, bowling or golfing	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than a mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of your physical health? (Circle the appropriate number for each question)		
a. Cut down on the amount of time you spent on work or other activities	Yes = 1	No = 2
b. Accomplished less than you would like	Yes = 1	No = 2
c. Were limited in the kind of work or other activities	Yes = 1	No = 2
d. Had difficulty performing the work or other activities (For example – requiring an extra effort)	Yes = 1	No = 2

5. During the past four weeks, have you had any of the following problems with your work or other regular daily activities as result of any emotional problems (such as feeling depressed or anxious)? (Circle the appropriate number for each question)		
a. Cut down on the amount of time you spent on work or other activities	Yes = 1	No = 2
b. Accomplished less than you would like	Yes = 1	No = 2
c. Didn't do work or other activities as carefully as usual	Yes = 1	No = 2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups? (Circle one)	1. Not at all 2. Slightly 3. Moderately 4. Quite a bit 5. Extremely

7. How much bodily pain have you had during the past 4 weeks? (Circle one)	1. None 2. Very mild 3. Mild 4. Moderate 5. Severe 6. Very severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Circle one)	1. Not at all 2. Slightly 3. Moderately 4. Quite a bit 5. Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks: (Circle one number on each line)

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of pep?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10.During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives etc.)?(Circle one)	1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

11.How TRUE or FALSE is each of the following statements to you?(Circle one for each line).

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5