Scott's Health Mart PHARMACY
Compounding & Wellness Center

One Wellness Program

We are dedicated to helping individuals achieve optimal health and wellness through **E**vidence **B**ased **N**utritional **T**herapy. As pharmacists it is not only our goal to have you free from disease but to help you FEEL GREAT again!!!

The following questionnaire is designed to evaluate your general health. By indentifying your symptoms and knowing how frequently they occur we can help get you started on the road to felling GREAT again. The questionnaire is divided into separate sections and each section evaluates a key metabolic system in your body.

Please be honest in your assessment and try not to overstate or understate your symptoms

It may be a good idea to complete the questionnaire with a close friend because many times others notice things that we do not about our selves.

Please remember that this not meant to replace medical treatment or visits to your physician.

1 = Very infrequently have the symptom, occurs every few months

2 = Occasionally have the symptom, occurs once or twice a month

3 = Mild, have the symptom once a week

4 = Moderate, have the symptom 3 or 4 days a week

5 = Severe, have the symptom daily, or when applicable cyclically (For example, PMS)

No = 0 Yes = 10

Name: _____ Contact #: _____

Date of Birth: _____

Please return this form to:
Bryan W. Scott, PharmD
(478) 750-8575 - Fax

Blood Sugar & Insulin Balance

Symptoms						
1. Do you feel shaky or jittery if going to long without eating?	Yes					No
2. Are you irritable if a meal is missed?	Yes					No
3. Do you feel tired or weak if a meal is missed?	Yes					No
4. Do you feel tired 1 to 3 hours after eating?	0	1	2	3	4	5
5. Do you crave carbohydrates or sweets excessively?	0	1	2	3	4	5
6. Are you calmer after eating?	0	1	2	3	4	5
7. Do you have headaches that are relieved after eating something sweet?						
8. Do you feel stimulated by exercise?	0	1	2	3	4	5
9. Have you been diagnosed with insulin resistance or diabetes	Yes					No
10. Have been diagnosed with metabolic syndrome?	Yes					No
11. Are you more than 20 pounds over your ideal weight?	Yes					No
12. Do you eat refined sugar or carbohydrates daily (cakes, cookies, candy, and white – flour products?	0	1	2	3	4	5
13. Do you have sporadic energy "boosts and drops" throughout the day?	0	1	2	3	4	5
14. Is your fasting blood sugar level consistently over 95?	Yes					No
Total Points						

Metabolism Function

Symptoms						
1. Do you feel exhausted from morning to night?	Yes					No
2. Do you have trouble getting up in the morning?	0	1	2	3	4	5
3. Are you stiff in the morning?	0	1	2	3	4	5
4. Do you have dry skin, brittle hair, or nails?	Yes					No
5. Do you have cold hands and feet?	Yes					No
6. Is your short – term memory failing?	0	1	2	3	4	5
7. Do you go to pieces easily or dislike working under pressure?	0	1	2	3	4	5
8. Do you have difficulty loosing weight no matter what diet or exercise plan you follow?	Yes					No
9. Are you depressed	0	1	2	3	4	5
10. Are you constipated	0	1	2	3	4	5
11. Do your muscles feel week as if they can not generate energy	0	1	2	3	4	5
12. Is your cholesterol above 200?	Yes					No
13. Do you have PMS or menstrual difficulties	0	1	2	3	4	5
14. Have you had trouble conceiving a child?	Yes					No
15. Is your 1st morning under arm body temperature less than 97.8?	Yes					No
Total Points						

Adrenal Function

Symptoms						
1. Are you under stress at home or at your job?	Yes					No
2. Do you have blue or dark rings under your eyes?	0	1	2	3	4	5
3. Do you crave sugars and carbohydrates especially at midday and in the evening	Yes					No
4. Have you gained weight around the belly or waistline	0	1	2	3	4	5
5. Do you have increased fat distribution all over your body	0	1	2	3	4	5
6. Do you have high blood pressure that may be influenced by stress?	0	1	2	3	4	5
7. Do you need coffee to get you going in the morning?	0	1	2	3	4	5
8. Do you have poor concentration and memory?	0	1	2	3	4	5
9. Are you exhausted physically or does emotional upset bring you to exhaustion?	Yes					No
10. Do you feel tired at midday	Yes					No
11. Do you feel emotionally flat or lacking a zest for living?	0	1	2	3	4	5
12. Do you consume 50% of your calories in the day after 5 pm and crave carbohydrates in the evening?	0	1	2	3	4	5
13. Do you feel anxious or nervous	0	1	2	3	4	5
14. Do you notice a decrease in your sex drive	0	1	2	3	4	5
15. Do you have trouble getting to sleep or do you wake in the middle of the night?	0	1	2	3	4	5
16. Do you feel overcommitted in your daily life?	Yes					No
Total Points						

Liver Function

Symptoms						
1. Do you have intolerance to greasy foods?	0	1	2	3	4	5
2. Do you get headaches after eating?	0	1	2	3	4	5
3. Do you have pain under the right side of your rib cage?	Yes					No
4. Is your stool yellow or gold in color?	0	1	2	3	4	5
5. Is there a yellow cast to your tongue?	0	1	2	3	4	5
6. Do you have a sour taste in your mouth or bad breath?	0	1	2	3	4	5
7. Do you have body odor	0	1	2	3	4	5
8. Are you more than 20 pounds overweight?	0	1	2	3	4	5
9. Do you have diabetes?	0	1	2	3	4	5
10. Do you have skin rashes or other skin disturbances?	0	1	2	3	4	5
11. Is your total cholesterol over 200?	Yes					No
12. Have you had problems with ovarian cysts, fibroids, or breast cancer?	Yes					No
13. Do you sweat profusely?	0	1	2	3	4	5
14. Do you have allergies?	0	1	2	3	4	5
15. Are you on prescription meds?	Yes					No
16. Do you use or have you taken recreational drugs?	0	1	2	3	4	5
17. Do you smoke?	0	1	2	3	4	5
18. Do you drink alcohol?	0	1	2	3	4	5
Total Points						

Yeast / Dysbiosis / Leaky Gut

Symptoms						
1. Do you feel mentally foggy, fatigued, bloated, gassy, stomach distress after eating a high – sugar or high carbohydrate meal?	Yes					No
2. Do you have a history of drug use, including chemo, radiation, antibiotics, steroids, NSAIDs, aspirin, H2 blockers, or birth control pills?	Yes					No
3. Do you have allergies, chronic sinusitis, or infections	Yes					No
4. Do damp, muggy days or moldy places provoke symptoms in you?	0	1	2	3	4	5
5. Do you crave alcohol, carbohydrates, or sugar?	Yes					No
6. Do you have persistent vaginal yeast, toe nail / skin fungus, or jock itch?	Yes					No
7. Do you have a tendency to feel depressed for no apparent reason?	0	1	2	3	4	5
8. Do you have trouble loosing weight?	0	1	2	3	4	5
9. Does your belly get distended and uncomfortable?	0	1	2	3	4	5
10. Do you have trouble with constipation, diarrhea, or pass mucus in your stool?	0	1	2	3	4	5
11. Do you have rashes or skin allergies?	0	1	2	3	4	5
12. Do you have intolerance to certain foods?	0	1	2	3	4	5
13. Do you have persistent urinary tract infections or cystitis	0	1	2	3	4	5
14. Do you suffer from PMS	0	1	2	3	4	5
Total Points						

Low Stomach Acid

Symptoms						
1. Do you constantly need to belch?	Yes					No
2. Do you feel fullness for extended periods of time after meals?	Yes					No
3. Do you feel bloated after eating?	Yes					No
4. Do you pass gas regularly?	0	1	2	3	4	5
5. Do you have know food allergies?	Yes					No
Total Points						

High Stomach Acid

1. Do you have chronic stomach pain?	Yes					No
2. Do you have stomach pain just before or after meals?	Yes					No
3. Do you have stomach pain when emotionally upset?	Yes					No
4. Does eating give you relief from stomach pain?	Yes					No
5. Do you need antacids regularly?	Yes					No
6. Do you have a history of taking chronic arthritis meds (NSAIDs like motrin, advil, or aspirn?)	Yes					No
7. Are you currently taking medication to alter your stomach acid production?	Yes					No
8. Do you suffer from PMS	Yes					No
Total Points						

Small / Large Instestinal Function

Symptoms						
1. Do you have abdominal discomfort?	Yes					No
2. Do you have indigestion 1 to 3 hours after eating?	Yes					No
3. Do you have chronic gas?	Yes					No
4. Do you have chronic constipation or diarrhea, or both?	Yes					No
5. Do you have skin rashes or allergies?	Yes					No
6. Do you have any know food allergies or intolerances?	Yes					No
7. Do you have mucus in your stools?	Yes					No
8. Do you have dry skin?	Yes					No
9. Do you chronically have hard or difficult bowl movements?	Yes					No
Total Points						

Hyper - Immunity

Symptoms						
1. Do you have allergic symptoms, itching or discharge from eyes, puffiness under the eyes, and / or excessive mucus production?	Yes					No
2. Do you have nasal congestion or sneeze often?	Yes					No
3. Do you get migraine headaches?	Yes					No
4. Have you been diagnosed with an autoimmune disorder?	Yes					No
5. Do you have diabetes?	Yes					No
6. Do you have skin rashes or disorders?	Yes					No
7. Do you have multiple chemical sensitivities?	Yes					No
Total Points						

Lowered Immune Function

Symptoms						
1. Do you have chronic infections of the ear nose and throat?	0	1	2	3	4	5
2. Do you often get cold sores or fever blisters?	0	1	2	3	4	5
3. Do you get boils and sties?	0	1	2	3	4	5
4. Do you get colds and the flu easily?	Yes					No
5. Do you get chronic swelling of the lymph glands?	0	1	2	3	4	5
6. Do your wounds heal slowly	0	1	2	3	4	5
7. Have you been diagnosed with chronic fatigue syndrome?	Yes					No
8. Have you been diagnosed with cancer?	Yes					No
9. Have you been diagnosed with HIV or Hepatitis C?	Yes					No
10. Do you have skin rashes or skin allergies?	0	1	2	3	4	5
Total Points						

Inflammation / Oxidative Stress (Heart Health)

Symptoms						
1. Is your C – reactive Protein Elevated?	Yes					No
2. Do you have more than 20 pounds of excess weight that is mainly around your belly?	Yes					No
3. Is your homocysteine level over 10?	Yes					No
4. Are your cholesterol and triglycerides elevated?	Yes					No
5. Are your fibrinogen levels elevated?	Yes					No
6. Are you a diabetic with an elevated HbA_1C?	Yes					No
7. Does your heart pound easily?	0	1	2	3	4	5
8. Does your heart miss or skip a beat?	0	1	2	3	4	5
9. Do you get calf cramps when walking?	0	1	2	3	4	5
10. Do you get swelling in your feet or ankles?	0	1	2	3	4	5
11. Do you get exhausted from minor exertion?	0	1	2	3	4	5
12. Do you feel heavy or achy in the legs?	0	1	2	3	4	5
13. Do you get numbness in your arms or legs?	0	1	2	3	4	5
14. Do you get vertigo?	0	1	2	3	4	5
Total Points						

Environmental Impacts

Symptoms						
1. Do you live in an industrialized area?	Yes					No
2. Do you use pesticides, herbicides, or isecticides, in your home or lawn?	0	1	2	3	4	5
3. Do you have 6 or more (mercury / silver) fillings in your teeth?	Yes					No
4. Is your water supply chlorinated and fluorinated?	Yes					No
5. Do you drink unfiltered water?	Yes					No
6. Is the water used in you home unfiltered?	Yes					No
7. Do you work in a job that exposes you to various solvents or pollutants?	0	1	2	3	4	5
8. Have you lived or worked in a new building over the last 5 years	Yes					No
9. Do you eat produce without washing it?	0	1	2	3	4	5
10. Do you eat lake fish or tuna more than once a month	Yes					No
11. Do you drink from plastic containers regularly	0	1	2	3	4	5
12. Do you microwave in plastic containers or with plastic wrap on a regular basis?	Yes					No
13. Do you exercise outdoors in high traffic areas?	0	1	2	3	4	5
14. Have you been diagnosed with ADHD or have difficulty with memory	Yes					No
15. Do you smoke?	Yes					No
16. Do you use or have you used aluminum cook ware?	Yes					No
17. Do you use aluminum containing deodorant?	Yes					No

18. Do you eat canned foods frequently?	Yes					No
19. Do you get a metallic taste in your mouth?	0	1	2	3	4	5
20. Do you get your clothes dry – cleaned regularly?	Yes					No
21. Have you been diagnosed with an autoimmune disorder such as lupus, rheumatoid arthritis, chronic fatigue syndrome or fibromyalgia?	Yes					No
22. Have been diagnosed with cancer?	Yes					No
22. Have been diagnosed with Parkinson's disease or alzheimers disease?	Yes					No
Total Points						

Medication List:

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

Scott's Health Mart PHARMACY
Compounding & Wellness Center

635 Pio Nono Ave
Macon, Ga 31204
478-742-3098

900 Gray Hwy
Macon, Ga 31211
478-741-3718

Please return this form to:
Bryan W. Scott, PharmD
(478) 750-8575 - Fax