Functional Diagnostic Medicine
Progress Questionnaire

Name:

Date of Exam:

The following questionnaire is a significant part of your care plan. May it be good, bad, or indifferent; your communication with us on your progress plays a major role in how best to proceed. Each patient has a different viewpoint on how well they are progressing. By giving careful thought to your responses on each of the below symptoms, it will allow us a greater opportunity to see eye to eye on your progress with care.

1. **Your Symptoms**: List your primary symptoms and grade your level of progress. Use the following Grading Scale: **(PLACE AN "X" in the APPROPRIATE BOX BELOW)**

- **Worse**
- **No Improvement -** (0% improvement)
- **Slight Better -** (25% improvement) Symptoms are still present however, you either experienced a 25% reduction in duration or intensity of your symptoms
- **Good -** (50% improvement) Symptoms are still present, however, you either experienced a 50%+ reduction in duration or intensity of your symptoms
- **Excellent -** (No symptoms/100% improvement)

Symptoms	Worse	No Improvement	Slightly Better	Significantly Improved	Feel Great
EXAMPLE				X	
How is your energy?					

In this box please update me on any new symptoms or health concerns. Use this box to record any and all details

ADDITIONAL INFORMATION

1. List present and new medications: Please make note if you have increased or decreased any dosages of present medications:

2. When was the date of your last physical exam with your primary care physician?

3. Have you had any blood tests or other diagnostic testing performed since your last nutritional test? Yes/No If yes, what have you had done?

4. Are you taking any other supplements or nutritional products other than what has been prescribed since your last nutritional test? Yes/No If yes, what have you taken:

5. Please list what you ate for breakfast, lunch, and dinner over the last **TWO days**.

6. What has been your greatest vice/difficulty in sticking with your care plan?

7. Is there any additional information you would have liked to have, know about, or have access to throughout this journey?

8. **Please check off everything you've noticed throughout the last 30 days:**

- ❑ Less Blemishes
- ❑ Glowing Skin
- ❑ Rashes
- ❑ Not sick as often
- ❑ Fewer Seasonal Allergies
- ❑ Fewer Migraines
- ❑ Less PMS Symptoms
- ❑ Less back/knee pain
- ❑ Improved Circulation
- ❑ Reduced Medications
- ❑ Reduction in food allergies
- ❑ Healthier Nails
- ❑ Stronger, thicker hair
- ❑ Fewer Mood Swings
- ❑ Less anxious
- ❑ Less depressed
- ❑ Handle stress better
- ❑ Improved self esteem
- ❑ Think more clearly
- ❑ Less ADD/ADHD
- ❑ More productive
- ❑ Improved performance
- ❑ Less Joint Swelling
- ❑ Leaner Appearance
- ❑ Clothes fit better
- ❑ Less Bloating
- ❑ Less IBS
- ❑ Less Acid Reflux/heartburn
- ❑ Less chronic fatigue
- ❑ More regular monthly cycle
- ❑ Fewer sugar cravings
- ❑ Fewer mood swings
- ❑ Happier
- ❑ More Outgoing
- ❑ More in control with food
- ❑ Don't use food for comfort
- ❑ Listening to body
- ❑ Identify Cravings vs hunger
- ❑ Eats to satiety
- ❑ More Energy
- ❑ Better Sleep
- ❑ Improved attention
- ❑ Awaken refreshed
- ❑ Less night sweats

9. **Please check off the following that you would like to achieve with my help:**

- ❑ Have more energy
- ❑ Sleep better
- ❑ Have better digestion
- ❑ Be able to eat more foods
- ❑ Get rid of my allergies
- ❑ Have a better immune system i.e. less colds and coughs
- ❑ Not be dependent on laxatives or stool softeners
- ❑ Be able to work out again
- ❑ Have better muscle tone
- ❑ Be in less pain
- ❑ No longer use pain medication
- ❑ No longer use allergy medication
- ❑ No longer use sleep medication
- ❑ To feel less sleepy in the afternoon
- ❑ Lose weight
- ❑ Increase my sex drive
- ❑ Increase my metabolism to burn more fat
- ❑ Increase my flexibility I want to reduce my stress
- ❑ I want to improve my memory
- ❑ I want to be able to be more focused
- ❑ I want a better mood
- ❑ I want to reduce my risk of developing a chronic disease
- ❑ I want to work on anti-aging program
- ❑ I want to detoxify my body
- ❑ I want to improve my diet
- ❑ I want to clear up my skin