

Middletown 717-944-2225

Mechanicsburg 717-796-2225



The Hetrick Center

You Have A Choice For Your Physical Therapy...Choose Us!

Mount Joy 717-492-0303

Harrisburg 717-652-4002

Dietary/Response Log Instructions: So that your diet can be accurately evaluated, please write down everything you eat for 4 days. It is important to write down everything, including snacks, candy, coffee, all beverages, amount of water, and additives (sugar, salt, Splenda, Nutri-Sweet, etc). Include the approximate amounts of the food, such as 2 tbsp. peas; 1 large hamburger; small glass of orange juice. If the information is not typical of your normal diet—for example, if you are not feeling well and you appetite is poor– include this in the last section of each column. Please also record how you are feeling that day and changes or improvements you have noticed. This may include physical, mental or emotional symptoms.

1st Day Date _____	2nd Day Date _____	3rd Day Date _____	4th Day Date _____
Breakfast	Breakfast	Breakfast	Breakfast
Snack	Snack	Snack	Snack
Lunch	Lunch	Lunch	Lunch
Snack	Snack	Snack	Snack
Dinner	Dinner	Dinner	Dinner
Snack	Snack	Snack	Snack
How are you feeling?	How are you feeling?	How are you feeling?	How are you feeling?

Patient Name _____ Date _____



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Confidential Health History

Please write or print clearly

Name: _____

Address: _____

Email address: _____

Telephone — Work: _____ Home: _____ Cell: _____

Age: _____ Height: _____ Date of birth: _____

Current weight: _____ Weight 6 months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Relationship status: _____ Children? _____

Occupation: _____ Hours of work per week: _____

Primary Physician Name/Phone #: _____

Please check any condition which you currently have or have had in the past:

___ AIDS ___ Arthritis ___ Asthma ___ High blood pressure /Hypertension ___ Low blood pressure

___ Heart attack ___ Stroke ___ Hardening of the arteries ___ Chronic Fatigue Syndrome

___ Depression ___ Diabetes ___ Eating disorder ___ Fibromyalgia ___ Hypothyroidism

___ Hyperthyroidism ___ Sinusitis ___ Chronic Pain/Numbness ___ Gallbladder Problems

___ High Cholesterol ___ Acid Reflux ___ Extreme Hot or Cold ___ Migraines ___ Cancer

___ Parkinson's Disease ___ Multiple Sclerosis ___ Gout ___ Gluten Intolerance

___ Irritable Bowel Syndrome ___ Crohn's Disease/Ulcerative Colitis ___ Stress

___ Inflammation ___ Obesity ___ Infertility ___ Other: _____

If applicable: Menstrual history: _____

Are you post-menopausal? _____ If so, at what age? _____

Any serious illness/hospitalizations/injuries? _____

Family Medical History (Mother, Father, Siblings):

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness or swelling? _____

Confidential Health History

Constipation/Diarrhea/Gas? _____ Explain: _____

Please list current medications: _____

Do you currently take any solid or liquid vitamins, minerals or herbal supplements?

Do you engage in regular exercise or activity? _____ If so, how often? _____

Rate your stress level. (High) 5 4 3 2 1 (Low) Explain. _____

What is your usual food intake during the week and on the weekend?

	<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
Weekday	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Weekend	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

How many times a week do you eat out? _____ For what meals? _____

List the top 5 places you eat out. _____

Do you cook when you are eating at home? _____

Do you eat processed or convenience foods (Hamburger Helper, TV dinners, frozen pot pies, etc)?

Do you eat fried food more than twice a week? _____

How often do you eat fast-food (McDonalds, KFC, etc)? _____

What is your usual breakfast? _____

Do you skip meals? If so, which ones? _____

Do you restrict or count calories? _____

Do you eat foods containing white flour, white rice, white potatoes or white bread? _____

Do you eat foods containing whole grains, such as brown rice, 100% whole wheat, whole oats, beans, buckwheat or quinona? _____

Do you eat dairy? Y or N Explain. _____

Do you tolerate dairy well? Y or N Explain. _____

Confidential Health History

Do you find yourself craving carbohydrates, such as pasta, bread, potatoes or candy? _____

If so, what times of day do you crave them the most? _____

What cooking methods do you use? (baking, frying, microwave, etc)

Do you add salt to food? _____

Who does the grocery shopping? _____

Do you understand how to read/interpret food labels? _____

Do you pay attention to or limit portion sizes? _____

How many servings of fruits and vegetables do you have per week? _____

Do any foods seem to irritate you in any way? _____

What beverages do you drink? Include details, such as cream or sugar that you may add.

What diets have you tried in the past? _____

Did you achieve the results you anticipated? _____

What are the top 2 things you could be doing for your health that you are not currently doing at this time?

1.

2.

Other notes: _____

THYROID TEMPERATURE TEST

(Barnes' Thyroid Test)

PATIENT NAME _____

This test is an excellent way to determine thyroid function using basal body temperature (the body's temperature at rest). If the thyroid is running low, the body's temperature will drop below normal while the body is at rest-sleep. This test is done by measuring the underarm temperature upon waking after a night's sleep. For accuracy, the test is performed five mornings in a row and then the average is calculated. The instructions for performing the test are as follows:

- The night before, shake down the thermometer (an oral glass thermometer only) and set it on the night stand next to the bed.
- Immediately upon waking, without raising your head from the pillow, place the thermometer under your arm.
- Leave the thermometer under your arm for 10 minutes.
- Move as little as possible in this process; you must remain flat on your back during this entire time. Otherwise, the thyroid gland will be activated and a false reading will be taken.
- After ten minutes, remove the thermometer and record the temperature.
- The test is invalidated if you expend any energy just before recording the temperature, i.e. getting up for any reason, shaking down the thermometer, etc.

Test Results:	<u>Date</u>	<u>Temperature</u>
Day 1		
Day 2		
Day 3		
Day 4		
Day 5		
<p><u>To figure average:</u> Total _____ / 5 = _____</p> <p>An average temperature of between 97.8 and 98.2 is considered normal.</p>		

1 2 3 ----- GROUP 6 -----DIG

- 98 ○ ○ ○ Loss of taste for meat
- 99 ○ ○ ○ Lower bowel gas several hours after eating
- 100 ○ ○ ○ Burning stomach sensations, eating relieves
- 101 ○ ○ ○ Coated tongue
- 102 ○ ○ ○ Pass large amounts of foul smelling gas
- 103 ○ ○ ○ Indigestion 1/2 -1 hour after eating; or up to 3-4 hrs.
- 104 ○ ○ ○ Mucus colitis or "irritable bowel"
- 105 ○ ○ ○ Gas shortly after eating
- 106 ○ ○ ○ Stomach "bloating" after eating

----- GROUP 7A -----HT

- 107 ○ ○ ○ Insomnia
- 108 ○ ○ ○ Nervousness
- 109 ○ ○ ○ Can't gain weight
- 110 ○ ○ ○ Intolerance to heat
- 111 ○ ○ ○ Highly emotional
- 112 ○ ○ ○ Flush easily
- 113 ○ ○ ○ Night sweats
- 114 ○ ○ ○ Thin, moist skin
- 115 ○ ○ ○ Inward trembling
- 116 ○ ○ ○ Heart palpitates
- 117 ○ ○ ○ Increased appetite without weight gain
- 118 ○ ○ ○ Pulse fast at rest
- 119 ○ ○ ○ Eyelids and face twitch
- 120 ○ ○ ○ Irritable and restless
- 121 ○ ○ ○ Can't work under pressure

----- GROUP 7B -----hT

- 122 ○ ○ ○ Increase in weight
- 123 ○ ○ ○ Decrease in appetite
- 124 ○ ○ ○ Fatigue easily
- 125 ○ ○ ○ Ringing in ears
- 126 ○ ○ ○ Sleepy during day
- 127 ○ ○ ○ Sensitive to cold
- 128 ○ ○ ○ Dry or scaly skin
- 129 ○ ○ ○ Constipation
- 130 ○ ○ ○ Mental sluggishness
- 131 ○ ○ ○ Hair coarse, falls out
- 132 ○ ○ ○ Headaches upon arising wear off during day
- 133 ○ ○ ○ Slow pulse, below 65
- 134 ○ ○ ○ Frequency of urination
- 135 ○ ○ ○ Impaired hearing
- 136 ○ ○ ○ Reduced initiative

----- GROUP 7C -----HP

- 137 ○ ○ ○ Failing memory
- 138 ○ ○ ○ Low blood pressure
- 139 ○ ○ ○ Increased sex drive
- 140 ○ ○ ○ Headaches, "splitting or rending" type
- 141 ○ ○ ○ Decreased sugar tolerance

----- GROUP 7D -----hP

- 142 ○ ○ ○ Abnormal thirst
- 143 ○ ○ ○ Bloating of abdomen
- 144 ○ ○ ○ Weight gain around hips or waist
- 145 ○ ○ ○ Sex drive reduced or lacking
- 146 ○ ○ ○ Tendency to ulcers, colitis
- 147 ○ ○ ○ Increased sugar tolerance
- 148 ○ ○ ○ Women: menstrual disorders
- 149 ○ ○ ○ Young girls: lack of menstrual function

----- GROUP 7E -----HA

- 150 ○ ○ ○ Dizziness
- 151 ○ ○ ○ Headaches
- 152 ○ ○ ○ Hot flashes
- 153 ○ ○ ○ Increased blood pressure
- 154 ○ ○ ○ Hair growth on face or body (female)
- 155 ○ ○ ○ Sugar in urine (not diabetes)
- 156 ○ ○ ○ Masculine tendencies (female)

1 2 3 ----- GROUP 7F -----hA

- 157 ○ ○ ○ Weakness, dizziness
- 158 ○ ○ ○ Chronic fatigue
- 159 ○ ○ ○ Low blood pressure
- 160 ○ ○ ○ Nails weak, ridged
- 161 ○ ○ ○ Tendency to hives
- 162 ○ ○ ○ Arthritic tendencies
- 163 ○ ○ ○ Perspiration increase
- 164 ○ ○ ○ Bowel disorders
- 165 ○ ○ ○ Poor circulation
- 166 ○ ○ ○ Swollen ankles
- 167 ○ ○ ○ Crave salt
- 168 ○ ○ ○ Brown spots or bronzing of skin
- 169 ○ ○ ○ Allergies - tendency to asthma
- 170 ○ ○ ○ Weakness after colds, influenza
- 171 ○ ○ ○ Exhaustion-muscular and nervous
- 172 ○ ○ ○ Respiratory disorders

----- FEMALE ONLY -----

- 173 ○ ○ ○ Very easily fatigued
- 174 ○ ○ ○ Premenstrual tension
- 175 ○ ○ ○ Painful menses
- 176 ○ ○ ○ Depressed feelings before menstruation
- 177 ○ ○ ○ Menstruation excessive and prolonged
- 178 ○ ○ ○ Painful breasts
- 179 ○ ○ ○ Menstruate too frequently
- 180 ○ ○ ○ Vaginal discharge
- 181 ○ ○ ○ Hysterectomy /ovaries Removed
- 182 ○ ○ ○ Menopausal hot flashes
- 183 ○ ○ ○ Menses scanty or missed
- 184 ○ ○ ○ Acne, worse at menses
- 185 ○ ○ ○ Depression-long standing

----- MALE ONLY -----

- 186 ○ ○ ○ Prostate trouble
- 187 ○ ○ ○ Urination difficult or Dribbling
- 188 ○ ○ ○ Night urination frequent
- 189 ○ ○ ○ Depression
- 190 ○ ○ ○ Pain on inside of legs or heels
- 191 ○ ○ ○ Feeling of incomplete bowel evacuation
- 192 ○ ○ ○ Lack of energy
- 193 ○ ○ ○ Migrating aches and pains
- 194 ○ ○ ○ Tire too easily
- 195 ○ ○ ○ Avoids activity
- 196 ○ ○ ○ Leg nervousness at night
- 197 ○ ○ ○ Diminished sex drive

Notes: