STEPS TO WELLNESS

NATURAL HEALING & HEALTHY LIVING

GUIDANCE AND SESSIONS—NATURAL MODALITIES FOR WELLNESS, LIFESTYLE, AND HEALTH-

ALEX GELLMAN & GURU ASSOCIATES

SIMPLE STEPS TO WELLNESS

Natural Health Practitioner Alexandra Gellman offers personal consultation and guidance as well as Simple Steps to Wellness workshops, keynote talks, presentations, and tele-coaching to boost health naturally. Alexandra specializes in teaching trusted, simple approaches to health, nutrition,

PATIENT HISTORY

LAST NAME:___________________________________ FIRST NAME:________________________________

APT: __________________ STREET: ____

CITY:___________________________ POSTAL CODE:

TEL: HOME____________________________ BUSINESS:________________________ EXT:

CELL:__________________________________ PREFERRED:________________________

EMAIL:

BIRTHDATE: (d/m/y) ______________________________ MARITAL STATUS:

OCCUPATION:____ HOURS PER WEEK:__________________

REFERRED BY:____

YOUR FAMILY DOCTOR: ____ PHONE:_______________________

ADDRESS: ____

FAMILY HISTORY *(Please indicate if deceased, cause of death, age or age now)*

FATHER:______________________________________ MOTHER: _____________________________________

PARTNER: ____________________________________ CHILDREN: ____________________________________

BROTHERS:____________________________________ SISTERS: ______________________________________

MATERNAL GRANDMOTHER:____________________ MATERNAL GRANDFATHER:___________________

PATERNAL GRANDMOTHER: ____________________ PATERNAL GRANDFATHER:___________________

_______Heart Disease
_______Hypertension
_______Cancer

_______Alcoholism
_______Diabetes
_______Osteoporosis

_______Drug Addiction
_______Allergies
_______Mental Illness

_______Intestinal Disease
_______Other
____

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HOMEOPATHIC QUESTIONNAIRE

PLEASE COMPLETE AND RETURN

1. On a scale of 1-10, rate the following

_______ Current state of health

_______ Ability to think clearly

_______ Your professional happiness

_______ Your willingness to change

_______ Your physical energy and vitality

_______ Your creativity

2. What do you do to have fun?

3. How do you express your creativity?

4. Have you experienced any of the following in the last three to five years?

- ☐ Death of a loved one
- ☐ Serious injury or illness
- ☐ Sexual problems
- ☐ Family problems
- ☐ Separation or divorce
- ☐ Job change
- ☐ Work problems
- ☐ Monetary problems

5. What would you like to change most about your life?

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6. Fears now and in the past, including childhood fears:

7. Dreams (if you dream, keep a diary of your dreams and have it with you).

8. Is there anything that makes you feel better when you're not feeling well?

9. Favorite foods?

10. Foods you dislike?

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11. Animals you dislike?

12. Animals you like or love?

13. Colors you like or love?

14. Colors you dislike?

15. How would you describe your emotional state when you do not feel well?

ALLOPATHIC TREATMENTS

Antibiotics: Y / N

Birth Control Pills: Y / N

- Present Medications:
- Past Medications (dates):
- Hospitalizations (dates):
- Major complaints:
- Allergies:
- Do you exercise? Describe:
- Do you actively participate in any spiritual discipline?
- Hours of sleep per night: ______________
- Do you wake feeling rested?
- What level of stress are you experiencing right now (1-10, 10 being high):
- Main stressors:

- What do you hope to accomplish here/in these sessions?

- Do you use any of the following?

		NOW	PAST
☐	Chocolate	______	_______
☐	Cigarettes	______	_______
☐	Coffee	______	_______
☐	Cow's milk	______	_______
☐	Fast food	______	_______
☐	Liquor	______	_______

		NOW	PAST
☐	Luncheon Meats	______	_______
☐	Margarine	______	_______
☐	Pop	______	_______
☐	Recreational drugs	______	_______
☐	Sugar	______	_______

- How many glasses of water do you drink per day? __________
- Do you eat three well-balanced meals daily? __________

•DESCRIBE A TYPICAL DAY'S FOOD CONSUMPTION:

BREAKFAST:

LUNCH:

DINNER :

SNACKS :

WATER/DRINKS:

OILS"

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- List your favorite foods:

____

____

____

____

____

____

- Foods you avoid:

____

____

____

____

____

____

- Do you experience any symptoms if meals are missed?

- Do you experience any symptoms after eating?

- How many bowel movements?

1 2 3 _______ X daily ______ every 2 days ______every 3 days

NOTES:

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STEPS TO WELLNESS — NATURAL HEALING & HEALTHY LIVING

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

CONDITION	*NOW*	*PAST*
Acid Stomach	______	______
Acne	______	______
Alcoholism	______	______
Allergies	______	______
Amnesia	______	______
Anal Fissure	______	______
Anal Itching	______	______
Anemia	______	______
Angina	______	______
Anorexia Nervosa	______	______
Anxiety	______	______
Appendicitis	______	______
Arteriosclerosis	______	______
Arthritis	______	______
Asthma	______	______
Athlete's Foot	______	______
Backache	______	______
Bad Breath	______	______
Bed Wetting	______	______
Bee Stings	______	______
Belching	______	______
Bladder Stones	______	______
Blood Pressure-High	______	______
Blood Pressure-Low	______	______
Blood Sugar-Low	______	______
Body Odor	______	______
Breast Lumps	______	______
Breast Tenderness	______	______
Broken Bones	______	______
Bronchitis	______	______
Bruises	______	______
Bulimia	______	______
Cancer	______	______
Candida/Yeast	______	______
Cataract	______	______
CarpalTunnel Syn..	______	______
Cellulite	______	______
Chicken Pox	______	______
Cholesterol-High	______	______
Cirrhosis (liver)	______	______
Colds	______	______
Chronic Fatigue	______	______
Cold Sores	______	______
Colitis	______	______
Conjunctivitis	______	______
Coughs	______	______
Constipation	______	______
Coronary Disease	______	______
Cramps-Calf	______	______
Cramps-Menstrual	______	______
Crohn's Disease	______	______
Cysts	______	______
Dandruff	______	______
Deafness	______	______
Depression	______	______
Diabetes	______	______
Diarrhea	______	______
Diverticulitis	______	______
Dizziness	______	______
Ear Infection	______	______
Eczema	______	______
Emphysema	______	______
Ejaculation Problems	______	______
Endometriosis	______	______
Epilepsy	______	______
Eyesight Problems	______	______
Facial Pain	______	______
Fainting	______	______
Fatigue	______	______
Feet-aching	______	______
Fever	______	______
Fibroids	______	______
Flatulence	______	______
Flu	______	______
Fibrositis (neck)	______	______
Fluid Retention	______	______
Food Poisoning	______	______
Fungal Infection	______	______
Gallstones	______	______
Gangrene	______	______
Gastritis (stomach)	______	______
Gingivitis (gums)	______	______
Glaucoma	______	______

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DO YOU SUFFER FROM ANY OF THE FOLLOWING?

CONDITION	*NOW*	*PAST*
Gout		
Headache		
Heatstroke		
Hemorrhoids		
Hepatitis		
Hernia		
Herpes-genital		
Herpes-simples		
Hiccups		
HIV		
Hives		
Hyperthyroidism		
Hypothyroidism		
Impotence		
Indigestion		
Infertility		
Insomnia		
Intercourse-painful		
Irritable-bladder		
Irritable-bowel		
Itchy groin		
Jaundice		
Kidney Stones		
Lactose Intolerance		
Laryngitis		
Lower Back Pain		
Manic Depression		
Measles		
Memory Problems		
Meniere's Disease		
Menopausal Problems		
Migraine		
Miscarriage		
Mononucleosis		
Mouth Ulcers		
Mumps		
Nausea		
Neuralgia		
Nightmare		
Nosebleeds		
Osteoarthritis		

CONDITION	*NOW*	*PAST*
Osteoporosis		
Ovarian Cyst		
Ovulation Pain		
Pain		
Palpitations		
Parkinson's Disease		
Pelvic Inflammatory		
Peptic Ulcer		
Periods-heavy		
Periods-irregular		
Periods-painful		
Phobia		
Pimples		
PMS		
Pneumonia		
Polyp		
Prostate-enlarged		
Prostatitis		
Psoriasis		
Rheumatoid Arthritis		
Ringworm		
Root Canals		
Rosacea		
Sciataca		
Sex-loss of desire		
Sexually-Transmitted Disease.		
Shingles		
Sinusitis		
Slipped Disc		
Sprains		
Stiffness		
Stroke		
Sty		
Tendonitis		
Tennis Elbow		
Throat-sore..		
Thrombosis		
Tinnitus		
Tonsillitis		
Toothache)		
Urinary Tract Infection		
Vaginal Infection		

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DO YOU SUFFER FROM ANY OF THE FOLLOWING?

CONDITION	*NOW*	*PAST*
Varicose Veins............	______	_______
Vomiting	______	_______
Warts	______	_______
Whiplash	______	_______
Whooping Cough	______	_______
Worms	______	_______

Anything we may have missed?

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DETOXIFICATION QUESTIONNAIRE

PATIENT NAME ________________________________ DATE ________________________________

Rate each of the following symptoms based on your typical health profile for the specific duration:

~ Past month ~ Past week ~ Past 48 hours

Point Scale:

0 – *Never or almost never* have the symptoms
1 – *Occasionally* have it, effect is **not** severe
2 – *Occasionally* have it, effect is **severe**
3 – *Frequently* have it, effect is **not** severe
4 – *Frequently* have it, effect is **severe**

1. MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

HEAD	______	Headaches	**EARS**	______	Itchy ears
Total:	______	Faintness	*Total:*	______	Earaches, infections
	______	Dizziness		______	Drainage from ear
	______	Insomnia		______	Ringing, hearing loss
EYES	______	Watery or itchy eyes	**NOSE**	______	Stuffy nose
	______	Swollen, red or sticky eyelids		______	Sinus problems
Total:	______	Dizziness	*Total:*	______	Hay fever
	______	Insomnia		______	Sneezing attacks
				______	Excessive mucus

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MOUTH/ THROAT

Total:

- _____ Chronic coughing
- _____ Gagging, frequent need to clear throat
- _____ Sore throat, loss of voice, hoarseness
- _____ Swollen or discolored tongue/gums/lips
- _____ Canker sores

SKIN

Total:

- _____ Acne
- _____ Hives, rashes, dry skin
- _____ Hair loss
- _____ Flushing, hot flashes
- _____ Excessive sweating

HEART

Total:

- _____ Chest pain
- _____ Irregular or skipped heartbeat
- _____ Rapid or pounding heartbeat

LUNGS

Total:

- _____ Chest congestion
- _____ Asthma, bronchitis
- _____ Shortness of breath
- _____ Difficulty breathing

DIGESTIVE TRACT

Total:

- _____ Nausea, vomiting
- _____ Diarrhea
- _____ Constipation
- _____ Bloated feeling
- _____ Belching, passing gas
- _____ Heartburn
- _____ Intestinal/stomach pain

JOINTS/ MUSCLES

Total:

- _____ Pain or aches in joints
- _____ Arthritis
- _____ Stiffness or limitation of movement
- _____ Feeling of weakness or tiredness
- _____ Pain or aches in muscles

WEIGHT

Total:

- _____ Binge eating/drinking
- _____ Craving certain foods
- _____ Excessive weight
- _____ Water retention
- _____ Underweight
- _____ Compulsive eating

ENERGY/ ACTIVITY

Total:

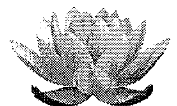
- _____ Fatigue, sluggishness
- _____ Apathy, lethargy
- _____ Hyperactivity
- _____ Restlessness

MIND

Total:

- _____ Poor memory
- _____ Confusion, poor comprehension
- _____ Difficulty in making decisions
- _____ Stuttering, stammering
- _____ Slurred speech
- _____ Learning disabilities
- _____ Poor concentration
- _____ Poor physical coordination

Grand Total:



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2. XENOBIOTIC TOLERABILITY TEST (XTT)

1. Are you presently using prescription drugs?
____ Yes (1 pt)
If yes, how many? ____ (1 pt each)
____ No (0 pts)

2. Are you presently taking one or more of the following over-the-counter drugs?
____ Cimetidine (2 pts)
____ Acetaminophen (2 pts)
____ Estradiol (2 pts)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them?
____ I experience side effects; drugs work well at lowered doses (3 pts)
____ I experience side effects; drugs work well at usual doses (2 pts)
____ I experience **no** side effects, drugs usually **do not** work well (1 pt)
____ I experience **no** side effects, drugs usually work well (0 pts)

4. Do you regularly use tobacco products (currently, or within the last 6 months)?
____ Yes (2 pts) ____ No (0 pts)

5. Do you have strong negative reactions to caffeine / products containing caffeine?
____ Yes (1 pt) ____ No/Don't Know (0 pts)

6. Do you commonly experience "brain fog", fatigue, or drowsiness?
____ Yes (1 pt) ____ No (0 pts)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
____ Yes (1 pt) ____ No/Don't Know (0 pts)

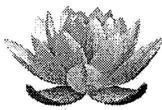
8. Do you feel ill after you consume even small amounts of alcohol?
____ Yes (1 pt) ____ No/Don't Know (0 pts)

9. Do you have a personal history of:
____ Environmental/chemical sensitivities (5 pts)
____ Chronic fatigue syndrome (5 pts)
____ Multiple chemical sensitivity (5 pts)
____ Fibromyalgia (3 pts)
____ Parkinson's type symptoms (3 pts)
____ Alcohol or chemical dependence (2 pts)
____ Asthma (1 pt)

10. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
____ Yes (1 pt) ____ No (0 pts)

11. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
____ Yes (1 pt) ____ No/Don't Know (0 pts)

Grand Total:



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OVERALL SCORE TABULATION

For Practitioner Use Only

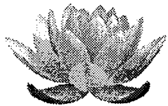
Recommended protocols based on new detoxification questionnaire (MSQ and XTT)

MSQ SCORE ________	(High > 50) (Moderate 15-49) (Low < 14)
XTT SCORE ________	(High > 10) (Moderate 5-9) (Low < 4)

			Functional Medicine Protocol		
MSQ SCORE	XTT SCORE	DESCRIPTION	MEDICAL FOOD	DIET	ADDITIONAL NUTRACEUTICAL SUPPORT
50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical foods for imbalanced detoxifiers	28-day elimination diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimination diet	Consider bifunctional, antioxidant and chlorophyllin nutraceuticals
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance

Additional Symptom-Specific Support	
SYMPTOMS	NUTRACEUTICAL SUPPORT
Water retention and/or frequent or urgent urination	Kidney support nutraceuticals
Heartburn and/or intestinal/stomach pain	Functional dyspepsia nutraceuticals
Diarrhea, constipation, and/or intestinal/stomach pain	Probiotics

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.



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