Bova
HEALTH & WELLNESS
207 SACANDAGA ROAD, SUITE 102 | SCOTIA, NY | 12302
P 518.608.4778 | F 518.348.6112 | E DRBOVA@ICLOUD.COM
BOVAHEALTHANDWELLNESS.COM

Patient Name: _____ Date: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

Date of Birth: _____ Sex: _____ Referred by: _____

METABOLIC ASSESSMENT

PART 1

Please list your 5 major health concerns in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Have you had any recent traumas or severe stressors prompting symptoms? If so, please describe.

_____

_____

_____

PART II

Please circle the appropriate number of all questions below. 0 as the least/never to 3 the most/always.

CATEGORY I

Feeling the bowels do not empty completely	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul-smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

CATEGORY II

Increasing frequency of food reactions	0 1 2 3
Unpredictable food reactions	0 1 2 3
Aches, pains, and swelling throughout the body	0 1 2 3
Unpredictable abdominal swelling	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3
Abdominal intolerance to sugars and starches	0 1 2 3

CATEGORY III

Intolerance to smells	0 1 2 3
Intolerance to jewelry	0 1 2 3
Intolerance to shampoo, lotion, detergents, etc.	0 1 2 3
Multiple smell and chemical sensitivities	0 1 2 3
Constant skin outbreaks	0 1 2 3

CATEGORY IV

Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables or undigested food found in stools	0 1 2 3

CATEGORY V

Stomach pain, burning, or aching 1-4 hours after eating	0 1 2 3
Use antacids	
Feel hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief by using antacids, food, milk, or carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3

CATEGORY VI

Roughage and fiber cause constipation	0 1 2 3
Indigestion and fullness last 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool, undigested, foul smelling, mucus-like, greasy or poorly formed	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3

CATEGORY VII

Greasy or high-fat foods cause distress	0 1 2 3
Lower bowel gas and/or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Burpy, fishy taste after consuming fish oils	0 1 2 3
Difficulty losing weight	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed?	Yes No

CATEGORY VIII

Acne and unhealthy skin	0 1 2 3
Excessive hair loss	0 1 2 3
Overall sense of bloating	0 1 2 3
Bodily swelling for no reason	0 1 2 3
Hormone imbalanced	0 1 2 3
Weight gain	0 1 2 3
Poor bowel function	0 1 2 3
Excessively foul-smelling sweat	0 1 2 3

CATEGORY IX

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep going/get started	0 1 2 3
Get light-headed if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, or have tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory/forgetful	0 1 2 3
Blurred vision	0 1 2 3

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CATEGORY X

Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve craving for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

CATEGORY XI

Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

CATEGORY XII

Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under high amount of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

CATEGORY XIII

Edema and swelling in ankles and wrists	0 1 2 3
Muscles cramping	0 1 2 3
Poor muscle endurance	0 1 2 3
Frequent urination	0 1 2 3
Frequent thirst	0 1 2 3
Crave salt	0 1 2 3
Abnormal sweating from minimal activity	0 1 2 3
Alteration in bowel regularity	0 1 2 3
Inability to hold breath for long periods	0 1 2 3
Shallow, rapid breathing	0 1 2 3

CATEGORY XIV

Tired/sluggish

Feel cold — hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight even with low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression/lack of motivation	0 1 2 3

CATEGORY XIV *(Cont'd)*

Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning hair on scalp, face, or genitals, or excessive hair loss	0 1 2 3
Dryness of skin/and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

CATEGORY XV

Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

CATEGORY XVI

Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars without symptoms	0 1 2 3
	0 1 2 3

CATEGORY XVII

Increased sex drive	0 1 2 3
Tolerance to sugars reduced	0 1 2 3
"Splitting" type headaches	0 1 2 3

CATEGORY XVIII *(Males Only)*

Urination difficulty or dribbling	0 1 2 3
Frequent urination	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel emptying	0 1 2 3
Leg twitching at night	0 1 2 3

CATEGORY XIX *(Males Only)*

Decreased libido	0 1 2 3
Decreased number of spontaneous morning erections	0 1 2 3
Decreased fullness of erections	0 1 2 3
Difficulty maintaining morning erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decreased physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

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CATEGORY XX ***(Menstruating Females Only)***

Peri-menopausal	**0 1 2 3**
Alternating menstrual cycle lengths	**0 1 2 3**
Extended menstrual cycle (greater than 32 days)	**0 1 2 3**
Shortened menstrual cycle (less than 24 days)	**0 1 2 3**
Pain and cramping during periods	**0 1 2 3**
Scanty blood flow	**0 1 2 3**
Heavy blood flow	**0 1 2 3**
Breast pain and swelling during menses	**0 1 2 3**
Pelvic pain during menses	**0 1 2 3**
Irritable and depressed during menses	**0 1 2 3**
Acne	**0 1 2 3**
Facial hair growth	**0 1 2 3**
Hair loss/thinning	**0 1 2 3**

CATEGORY XXI ***(Menopausal Females Only)***

How many years have you been menopausal?	**___ years**
Since menopause, do you ever have uterine bleeding	**Yes No**
Hot flashes	**0 1 2 3**
Mental fogginess	**0 1 2 3**
Disinterest in sex	**0 1 2 3**
Mood swings	**0 1 2 3**
Depression	**0 1 2 3**
Painful intercourse	**0 1 2 3**
Shrinking breasts	**0 1 2 3**
Facial hair growth	**0 1 2 3**
Acne	**0 1 2 3**
Increased vaginal pain, dryness, or itching	**0 1 2 3**

PART III

Please list what a normal day of eating looks like for you and at what time you typically eat. Please circle N/A when you do not eat a meal or snack.

Breakfast Time: N/A

Snack Time: N/A

Lunch Time: N/A

Snack Time: N/A

Dinner Time: N/A

Snack Time: N/A

Please list any other times you eat during the day and what you eat:

PART IV

Please list any medications you currently take and for what conditions:

_____

_____

_____

_____

Please list any natural supplements you currently take and for what conditions:

_____

_____

_____

_____

HISTORY & CURRENT CONCERNS

1. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 *(please circle one)*

2. Who else have you seen for your problem?

- ☐ Chiropractor
- ☐ ER Physician
- ☐ Massage Therapist
- ☐ Neurologist
- ☐ Orthopedist
- ☐ No One
- ☐ Primary Care Physician
- ☐ Physical Therapist
- ☐ Other: _____

3. How long have you had your problem? _____

4. What aggravates your problem? _____

5. What concerns you the most about your problem? What does it prevent you from doing?

_____

6. What is your: Height _____ Weight _____

Occupation _____

7. Please indicate any family members with the following diseases:

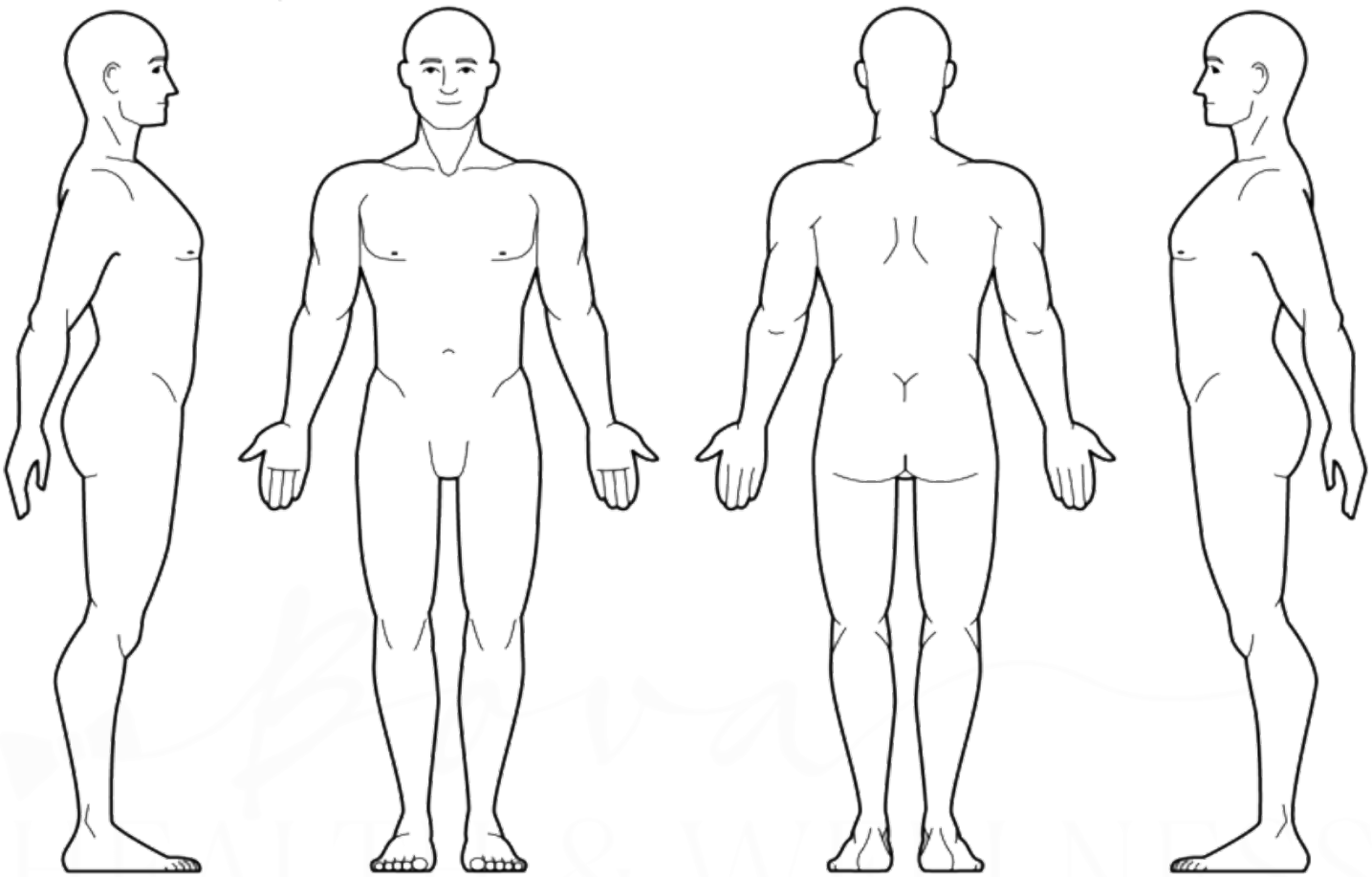
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Heart Problems
- ☐ Diabetes
- ☐ MS
- ☐ Colitis/IBS
- ☐ Cancer
- ☐ Hypothyroid/Hashimoto's
- ☐ Other: _____

8. Do you currently suffer from any of these conditions?

- ☐ Headaches
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Elbow/Upper Arm Pain
- ☐ Wrist Pain
- ☐ Hand Pain
- ☐ Hip Pain
- ☐ Upper Leg Pain
- ☐ Knee Pain
- ☐ Ankle/Foot Pain
- ☐ Jaw Pain
- ☐ Joint Pain/Stiffness
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Dizziness
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Chest Pains
- ☐ Stroke
- ☐ Angina
- ☐ Kidney Stones
- ☐ Kidney Disorders
- ☐ Bladder Infections
- ☐ Painful Urination
- ☐ Loss of Bladder Control
- ☐ Prostate Problems
- ☐ Abnormal Weight Gain/Loss
- ☐ Loss of Appetite
- ☐ Abdominal Pain
- ☐ Ulcer
- ☐ Hepatitis
- ☐ Liver/Gall Bladder Disorder
- ☐ Other: _____
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Frequent Urination
- ☐ Smoking
- ☐ Drug/Alcohol Dependence
- ☐ Allergies
- ☐ Depression
- ☐ Systemic Lupus
- ☐ Epilepsy
- ☐ Dermatitis/Eczema
- ☐ Cancer
- ☐ Tumor
- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ General Fatigue
- ☐ Muscular In-coordination
- ☐ Visual Disturbances

9. Indicate on the drawings below where you have pain/symptoms or check the box below:

- ☐ N/A



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10. List all surgical procedures you have had:

_____

_____

_____

11. Have you ever been hospitalized? ☐ No ☐ Yes

If yes, why _____

12. *Females Only* — **Please list any pregnancies, births, or complications:**

_____

_____

_____

Patient Signature: _____ **Date:** _____

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