



Client Labwork & Health Data

Results to be faxed to (888) 826-1620
or e-mailed to heather@heatherdegeorge.com

Date: _____

Height: _____

Weight: _____

Temperature: _____

Blood pressure: _____

Pulse: _____

Bust measurement: _____

Chest measurement: _____

Waist measurement: _____

Hip measurement: _____

If your medical practitioner is not doing these measurements, you will find guidelines to help you do them yourself below. You can also Google for imagery or check YouTube for assistance.

Bust: Place the measuring tape across your nipples and measure around the largest part of your chest. Be sure to keep the tape parallel to the floor.

Chest: Place the measuring tape just under your breasts/pecs and measure around the torso while keeping the tape parallel to the floor.

Waist: Place the measuring tape about a 1/2 inch above your bellybutton (at the narrowest part of your waist) to measure around your torso. When measuring your waist, exhale and measure before inhaling again.

Hips: Place the measuring tape across the widest part of your hips/buttocks and measure all the way around while keeping the tape parallel to the floor.

Health Profile Questionnaire

Name _____ Date _____

Rate each of the following symptoms based on how you've been feeling for the: Past 48 hours **Past Week** Past 30 days

Point Scale

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

Head

_____ Headaches

_____ Faintness

_____ Dizziness

_____ Insomnia

Total _____

Eyes

_____ Watery or itchy eyes

_____ Swollen, reddened or sticky eyelids

_____ Bags or dark circles under eyes

_____ Blurred or tunnel vision (does not include near- or farsightedness)

Total _____

Ears

_____ Itchy ears

_____ Earaches, ear infections

_____ Drainage from ear

_____ Ringing in ears, hearing loss

Total _____

Nose

_____ Stuffy nose

_____ Sinus problems

_____ Hay fever

_____ Sneezing attacks

_____ Excessive mucus formation

Total _____

Mouth/Throat

_____ Chronic coughing

_____ Gagging, frequent need to clear throat

_____ Sore throat, hoarseness, loss of voice

_____ Swollen or discolored tongue, gums or lips

_____ Canker sores

Total _____

Skin

_____ Acne

_____ Hives, rashes, dry skin

_____ Hair loss

_____ Flushing, hot flashes

_____ Excessive sweating

Total _____

Heart

_____ Irregular or skipped heartbeat

_____ Rapid or pounding heartbeat

_____ Chest pain

Total _____

Lungs

_____ Chest congestion

_____ Asthma, bronchitis

_____ Shortness of breath

_____ Difficulty breathing

Total _____

Digestive Tract

_____ Nausea, vomiting

_____ Diarrhea

_____ Constipation

_____ Bloating feeling

_____ Belching, passing gas

_____ Heartburn

_____ Intestinal/stomach pain

Total _____

Joints/Muscles

_____ Pain or aches in joints

_____ Arthritis

_____ Stiffness or limitation of movement

_____ Pain or aches in muscles

_____ Feeling of weakness or tiredness

Total _____

Weight

_____ Binge eating/drinking

_____ Craving certain foods

_____ Excessive weight

_____ Compulsive eating

_____ Water retention

_____ Underweight

Total _____

Energy/Activity

_____ Fatigue, sluggishness

_____ Apathy, lethargy

_____ Hyperactivity

_____ Restlessness

Total _____

Mind

_____ Poor memory

_____ Confusion, poor comprehension

_____ Poor concentration

_____ Poor physical coordination

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities

Total _____

Emotions

_____ Mood swings

_____ Anxiety, fear, nervousness

_____ Anger, irritability, aggressiveness

_____ Depression

Total _____

Other

_____ Frequent illness

_____ Frequent or urgent urination

_____ Genital itch or discharge

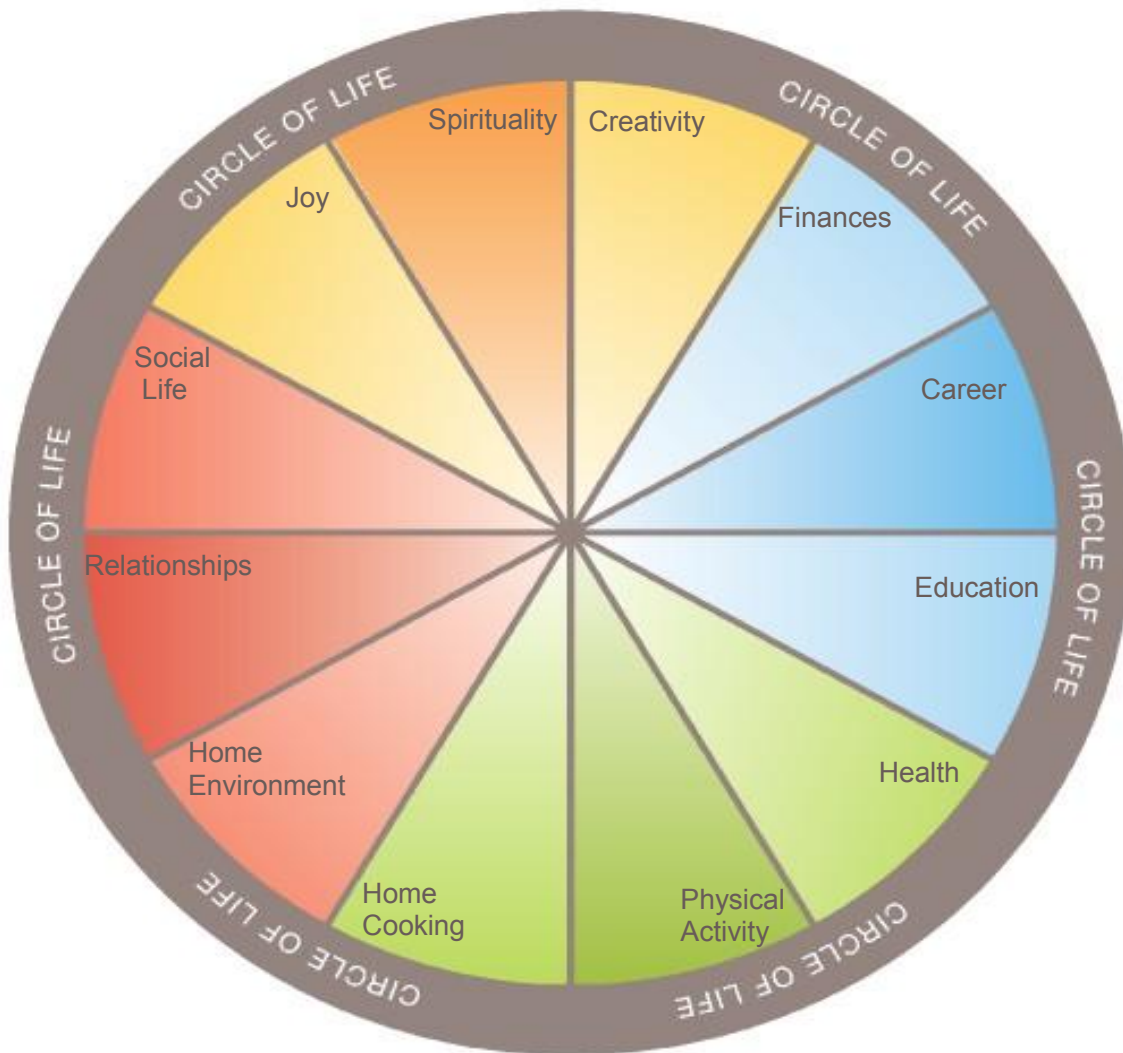
Total _____

Grand Total _____

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Circle of Life

This exercise will help you discover which primary foods need attention to create more balance in your life. The circle has twelve sections. Place a dot on the line for each section to designate how satisfied you are with that aspect of your life. A dot placed towards the center of the circle indicates dissatisfaction, while a dot placed towards the periphery indicates ultimate happiness. When you have placed a dot on each line, connect the dots to see your Circle of Life. Now you have a clear visual of any areas that may need your attention. You will complete this exercise again next month to see if your circle has become more balanced.





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Necessary baseline labwork:

Total cholesterol
HDL cholesterol
Triglycerides
NMR lipid profile
Lipoprotein (a)
Fibrinogen
Uric acid
AST
ALT
GGT
BUN
Creatinine
Microalbumin
25OH vitamin D
Homocysteine
Ferritin
Hemoglobin A1C
Insulin response test (fasting, 30-minute, 1-hour & 2-hour levels glucose and insulin levels)
High sensitivity C-reactive protein
TSH
free T3
free T4
reverse T3
TPO antibodies

Men add:

Total testosterone
Free testosterone

Women add:

Free testosterone Estradiol
FSH Progesterone
LH Sex hormone binding globulin
DHEA-S

Heather
DeGeorge



Health & Wellness
COACH

Life Change Tracking Journal

A helpful way to identify the things that affect
your health and wellness.



How to Use this Workbook.

Keeping a detailed log can seem tedious, but it's worth its weight in gold when trying to determine the source of a problem--especially when dealing with medical professionals. Often, we think we're remembering what really happened but we truly do lose the details. The log is an objective, detailed record of some critical health information. It's so worthwhile that I have kept logs on children (especially my own foster children) who had no health problems just to help with their medical care. *Please note that there is a different version for tracking infants/nursing toddlers.*

Print Workbook Pages. Print one copy of Page 3 to make sure no adjustments are needed. Then you can make 30-60 copies for your workbook. If you do that onto 3-holed paper, it's easier than punching the holes. ;)

1) Get a Baseline. Use one sheet per day for one person and stick them in a binder or report cover. Use the back of the prior day's page for any additional notes (be sure to put the TIME down for them!). Do this for at least two weeks before trying anything new so you can document improvements. You might also notice a pattern that exists (more likely if you baseline for a full month first) so that you're targeting something that's truly an issue. *For example, you might see the worst problems come after a night of disrupted sleep--and so you'd attack sleep issues (there are lots of remedies for this) before you attempted diet.*

You may want to use the back of the prior day's page to note the brand of what you're eating (note it in the grid with a letter and then make a list on the blank page--I did that for a while). Be sure to note behaviors, attitudes, crankiness, happiness, etc. In the "OUTPUT L/S" column L=liquid/urine and S=solid/bowel movement. Be sure to describe bowel movements to include as much detail as possible. They are a huge factor in finding health issues. Amount (relative), formed or liquid, color, smell, and anything visibly recognizable in it are all worth noting.

With children, you may need to assign each a bathroom (if you have this luxury) and implement a "no flushing" rule temporarily to get this detail.

2) Only Change One Thing at a Time. If you're going to start a diet change, do NOT ALSO start a new supplement. You want to know WHAT worked--and you can't do that if you try more than one new thing close together.

3) Give Your Changes 2 Months. Remind yourself that if you don't see improvements that make it worth the effort in 2 months--you go back to the old way. This way, you give the change a good, fair, strong chance to prove it's worth; but you also have a light at the end of the tunnel. You can tolerate just about anything for 60 days--if you know that's the end of it. In reality, at the end of 60 days you'll either be so thrilled that it won't even bother you to make the effort, or you'll know it's not working and you don't have to do it anymore--ya know? But it won't hang over your head indefinitely.



Sleep Output (L/S)

Meds/Vits

Food

Notes

Supplements (List)	NAME
oz. Water	DATE
Bowel Movements	

AM

MidNt					
1am					
2am					
3am					
4am					
5am					
6am					
7am					
8am					
9am					
10am					
11am					

PM

Noon					
1pm					
2pm					
3pm					
4pm					
5pm					
6pm					
7pm					
8pm					
9pm					
10pm					
11pm					