Name_____ Date_____ consistently taking supplements_____%

SURVEY OF YOUR OVERALL HEALTH OF YOUR BODY'S SYSTEMS

For your 1st visit-checkmark any symptom you have experienced in last 6 months. For Re-exams-checkmark symptoms you are currently experiencing.

HEADACHES
___ Base of Skull (back)
___ Side of head (Temples)
___ Frontal (above eyes)
___ Top of head
___ Entire Head
___ Migraines
___ Cluster
___ Other_____

EARS
___ Noise (Ring/Hiss/Pound)
___ Plugged
___ Popping
___ Ear Ache
___ Ear Infections
___ Draining
___ Itchy
___ Hearing Loss
___ Dizziness/ Vertigo
___ Excessive Ear Wax
___ Other_____

EYES
___ Burn
___ Tear
___ Ache
___ Red
___ Dry
___ Eye Film
___ Crust in morning
___ Itchy Eyes
___ Bouts of Blurriness
___ Floaters
___ Spots
___ Tired
___ Puffy
___ Stye
___ Twitching around eyes
___ Dark Circles
___ Light Bothers Eyes
___ Nearsighted
___ Farsighted
___ Other_____

SINUS
___ Nosebleeds
___ Dry
___ Drain
___ Stuffy/ plugged up
___ Sneeze frequently
___ Smell Loss
___ Taste Loss
___ Post nasal drip...circle color:
white/yellow/green/gray
brown/blood/blood/clear
___ Other_____

MOUTH/ THROAT/ IMMUNE
___ Blisters
___ Canker Sore
___ Bad Breath
___ Bleeding gums
___ Receding gums
___ Teeth Health Problems
___ Dry Mouth
___ Swelling of Glands
___ Difficulty Swallowing
___ Sore Throat
___ Hoarseness
___ Fever
___ Chills

CHEST
___ Tension
___ Tight
___ Pressure
___ Heaviness
___ Congestion
___ Chest Pain
___ Sternal Pain
___ Sharp Heart Pain
___ Palpitations-Heart Skip/Flutter
___ Heart Racing
___ Heart Slowing down
___ Mitral Valve Prolapse
___ Murmur
___ Other_____

SHORTNESS OF BREATH
___ Constant
___ Upon Exertion
___ Wheeze
___ Air Hunger
___ Asthma
___ Frequent Sighs
___ Emphysema
___ Other_____

STOMACH
___ Heartburn
___ Indigestion
___ Stomach Aches
___ Stomach Cramps
___ Nausea/ Queasy
___ Bloat after Eat
___ Gas/ Flatulence
___ Belching
___ Ulcer
___ Hiatal Hernia
___ Other_____

BOWELS
Bowel Movements_____ Per day
___ Regular
___ Incomplete
___ Skip days _____ per (week/month)
___ Sluggish bowels every ___ days
___ Cramps in Abdomen
___ Taking Laxatives
___ Using Suppositories
___ Enemas
___ Colonics
___ Bulky
___ Pain with Bowel Movements
___ Irritable Bowel Syndrome
___ Chrons
___ Colitis
___ Other_____

FECAL CONSISTENCY
Color feces light or dark _____
___ Normal
___ Soft
___ Hard
___ Pebbles
___ Dry
___ Ribbon-like
___ Mucous
___ Diarrhea
___ Constipation
___ Other_____

HEMORRHOIDS

URINATION
_____times per day-frequency
___ Urinate at night ____ per night
___ Urgency
___ Burning
___ Pain
___ Odor
___ Spasm
___ Leakage
___ Urinary Tract Infection
___ Incontinence
___ Kidney Troubles
___ Other_____

ENERGY
___ Low
___ Variable
___ Normal
___ High
___ Slow to start in the morning
___ Low Energy after meals
___ Energy Crash_____am/pm
___ Other_____

SLEEP
Quality (poor/fair/good/great)
____ Hours in bed
____ Hours asleep
___ Difficulty falling asleep
___ Difficulty staying asleep
___ Interrupted ___ per night
___ Crave Sleep during day
___ Awaken Suddenly (Jolt)
___ Don't Remember Dreams
___ Nightmares
___ Night sweats
___ Restlessness
___ Sleep Apnea
___ Other_____

EMOTIONS
___ Stressed
___ Sad
___ Grief
___ Depression
___ Moodiness
___ Frustrated
___ Irritable
___ Angry
___ Worrisome
___ Nervous
___ Anxiety
___ Panic
___ Cry
___ Fear
___ Shame
___ Other_____

APPETITE/ DIET
___ Low Appetite
___ Normal Appetite
___ High Appetite
___ Starch (pasta/bread/potatoes/rice)
___ Sweets
___ Chocolate
___ Coffee ____cups/ day
___ Caffeinated Tea ____cups/day
___ Beer ____per week
___ Wine____per week
___ Juice ____per week
___ Soda ____per week

MEMORY
___ Forget Names
___ Forget Numbers
___ Forget Words
___ Forget Actions
___ Difficulty Concentrating
___ Other_____

LIBIDO/ SEXUALITY
___ Flat
___ Low
___ Normal
___ Erectile Dysfunction (men)
___ Orgasm Quality (poor/ good/ great)
___ Other_____

SKIN/ HAIR/ NAILS
___ Skin Rash
___ Acne
___ Dry Skin
___ Itchy Skin
___ Patches skin look different
___ Cellulite
___ Nails (weak/ spots/ lines)
___ Hair loss
___ Limp Hair
___ Other_____

CRAMPS/ ACHES/ RESTLESS
___ Cramps (legs/feet/arms/hands)
___ Aches (legs/feet/arms/hands)
___ Restless (legs/feet/arms/hands)
___ Other_____

PAIN/ STIFFNESS/ SWELLING NUMBNESS/ TINGLING
___ Facial
___ Neck
___ Trapezius
___ Upper Back
___ Shoulders
___ Arms
___ Elbows
___ Wrist
___ Hand
___ Mid Back
___ Low Back
___ Sacral Iliac
___ Hips
___ Buttocks
___ Legs
___ Sciatica
___ Knees
___ Ankles
___ Feet
___ Other_____

For Men Only: PROSTATE
___ Burn
___ Achyness
___ Pain
___ Restriction
___ Dribbling
___ Emission
___ Swelling
___ Other_____

List Your Primary Concerns in order of importance to you:
1)_____

MENSES (women only)
Last Menstrual Period_____
Length of Menses_____
___ Regular
___ Irregular
___ Early (less than 28 days)
___ Late (more than 28 days)
___ Skip
___ Birth Control Pill
___ Flow (heavy/ moderate/ light)
___ Clotting/ Spotting
___ Cramps (mild/ mod/ severe)
___ Low Abdominal Puffiness
___ Fluid Retention Face
___ Fluid Retention Hands
___ Fluid Retention Feet
___ Tired during cycle
___ Acne (pre/post)
___ mood swings/irritable/depression
___ Breast Tender around cycle

BREASTS (women only)
___ Breast Tender constant
___ Breast Feeding
___ Fibrosis
___ Lump
___ Discharge
___ Prosthesis
___ Augmentation Surgery
___ Reduction Surgery
___ Pathology
___ Other_____

VAGINA (women only)
___ Burn
___ Itch
___ Dry
___ Pain
___ Blood
___ Discharge
- Clear
- White
- Yellow
- Green
- Brown
- Odor
___ Other_____

MENOPAUSE (women only)
___ Natural
___ Surgical (partial/complete)
___ Hormones
___ Patch
___ Hot Flashes
___ Skin Crawling
___ Cherry Hemangiomas
___ Facial Hair
___ Hair growing up towards belly button
___ Dark Nipple Hair
___ Other_____

For Doctor's Use
___ Frenular Cyst
___ Cracks in Tongue
___ Allergy Patches Tongue
___ Geographic Tongue
___ Red Spots Tongue
___ Swollen Tongue
___ Color Tongue_____
___ Dark Veins Tongue
___ Coated Tongue (mild/mod/severe)

___	Cold/ sweaty hands or feet	___	Swollen	___	Artificial Sweeteners		___ Ear Creases (Rt/ Lt) mild/mod/severe)
___	Cough (dry/productive)	___	Burning	___	Eat a lot of Spicy Foods	2)	Weight ____(+/-___lbs) overall(+/-___)
___	Environmental Allergies	___	Blood	___	Ice Cream		Height_____
___	Upper Respiratory Infection	___	Distended			3)	Pulse_____BP:(_____/_____)
___	Frequent Colds/ Flu	___	Itchy		**EXERCISE**		saliva pH_____ Urine pH_____
___	Chronic Bronchitis	___	Stingy		Cardiovascular ____ times/ week	4)	Allergies_____
	Other_____	___	Achy		Weight Train ____times/per week		Current Meds:_____