

Please check the appropriate box for any of the following symptoms which you have experienced in the **last year**. Be sure to include the symptoms that you have "learned to live with."

Enter the number of symptom occurrence **1-2-3** after each symptom that best describes your condition:

1 = mild - this symptom occurs once or twice a month.

2 = moderate - this symptom occurs one to three times a week

3 = severe - this symptom occurs daily.

Blank = this symptom does not apply to me.

<u>Cardiovascular</u>	_____ Hay Fever	_____ <i>Insomnia / Loss of Sleep</i>	_____ <i>Eczema</i>
_____ Arteriosclerosis	_____ Hearing Loss	_____ <u>Mind</u>	_____ <i>Excessive Sweating</i>
_____ Chest Pains	_____ <i>Itchy Ears / Eyes</i>	_____ Confusion	_____ <i>Hair Loss</i>
_____ High/Low Blood Pressure	_____ Often Clear Throat	_____ Learning Disabilities	_____ <i>Hives / Rashes</i>
_____ Irregular Heartbeat	_____ <i>Sinus Problems / Infections</i>	_____ Poor Concentration	_____ <i>Itching</i>
_____ Pain Over Heart	_____ Sneezing Attacks	_____ Poor Memory	_____ <u>Weight</u>
_____ Poor Circulation	_____ Sore Throat	_____ Stuttering / Stammering	_____ <i>Binge Eating</i>
_____ Rapid/Slow Heart Beat	_____ Sticky Eyelids	_____ <u>Muscle & Joints</u>	_____ <i>Compulsive Eating</i>
_____ Swelling of Ankles	_____ Stuffy Nose	_____ <i>Aches in Muscles</i>	_____ <i>Cravings</i>
_____ Varicose Veins	_____ Swollen Eyelids	_____ <i>Arthritis / Pain in Joints</i>	_____ <i>Excessive Weight</i>
_____ <u>Emotions</u>	_____ Swollen Tongue/Lips/Gums	_____ Bursitis	_____ <i>Underweight</i>
_____ Aggressiveness	_____ Watery Eyes	_____ <i>Feeling of Weakness</i>	_____ <i>Water Retention</i>
_____ Anxiety / Fear	_____ <u>Gastrointestinal</u>	_____ Foot Trouble	_____ <u>Other</u>
_____ Depression	_____ Belching	_____ Hernia	_____ <i>Allergies</i>
_____ Irritability / Anger	_____ Bloated Feeling	_____ Limited Movement	_____ <i>Anaphylactic Reactions</i>
_____ Mood Swings	_____ Colitis	_____ Low Back Pain	_____ Convulsions
_____ Nervousness	_____ Colon Trouble	_____ Neck Pain / Stiff	_____ Fainting
_____ <u>Energy / Activity</u>	_____ Constipation	_____ Pain between Shoulders	_____ Fever
_____ Apathy	_____ Diarrhea	_____ Pain or Numbness in:	_____ Frequent Illness
_____ Fatigue	_____ Difficult Digestion	_____ Shoulders	_____ Genital Itch
_____ Hyperactivity	_____ Gallbladder Trouble	_____ Arms/Elbows/Hands	_____ Loss of Weight
_____ Lethargy	_____ Hemorrhoids	_____ Hips/Legs/Knees/Feet	_____ Neuralgia / Nerve Pain
_____ Restlessness	_____ Indigestion / Heartburn	_____ Painful Tailbone	_____ Numbness
_____ Sluggishness	_____ Intestinal Parasites	_____ Poor Posture	_____ Sweats
_____ <u>Eyes, Ears, Nose & Throat</u>	_____ Liver Trouble	_____ Sciatica	_____ <u>For Women Only</u>
_____ Blurred Vision	_____ Nausea / Vomiting	_____ Spinal Curvature	_____ Fibrocystic / Congested Breasts
_____ Canker Sores	_____ Pain Over Stomach	_____ Stiffness	_____ Cramps &/or Back Pain
_____ Colds	_____ Passing Gas	_____ Swollen Joints	_____ Excessive Menstrual Flow
_____ Dark Circles Under Eyes	_____ Poor Appetite	_____ <u>Respiratory</u>	_____ Hot Flashes / Flushing
_____ Deafness	_____ Vomiting Blood	_____ Asthma / Bronchitis	_____ Irregular Cycle
_____ Dental Decay	_____ <u>Genitourinary</u>	_____ Chest Congestion / Pain	_____ Menopausal Symptoms
_____ Ear Ache	_____ Bed Wetting	_____ Chronic Cough	_____ Night Sweats
_____ Ear Discharge	_____ Blood in Urine	_____ Difficulty Breathing	_____ Painful Menstruation
_____ Ear Infections	_____ Frequent Urination	_____ Shortness of Breath	_____ Vaginal Discharge
_____ Ear Noises / Ringing	_____ Kidney Infection or Stones	_____ Spitting Up Blood/Phlegm	_____ Yeast Infections
_____ Enlarged Glands / Thyroid	_____ Painful Urination	_____ Wheezing	_____ Pregnant? Y N
_____ Eye Pain	_____ Prostate Trouble	_____ <u>Skin</u>	
_____ Failing Vision	_____ Urgent Urination	_____ Acne	
_____ Far / Nearsightedness	_____ <u>Head</u>	_____ Bruise Easily	
_____ Gagging	_____ Dizziness / Lightheaded	_____ Dermatitis	
_____ Gum Trouble	_____ Headache	_____ Dryness	

****If you have one or more of these symptoms (bold & italics), there is a 95% probability you'll benefit from a food sensitivity test.**

Identify any conditions that **you or any of your family members** have now or have had in the past:

G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self

- | | | | | | |
|---|--|---|-----------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Chorea | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Goiter | <input type="checkbox"/> Detached retina | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart disease | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Measles | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Mumps | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal disease | | <input type="checkbox"/> Deep vein thrombosis | | <input type="checkbox"/> Macular Degeneration | |

HAVE YOU EVER:

DESCRIBE BRIEFLY

Been knocked unconscious? Y N _____
 Been treated for a spine or nerve disorder? Y N _____
 Had a broken bone? Y N _____

DO YOU:

Think that you may need vitamins or minerals? Y N Unsure _____
 Have an allergy to any drug? Y N _____

Please answer the following questions:

- Does your whole arm or leg feel painful? _____ Y N
- Does your whole arm or leg feel numb? _____ Y N
- Have you had any pain-free times in the past year? _____ Y N
- Have you had any intolerance or reactions to treatments? _____ Y N
- Have you ever been to the emergency room for back pain? _____ Y N
- Have you felt irritable / keyed up or on edge? _____ Y N
- Have you had hormone problems? _____ Y N
- Have you had recurrent infections? _____ Y N
- Have you had blood sugar imbalances? Hypo/ Hyperglycemia? _____ Y N
- Have you had decreased libido / sex drive? _____ Y N
- Have you had a difficult time relaxing? _____ Y N
- Have you been sleeping poorly? _____ Y N
- Have you had difficulty falling asleep? _____ Y N
- Have you been waking up early? _____ Y N
- Do you tend to feel worse in the morning? _____ Y N
- Do you get dizzy when rising from sitting or lying? _____ Y N
- Have you been worried about your health? _____ Y N

DATE OF LAST:

Less than 6 months

6-18 months

Over 18 months

Never

Spinal examination
Physical examination
Blood test
Urine test

HABITS

Heavy

Moderate

Light

None

Alcohol
Appetite
Coffee
Exercise
Recreational Drugs
Tobacco
Sleep
Soda / Diet Soda
Water

Have you been treated for any health condition by a physician in the last year? Y N If so, please identify:

Condition: _____ Doctor: _____ Outcome: Resolved / Ongoing / Other

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Medications, Supplements, Surgeries & Hospitalizations

1. Please list ALL **medications** taken within the last 30 days, how often and why you are taking them.
2. Please list ALL **supplements** taken within the last 30 days, how often and why you are taking them.

Meds/Supplement	Started Taking	Why do you take this?

Please list ALL surgeries performed on you, when it was done and how you have felt since having the surgery.

Surgical Procedure?	What approx. year?	How you have felt since the procedure?

Please list any hospitalizations you have had (other than the above listed surgeries).

Why were you there?	When?	What was the outcome?

Please list any additional information that you would like your practitioner to know regarding your health. If necessary please use a separate sheet of paper and label it with your name and date of birth. Thank You!