

Survey of the Overall Health of Your Body's Systems

Patient Name _____ Date _____ Consistency in Taking Supplements _____%

For your 1st visit — check any symptoms you have had in the last 6 months.

For re-exams — check 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
- Earache
- 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/bloody/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
- Cold/ sweaty hands or feet
- Cough (dry/productive)
- Environmental Allergies
- Upper Respiratory Infection
- Frequent Colds/ Flu
- Chronic Bronchitis
- Other _____

CHEST

- Tension
- Tight
- Pressure
- Heaviness
- Congestion
- Chest Pain
- Sterna Pain
- Sharp Heart Pain
- Palpitations-Heart Skip/Flutter
- Heart Racing
- Heart Slowing down
- Mitral Valve Prolapses
- 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
- Crohn's
- Colitis
- Other _____

FECAL CONSISTENCY

- Color feces light or dark _____
- Normal
- Soft
- Hard
- Pebbles
- Dry
- Ribbon-like
- Mucous
- Diarrhea
- Constipation
- Other _____

HEMORRHOIDS

- Swollen
- Burning
- Blood
- Distended
- Itchy
- Stinging
- Achy
- Other _____

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
- Artificial Sweeteners
- Eat a lot of Spicy Foods
- Ice Cream

EXERCISE

- cardiovascular times/ week
- Weight Train ____ times per week

MEMORY

- Forget Numbers
- Forget Words
- Forget Actions
- Difficulty Concentrating
- Other _____

LIBIDO/SEXUALITY

- High
- Low
- Normal
- Erectile Dysfunction (men)
- Orgasm Qty (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
- Achiness
- Pain
- Restriction
- Dribbling
- Emission
- Swelling
- Other _____

List Your Primary Concerns

In Order of Importance to You

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

For Women Only MENSES

- 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/depress)
- Breast Tender around cycle

For Women Only BREASTS

- Breast Tender constant
- Breast Feeding
- Fibrosis
- Lump
- Discharge
- Prosthesis
- Augmentation Surgery
- Reduction Surgery
- Pathology
- Other _____

For Women Only VAGINA

- Burn
- Itch
- Dry
- Pain Blood
- Discharge
- Clear - White - Yellow
- Green - Brown - Odor
- Other _____

For Women Only MENOPAUSE

- Natural
- Surgical (partial/complete)
- Hormones
- Patch
- Hot Flashes
- Skin Crawling
- Cherry Hemangioma
- Facial Hair
- Hair growing up towards belly button
- Dark Nipple Hair
- Other _____

FOR DOCTOR'S USE ONLY

- Frenular Cyst
- Cracks in Tongue
- Allergy Patches Tongue
- Geographic Tongue
- Red Spots Tongue
- Swollen Tongue
- Color Tongue _____
- Dark Veins Tongue
- Coated Tongue (mild/mod/sev)
- Ear Creases (Rt/Lt) (mild/mod/severe)
- Weight (____ +/- ____ lbs) overall (+/- ____)
- Height _____
- Pulse ____ BP: (____/____)
- Saliva pH ____ Urine pH ____
- Allergies _____

Current Meds _____