SURVEY OF YOUR OVERALL HEALTH OF YOUR BODY'S SYSTEMS

Patient Name__________________________ Date____________________ consistently taking supplements______%

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
___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
___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
___Swollen
___Burning
___Blood
___Distended
___Itchy
___Stingy
___Achy

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 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)___________________
____
2)___________________
____
3)___________________
____
4)___________________
____

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)
___Ear Creases (Rt/ Lt) mild/mod/severe)
Weight ____(+/-___lbs) overall(+/-___)
Height______
Pulse_____BP:(____/____)
saliva pH______ Urine pH______
Allergies___________________
Current Meds:___________________