INITIAL INTERVIEW

Name: Date:

Consultation Time:

To ensure the maximum benefit of my consultation, it is important that your information is accurate and up-to-date. If you notice any changes to your health, begin taking new prescriptions, etc., please notify your me as soon as possible. It is also your right as a client to access, update, or delete your records at any time. In my practices I have always been and always will be committed to protecting client privacy and delivering you best practices and the policies laid out in the U.S. *Standards for Privacy of Individually Identifiable Health Information*.

CONTACT INFORMATION

Address 1:

Address 2:

City: State: Zip:

Phone: Type (Cell, Home, Work):

Email:

REFERRED BY

Name:

Email:

BACKGROUND INFORMATION

DOB: Place of Birth: Blood Type:

Age: Gender: Height: Weight:

Occupation: Average Work Hours/Week:

Relationship Status: Number of Children:

HOBBIES & ACTIVITIES

GOALS & HEALTH CONCERNS

What are your top 3-5 health concerns?

What would you like to gain from my consultation? What are your personal health goals?

SLEEP

Do you sleep well? Yes: ☐ No: ☐

Do you wake up during the night? Yes: ☐ No: ☐ If yes, at what time?

What time do you usually go to bed? What time do you usually wake up?

How do you feel when you wake up?

FOOD & DRINK

How much pure water do you drink per day? (add amount & circle "fl. oz." or "mL") fl. oz. / mL

Do you drink caffeinated drinks (e.g. coffee, black tea, soda, etc.)? Yes: ☐ No: ☐

If yes, how much per day on average? (add amount & circle "fl. oz." or "mL") fl. oz. / mL

What were your eating habits like as a child? (list typical types of food below)

What % of your food is home cooked? % How many days/week do you typically eat out?

What kind of cookware do you usually use (e.g. cast iron, Teflon, aluminum)?

What kind of fats do you usually cook with (butter, olive oil, canola, etc.)?

In your opinion, what do you think are the three *least healthy* foods you eat each week and why?

Conversely, what do you think are the three *healthiest* foods you eat each week and why?

DIGESTION & APPETITE

Do you often feel tired after meals? Yes: No:

Do you often feel bloated after meals? Yes: No:

Do you often feel gassy after meals? Yes: No:

Do you experience constipation often? Yes: No: If yes, how many days/week?

Do you experience diarrhea often? Yes: No: If yes, how many days/week?

Do you often feel excessively hungry? Yes: No:

Do you often have little or no appetite? Yes: No:

Do you often crave sugar? Yes: No:

Do you often crave salt? Yes: No:

BIRTH & INFANCY

Were you born vaginally or by Cesarean Section? Vaginally: Cesarean Section:

Were you breastfed as a baby? Yes: No: If yes, until what age?

SMOKING & TOXIC EXPOSURE

Do you smoke? Yes: ☐ No: ☐

If so, how many cigarettes per day on average? /day

Are you regularly exposed to secondhand smoke? Yes: ☐ No: ☐

If so, how many days per week on average? /day

Do you have amalgam fillings? Yes: ☐ No: ☐

Have you had amalgam fillings removed or replaced? Yes: ☐ No: ☐

Have you been exposed to toxic substances at work or home? Yes: ☐ No: ☐

If so, what toxins were you exposed to?

MOVEMENT & RELAXATION

Do you enjoy playing sports or being active outside? Yes: ☐ No: ☐

If yes, what are your favorite sports or activities?

On average, how many days a week do you walk? /days

On average, how many days a week do you run? /days

On average, how many days a week do you do high-intensity interval training? /days

On average, how many days a week do you lift weights? /days

On average, how many days a week do you do cardio, aerobics, etc.? /days

On average, how many days a week do you stretch or do yoga? /days

On average, how many hours a day are you sitting? /hours

On average, what is your daily screen time (TV, computer, smartphone, etc.)? /hours

On average, how many days per week do you meditate? /days

On a scale of 1-10 (1 being low and 10 being high), what is your average stress level?

SUPPLEMENTS, HERBS & MEDICATIONS

Are you currently taking any vitamins, minerals, herbs, homeopathic remedies, prescription or non-prescription medications, aspirin, laxatives, diet pills, or any other supplements? Yes: ☐ No: ☐

If yes, please list all of these below including specific product names and dosages/amounts:

Do you have any known allergies to medications or herbs? Yes: ☐ No: ☐

If yes, please list all known allergies below:

MEDICAL HISTORY

Are you currently under a practitioner's care for a specific issue? Yes: ☐ No: ☐

If so, what treatments are you undergoing?

What is your doctor or practitioner's name and contact information?

Name: Licensure:

Address:

City: State: Zip:

Phone: Type (Cell, Home, Work):

Email:

Have you ever been seriously injured, hospitalized, or suffered from a disease? Yes: ☐ No: ☐

If so, please list all accidents, injuries, diagnoses, surgeries, etc. you have had below, including the date of the event or diagnosis:

FAMILY HEALTH HISTORY

Please check all conditions below that apply to your parents and grandparents:

Diabetes:	☐	Heart Disease:	☐	Stomach/Intestinal Disorders:	☐
Asthma:	☐	Arthritis:	☐	Gallbladder Disease:	☐
Kidney Disease:	☐	Cancer:	☐	Type of Cancer:	

If not listed above, please write in the condition(s) below:

Please list the ages of your parents and grandparents. If a family member is deceased, please write their age of death and cause (if known).

Mother's Age:		Cause of Death (if Deceased)	
Father's Age:		Cause of Death (if Deceased)	
Maternal Grandmother's Age:		Cause of Death (if Deceased)	
Paternal Grandmother's Age:		Cause of Death (if Deceased)	
Maternal Grandfather's Age:		Cause of Death (if Deceased)	
Paternal Grandfather's Age:		Cause of Death (if Deceased)	

WOMEN ONLY

Do you feel your libido is adequate? Yes: ☐ No: ☐

Are your periods regular? Yes: ☐ No: ☐ Age of your first period: ☐

How frequent are your periods on average? ☐ /days

How many days is your flow on average? ☐ /days

On average, how heavy is your flow? (Light, Medium, or Heavy) ☐

Do you experience cramps? Yes: ☐ No: ☐ If so, how severe? (Mild, Moderate, or Severe) ☐

Do you experience PMS? Yes: ☐ No: ☐ If so, how severe? (Mild, Moderate, or Severe) ☐

Are you currently pregnant or could you be pregnant? Yes: ☐ No: ☐ If so, how many months? ☐ /months

How many children have you delivered? ☐

Were there any birth complications? Yes: ☐ No: ☐ If so, please elaborate below:

Did you receive antibiotics during labor? Yes: ☐ No: ☐

Have you ever had a miscarriage? Yes: ☐ No: ☐ If so, how many? ☐

Have you undergone fertility treatments? Yes: ☐ No: ☐ If so, what kind? ☐

Are you perimenopausal? Yes: ☐ No: ☐ If so, when did changes begin? ☐

Are you menopausal? Yes: ☐ No: ☐ If so, when was your last period? ☐

If you are perimenopausal or menopausal, please list your symptoms below:

MEN ONLY

Approximate age of onset of puberty: ☐

Number of children: ☐

Do you feel your libido is adequate?	Yes: ☐	No: ☐
Do you often wake at night to urinate?	Yes: ☐	No: ☐
If yes, how many times per night on average?		☐
Do you have any difficulty or pain with urination?	Yes: ☐	No: ☐
Do you have diminished volume or flow?	Yes: ☐	No: ☐
Have you lost interest in activities you used to greatly enjoy? (e.g. sports, hobbies, etc.)	Yes: ☐	No: ☐
Do you often feel more agitated or irritable than you used to?	Yes: ☐	No: ☐
Do you often feel less assertive in daily life than you used to?	Yes: ☐	No: ☐

NOTES

Additional Questionnaire

Name: | Date:

Gender: | Date of Birth:

TOP 5 HEALTH CONCERNS

1:

2:

3:

4:

5:

Directions: Please read the following questions and circle the number that applies. Unless otherwise noted, use the default scale shown at the top of each section or page. Trust your instincts and choose quickly without overthinking.

Part 1

DIET

Section Subtotal / 58

0: Never Consume | 1: Consume 1-2x/month | 2: Consume Weekly | 3: Consume Daily

1.	0	1	2	3	Alcohol	11.	0	1	2	3	Processed Lunch Meats
2.	0	1	2	3	Artificial Sweeteners	12.	0	1	2	3	Margarine
3.	0	1	2	3	Candy, Desserts, Sugar	13.	0	1	2	3	Milk Products
4.	0	1	2	3	Carbonated Beverages	14.	0	1			Radiation Exposure (0=No, 1=Yes)
5.	0	1	2	3	Chewing Tobacco	15.	0	1	2	3	Refined Flour & Baked Goods
6.	0	1	2	3	Cigarettes	16.	0	1	2	3	Vitamins & Minerals
7.	0	1	2	3	Cigars or Pipes	17.	0	1	2	3	Distilled Water
8.	0	1	2	3	Caffeinated Beverages	18.	0	1	2	3	Tap Water
9.	0	1	2	3	Fast Food	19.	0	1	2	3	Well Water
10.	0	1	2	3	Fried Foods	20.	0	1	2	3	Restrict Calories for Weight Control

LIFESTYLE

Section Subtotal / 12

See each question below for the rating key.

21.	0	1	2	3	Exercise Sessions Per Week	0 = 2+ times/week; 1 = 1 time/week; 2 = 1-2 times/month; 3 = < 1 time/month
22.	0	1	2	3	Changed Jobs	0 = over 12 mo. ago; 1 = last 12 mo.; 2 = last 6 mo.; 3 = last 2 mo.
23.	0	1	2	3	Divorced	0 = never or over 2 years ago; 1 = last 2 years.; 2 = last year; 3 = last 6 mo.
24.	0	1	2	3	Work 60+ Hours Per Week	0 = never; 1 = occasionally; 2 = usually; 3 = always

MEDICATIONS

Section Subtotal / 27

0: No (Not Taking or Have Not Taken in the Last Month) 1: Yes (Currently Taking or Have Taken in the Last Month)

25.	0	1	Antacids	39.	0	1	Diuretics
26.	0	1	Antianxiety Medications	40.	0	1	Estrogen or Progesterone (Prescript.)
27.	0	1	Antibiotics	41.	0	1	Estrogen or Progesterone (Natural)
28.	0	1	Anticonvulsants	42.	0	1	Heart Medications
29.	0	1	Antidepressants	43.	0	1	High Blood Pressure Medications
30.	0	1	Antifungals	44.	0	1	Laxatives
31.	0	1	Aspirin/Ibuprofen	45.	0	1	Recreational Drugs
32.	0	1	Asthma Inhalers	46.	0	1	Relaxants/Sleeping Pills
33.	0	1	Beta Blockers	47.	0	1	Testosterone (Prescript. or Natural)
34.	0	1	Birth Control Pill/Implant	48.	0	1	Thyroid Medication
35.	0	1	Chemotherapy	49.	0	1	Acetaminophen (Tylenol®)
36.	0	1	Cholesterol Lowering Medications	50.	0	1	Ulcer Medications
37.	0	1	Cortisone/Steroids	51.	0	1	Sildenafil Citrate (Viagra®)
38.	0	1	Diabetic Medications/Insulin				

Part 2

SECTION 1: UPPER G.I.

Section Subtotal / 55

0: Never Occurs 1: Minor; Rarely Occurs (1x/month) 2: Moderate; Occasional (Weekly) 3: Severe; Frequent (Daily)

52.	0	1	2	3	Belching/Gas Within 1 Hour of Eating	62.	0	1	2	3	Feel Better if You Don't Eat
53.	0	1	2	3	Heartburn or Acid Reflux	63.	0	1	2	3	Sleepy After Meals
54.	0	1	2	3	Bloating Within 1 Hour of Eating	64.	0	1	2	3	Fingernails Chip, Peal or Break Easily
55.	0	1			Vegan Diet [1]	65.	0	1	2	3	Anemia Unresponsive to Iron
56.	0	1	2	3	Bad Breath (Halitosis)	66.	0	1	2	3	Stomach Pains or Cramps
57.	0	1	2	3	Loss of Taste for Meat	67.	0	1	2	3	Chronic Diarrhea
58.	0	1	2	3	Strong Smelling Sweat	68.	0	1	2	3	Diarrhea Shortly After Meals
59.	0	1	2	3	Stomach Upset by Taking Vitamins	69.	0	1	2	3	Black or Tarry Colored Stools
60.	0	1	2	3	Sense of Excess Fullness After Meals	70.	0	1	2	3	Undigested Food in Stool
61.	0	1	2	3	Feel Like Skipping Breakfast						

[1] 0 = No 1 = Yes No animal products (meat, fish, eggs, dairy, etc.)

0: Never Occurs 1: Minor; Rarely Occurs (1x/month) 2: Moderate; Occasional (Weekly) 3: Severe; Frequent (Daily)

SECTION 2: LIVER & GALLBLADDER

Section Subtotal / 64

71.	0	1	2	3	Pain Between Shoulder Blades	85.	0	1			Easily Hungover from Wine [1]
72.	0	1	2	3	Stomach Upset by Greasy Foods	86.	0	1	2	3	Alcoholic Beverages Per Week [3]
73.	0	1	2	3	Greasy or Shiny Stools	87.	0	1			Recovering Alcoholic [1]
74.	0	1			Nausea [1]	88.	0	1			History of Drug Abuse [1]
75.	0	1	2	3	Motion Sickness (Sea, Car, Airplane)	89.	0	1			History of Hepatitis [1]
76.	0	1			History of Morning Sickness [1]	90.	0	1			Long-term Use of Prescript./Rec. Drugs [1]
77.	0	1	2	3	Light or Clay Colored Stools	91.	0	1	2	3	Sensitive to Chemicals (e.g. Perfume, Cleaning Agents, etc.)
78.	0	1	2	3	Dry Skin, Itchy or Peeling Feet	92.	0	1	2	3	Sensitive to Tobacco Smoke
79.	0	1	2	3	Headache Over Eyes	93.	0	1	2	3	Exposure to Diesel Fumes
80.	0	1	2	3	Gallbladder Attacks [2]	94.	0	1	2	3	Pain Under Right Side of Rib Cage
81.	0	1			Gallbladder Removed [1]	95.	0	1	2	3	Hemorrhoids or Varicose Veins
82.	0	1	2	3	Bitter Taste in Mouth, Especially After Meals	96.	0	1	2	3	Consume NutraSweet® (Aspartame)
83.	0	1			Become Sick When Drinking Wine [1]	97.	0	1	2	3	Sensitive to Aspartame
84.	0	1			Easily Intoxicated from Wine [1]	98.	0	1	2	3	Chronic Fatigue or Fibromyalgia

[1] 0 = No 1 = Yes [2] 0 = Never 1 = Years Ago 2 = Within Last Year 3 = Within Past 3 Months [3] 0 = < 3 1 = < 7 2 = < 14 3 = > 14

SECTION 3: SMALL INTESTINE

Section Subtotal / 47

99.	0	1	2	3	Food Allergies	108.	0	1	2	3	Crohn's Disease [2]
100.	0	1	2	3	Abdominal Bloating 1-2 Hours After Meal	109.	0	1	2	3	Wheat or Grain Sensitivity
101.	0	1			Specific Foods Make You Tired / Bloated [1]	110.	0	1	2	3	Dairy Sensitivity
102.	0	1	2	3	Pulse Speeds After Eating	111.	0	1			Are There Any Foods You Can't Give Up? [1]
103.	0	1	2	3	Airborne Allergies	112.	0	1	2	3	Asthma, Sinus Infections, Stuffy Nose
104.	0	1	2	3	Experience Hives	113.	0	1	2	3	Bizarre, Vivid Dreams; Nightmares
105.	0	1	2	3	Sinus Congestion, "Stuffy Head"	114.	0	1	2	3	Use Over-the-Counter Pain Meds
106.	0	1	2	3	Crave Bread or Noodles	115.	0	1	2	3	Feel Spacey or Unreal
107.	0	1	2	3	Alternating Constipation/Diarrhea						

[1] 0 = No 1 = Yes [2] 0 = No 1 = Yes in the Past 2 = Currently Mild 3 = Currently Severe

0: Never Occurs 1: Minor; Rarely Occurs (1x/month) 2: Moderate; Occasional (Weekly) 3: Severe; Frequent (Daily)

SECTION 4: LARGE INTESTINE

Section Subtotal / 58

116.	0	1	2	3	Anus Itches	126.	0	1	2	3	Stools Have Corners/Edges, are Flat, or Ribbon Shaped
117.	0	1	2	3	Coated Tongue	127.	0	1	2	3	Stools are Not Well Formed (Loose)
118.	0	1	2	3	Feel Worse in Moldy/Musty Places	128.	0	1	2	3	Irritable Bowel or Mucus Colitis
119.	0	1	2	3	Total Antibiotic Use [2]	129.	0	1	2	3	Blood in Stool
120.	0	1	2	3	Fungal or Yeast Infections	130.	0	1	2	3	Mucus in Stool
121.	0	1	2	3	Ring Worm, Jock Itch, Athletes Foot, Nail Fungus	131.	0	1	2	3	Excessive, Foul Smelling Flatulence
122.	0	1	2	3	Yeast Symptoms Increase with Sugar, Starch, or Alcohol Consumption	132.	0	1	2	3	Bad Breath or Strong Body Odors
123.	0	1	2	3	Hard or Difficult to Pass Stool	133.	0	1	2	3	Painful to Press Along Outer Thighs (Iliotibial Bands)
124.	0	1			History of Parasites [1]	134.	0	1	2	3	Cramps in Lower Abdominal Region
125.	0	1	2	3	Less Than 1 Bowel Movement/Day	135.	0	1	2	3	Dark Circles Under Eyes

[1] 0 = No 1 = Yes [2] 0 = Never 1 = Less than 1 Month 2 = Less than 3 Months 3 = More than 3 Months

SECTION 5: MINERAL NEEDS

Section Subtotal / 75

136.	0	1			History of Carpal Tunnel Syndrome [1]	151.	0	1	2	3	Morning Stiffness
137.	0	1			History of Lower Right Abdominal Pains or Ileocecal Valve Problems [1]	152.	0	1	2	3	Nausea with Vomiting
138.	0	1			History of Stress Fracture [1]	153.	0	1	2	3	Crave Chocolate
139.	0	1	2	3	Bone Loss (Reduced Density on Bone Scan)	154.	0	1	2	3	Feet Have a Strong Odor
140.	0	1			Are You Shorter Than You Used to Be? [1]	155.	0	1	2	3	History of Anemia
141.	0	1	2	3	Calf, Foot, or Toe Cramps at Rest	156.	0	1	2	3	Whites of Eyes (Sclera) are Blue Tinted
142.	0	1	2	3	Cold Sores, Fever Blisters, or Herpes Lesions	157.	0	1	2	3	Hoarseness
143.	0	1	2	3	Frequent Fevers	158.	0	1	2	3	Difficulty Swallowing
144.	0	1	2	3	Frequent Skin Rashes or Hives	159.	0	1	2	3	Lump in Throat
145.	0	1			Herniated Disc [1]	160.	0	1	2	3	Dry Mouth, Eyes, or Nose
146.	0	1	2	3	Excessively Flexible Joints / "Double Jointed"	161.	0	1	2	3	Gag Easily
147.	0	1	2	3	Joints Pop or Click	162.	0	1	2	3	White Spots on Fingernails
148.	0	1	2	3	Pain or Swelling in Joints	163.	0	1	2	3	Cuts Heal Slowly and/or Scar Easily
149.	0	1	2	3	Bursitis or Tendonitis	164.	0	1	2	3	Decreased Sense of Taste or Smell
150.	0	1			History of Bone Spurs [1]						

[1] 0 = No 1 = Yes

0: Never Occurs 1: Minor; Rarely Occurs (1x/month) 2: Moderate; Occasional (Weekly) 3: Severe; Frequent (Daily)

SECTION 6: FATTY ACIDS

Section Subtotal / 22

165.	0	1			Experience Pain Relief with Aspirin [1]	169.	0	1	2	3	Headaches When Out in the Hot Sun
166.	0	1	2	3	Crave Fatty or Greasy Foods	170.	0	1	2	3	Sunburn Easily or Get "Sun Poisoning"
167.	0	1	2	3	Low-Fat or Reduced-Fat Diet [2]	171.	0	1	2	3	Muscles Easily Fatigued
168.	0	1	2	3	Tension Headaches at Base of Skull	172.	0	1	2	3	Dry, Flaky Skin or Dandruff

[1] 0 = No 1 = Yes [2] 0 = Never 1 = Years Ago 2 = Within Past Year 3 = Currently

SECTION 7: SUGAR HANDLING

Section Subtotal / 39

173.	0	1	2	3	Awaken a Few Hours After Falling Asleep & Have Difficulty Falling Back to Sleep	180.	0	1	2	3	Headache if Meals are Skipped / Delayed
174.	0	1	2	3	Crave Sweets	181.	0	1	2	3	Irritable Before Meals
175.	0	1	2	3	Binging or Uncontrolled Eating	182.	0	1	2	3	Shaky if Meals are Delayed
176.	0	1	2	3	Excessive Appetite	183.	0	1	2	3	Family Members with Diabetes [1]
177.	0	1	2	3	Crave Coffee or Sugar in the Afternoon	184.	0	1	2	3	Frequent Thirst
178.	0	1	2	3	Sleep in the Afternoon	185.	0	1	2	3	Frequent Urination
179.	0	1	2	3	Fatigue that is Relieved by Eating	[1] 0 = None 1 = 1-2 People 2 = 3-4 People 3 = > 4 People					

SECTION 8: VITAMIN NEEDS

Section Subtotal / 79

186.	0	1	2	3	Muscles Become Easily Fatigued	200.	0	1	2	3	Can Hear Heartbeat on Pillow at Night
187.	0	1	2	3	Feel Exhausted or Sore After Moderate Exercise	201.	0	1	2	3	Whole Body or Limb Jerk as Falling Asleep
188.	0	1	2	3	Vulnerable to Insect Bites	202.	0	1	2	3	Night Sweats
189.	0	1	2	3	Loss of Muscle Tone, Heaviness in Arms/Legs	203.	0	1	2	3	Restless Leg Syndrome
190.	0	1	2	3	Enlarged Heart or Congestive Heart Failure	204.	0	1	2	3	Cracks at Corner of Mouth (Cheilosis)
191.	0	1			Pulse Below 65 Beats Per Minute [1]	205.	0	1	2	3	Fragile, Easily Chaffed Skin (e.g. When Shaving)
192.	0	1	2	3	Ringing in the Ears (Tinnitus)	206.	0	1	2	3	Polyps or Warts
193.	0	1	2	3	Numbness, Tingling, or Itching in Hands & Feet	207.	0	1	2	3	MSG Sensitivity
194.	0	1	2	3	Depressed	208.	0	1	2	3	Wake Up Without Remembering Dreams
195.	0	1	2	3	Fear of Impending Doom	209.	0	1	2	3	Small Bumps on Back of Arms
196.	0	1	2	3	Worrier, Apprehensive, Anxious	210.	0	1	2	3	Strong Light at Night Irritates Eyes
197.	0	1	2	3	Nervous or Agitated	211.	0	1	2	3	Nose Bleeds and/or Tends to Bruise Easily
198.	0	1	2	3	Feelings of Insecurity	212.	0	1	2	3	Bleeding Gums, Especially When Brushing
199.	0	1	2	3	Heart Races	[1] 0 = No 1 = Yes					

0: Never Occurs 1: Minor; Rarely Occurs (1x/month) 2: Moderate; Occasional (Weekly) 3: Severe; Frequent (Daily)

SECTION 9: ADRENALS

Section Subtotal / 78

213.	0	1	2	3	Tend to be a "Night Person"	226.	0	1	2	3	Arthritic Tendencies
214.	0	1	2	3	Difficulty Falling Asleep	227.	0	1	2	3	Crave Salty Foods
215.	0	1	2	3	Slow Starter in the Morning	228.	0	1	2	3	Salt Foods Before Tasting
216.	0	1	2	3	Tend to be "Keyed Up", Trouble Calming Down	229.	0	1	2	3	Perspire Easily
217.	0	1	2	3	Blood Pressure Above 120/80	230.	0	1	2	3	Chronic Fatigue or Get Drowsy Often
218.	0	1	2	3	Headache After Exercising	231.	0	1	2	3	Afternoon Yawning
219.	0	1	2	3	Feeling Wired or Jittery After Drinking Coffee	232.	0	1	2	3	Afternoon Headache
220.	0	1	2	3	Clench or Grind Teeth	233.	0	1	2	3	Asthma, Wheezing, or Difficulty Breathing
221.	0	1	2	3	Calm on the Outside, Troubled on the Inside	234.	0	1	2	3	Pain on the Medial or Inner Side of Knee
222.	0	1	2	3	Chronic Lower Back Pain, Worse with Fatigue	235.	0	1	2	3	Tendency to Sprain Ankles or Get "Shin Splints"
223.	0	1	2	3	Become Dizzy When Standing Up Quickly	236.	0	1	2	3	Tendency to Need Sunglasses
224.	0	1	2	3	Difficulty Maintaining Manipulative Correction	237.	0	1	2	3	Allergies and/or Hives
225.	0	1	2	3	Pain After Manipulative Correction	238.	0	1	2	3	Weakness, Dizziness

SECTION 10: PITUITARY

Section Subtotal / 29

239.	0	1			Height Over 6' 6" [1]	246.	0	1	2	3	Decreased Libido
240.	0	1			Early Sexual Development [1] (Before Age 10)	247.	0	1	2	3	Excessive Thirst
241.	0	1	2	3	Increased Libido	248.	0	1	2	3	Weight Gain Around Hips or Waist
242.	0	1	2	3	Splitting Type Headache	249.	0	1	2	3	Menstrual Disorders
243.	0	1	2	3	Memory Failing	250.	0	1			Delayed Sexual Development [1] (After Age 13)
244.	0	1			Tolerate / Feel Fine When Eating Sugar [1]	251.	0	1	2	3	Tendency to Ulcers or Colitis
245.	0	1			Height Under 4' 10" [1]						

[1] 0 = No 1 = Yes

0: Never Occurs 1: Minor; Rarely Occurs (1x/month) 2: Moderate; Occasional (Weekly) 3: Severe; Frequent (Daily)

SECTION 11: THYROID

Section Subtotal / 48

252.	0	1	2	3	Sensitive/Allergic to Iodine	260.	0	1	2	3	Mentally Sluggish / Reduced Initiative
253.	0	1	2	3	Difficulty Gaining Weight (Even With Large Appetite)	261.	0	1	2	3	Easily Fatigued / Sleepy During the Day
254.	0	1	2	3	Nervous or Emotional (Can't Work Under Pressure)	262.	0	1	2	3	Sensitive to Cold / Poor Circulation (Cold Hands & Feet)
255.	0	1	2	3	Inward Trembling	263.	0	1	2	3	Chronic Constipation
256.	0	1	2	3	Flush Easily	264.	0	1	2	3	Excessive Hair Loss and/or Course Hair
257.	0	1	2	3	Fast Pulse at Rest	265.	0	1	2	3	Morning Headaches (Wear Off During the Day)
258.	0	1	2	3	Intolerance to High Temperatures	266.	0	1	2	3	Loss of Lateral (Outside) ⅓ of Eyebrow
259.	0	1	2	3	Difficulty Losing Weight	267.	0	1	2	3	Seasonal Sadness

SECTION 12: MEN ONLY

Section Subtotal / 27

268.	0	1	2	3	Prostate Problems	273.	0	1	2	3	Interruption of Stream During Urination
269.	0	1	2	3	Difficulty with Urination / Dribbling	274.	0	1	2	3	Pain on Inside of Legs or Heels
270.	0	1	2	3	Difficult to Start & Stop Urine Stream	275.	0	1	2	3	Feeling of Incomplete Bowel Evacuation
271.	0	1	2	3	Pain or Burning During Urination	276.	0	1	2	3	Decreased Sexual Function*
272.	0	1	2	3	Waking to Urinate at Night						

* Dysfunction related to prostate issues only.

SECTION 13: WOMEN ONLY

Section Subtotal / 60

If you are in menopause or no longer menstruating, please indicate the average symptoms that occurred when you were last menstruating.

277.	0	1	2	3	Depression During Periods	287.	0	1	2	3	Breast Fibroids / Benign Masses
278.	0	1	2	3	Mood Swings Associated with Periods (Premenstrual Syndrome)	288.	0	1	2	3	Painful Intercourse (Dyspareunia)
279.	0	1	2	3	Crave Chocolate Around Periods	289.	0	1	2	3	Vaginal Discharge
280.	0	1	2	3	Breast Tenderness Associated with Cycle	290.	0	1	2	3	Vaginal Dryness
281.	0	1	2	3	Excessive Menstrual Flow	291.	0	1	2	3	Vaginal Itchiness
282.	0	1	2	3	Scanty Blood Flow During Periods	292.	0	1	2	3	Gain Weight Around Hips, Thighs & Buttocks
283.	0	1	2	3	Occasional Skipped Periods	293.	0	1	2	3	Excess Facial or Body Hair
284.	0	1	2	3	Variations in Menstrual Cycles	294.	0	1	2	3	Hot Flashes
285.	0	1	2	3	Endometriosis	295.	0	1	2	3	Night Sweats (in Menopausal Women)
286.	0	1	2	3	Uterine Fibroids	296.	0	1	2	3	Thinning Skin

0: Never Occurs 1: Minor; Rarely Occurs (1x/month) 2: Moderate; Occasional (Weekly) 3: Severe; Frequent (Daily)

SECTION 14: CARDIOVASCULAR

Section Subtotal / 30

297.	0	1	2	3	Aware of Heavy or Irregular Breathing	302.	0	1	2	3	Ankles Swell, Especially at End of Day
298.	0	1	2	3	Discomfort at High Altitudes	303.	0	1	2	3	Cough at Night
299.	0	1	2	3	"Air Hunger" or Sigh Frequently	304.	0	1	2	3	Blush / Face Turns Red for No Reason
300.	0	1	2	3	Compelled to Open Windows in a Closed Room	305.	0	1	2	3	Dull Pain or Tightness in Chest and/or Radiating Into Right Arm (Worse with Exertion)
301.	0	1	2	3	Shortness of Breath with Moderate Exertion	306.	0	1	2	3	Muscle Cramps with Exertion

SECTION 15: KIDNEY & BLADDER

Section Subtotal / 13

307.	0	1	2	3	Pain in Mid-Back Region	310.	0	1	2	3	Cloudy, Bloody, or Darkened Urine
308.	0	1	2	3	Puffy / Dark Circles Around the Eyes	311.	0	1	2	3	Urine Has a Strong Odor
309.	0	1			History of Kidney Stones [1]						

[1] 0 = No 1 = Yes

SECTION 16: IMMUNE SYSTEM

Section Subtotal / 30

312.	0	1	2	3	Runny or Drippy Nose	317.	0	1	2	3	Never Get Sick[2]
313.	0	1	2	3	Catch Colds at the Beginning of Winter	318.	0	1	2	3	Adult Acne
314.	0	1	2	3	Mucus Producing Cough	319.	0	1	2	3	Itchy Skin (Dermatitis)
315.	0	1	2	3	Frequent Colds of Flu[1]	320.	0	1	2	3	Cysts, Boils, or Rashes
316.	0	1	2	3	Other Infections[1] (e.g. Sinus, Ear, Lung, Skin, Bladder, Kidney, etc.)	321.	0	1	2	3	History of Chronic Viral Condition[3] (e.g. Mono, Epstein Bar, Herpes, Shingles, Chronic Fatigue Syndrome)

[1] 0 = 1 or Less Per Year 1 = 2 to 3 per Year 2 = 4 to 5 Per Year 3 = 6 or More Per Year

[2] 0 = Sick Only 1 or 2 Times in Last 2 Years 1 = Not Sick in Last 2 Years 2 = Not Sick in Last 4 Years 3 = Not Sick in Last 7 Years

[3] 0 = No 1 = Yes in the Past 2 = Currently Mild Condition 3 = Severe