



Client Name _____

Date _____

INSTRUCTIONS

Please **Circle the number** next to the symptom in the **GROUPS** below that are **applicable to you**

- 1) Mild Symptoms – Symptoms occurring once to twice a month
- 2) Moderate Symptoms – Symptoms occurring once to twice a week
- 3) Severe Symptoms – Symptoms occurring daily

Skip if you do not have the symptom

GROUP ONE

- | | | | | | | | | | | | |
|-----------------------------|---|---|---|--------------------------------|---|---|---|--------------------------|---|---|---|
| 1. "Nervous" Stomach | 1 | 2 | 3 | 5. Mental Alert, Quick | 1 | 2 | 3 | 9. Fever Easily Raised | 1 | 2 | 3 |
| 2. Dry Mouth-Eyes-Nose | 1 | 2 | 3 | 6. Extremities - Cold, Clammy | 1 | 2 | 3 | 10. Cold Sweats Often | 1 | 2 | 3 |
| 3. Pulse Speeds After Meals | 1 | 2 | 3 | 7. Heart Pounds After Retiring | 1 | 2 | 3 | 11. Neuralgia Like Pains | 1 | 2 | 3 |
| 4. Keyed Up - Fail to Calm | 1 | 2 | 3 | 8. Acidic Foods Upset Stomach | 1 | 2 | 3 | | | | |

ARE YOUR SYMPTOMS MADE WORSE BY EMOTIONAL STRESS? Yes _____ No _____

GROUP TWO

- | | | | | | | | | | | | |
|------------------------------------|---|---|---|--|---|---|---|--|---|---|---|
| 12. Perspire Easily | 1 | 2 | 3 | 16. Digestion Rapid | 1 | 2 | 3 | 20. Joint Stiffness After Rising | 1 | 2 | 3 |
| 13. Muscle-Leg-Toe Cramps at Night | 1 | 2 | 3 | 17. Frequent Vomiting | 1 | 2 | 3 | 21. Poor Circulation - Sensitive to Cold | 1 | 2 | 3 |
| 14. Eyelids Swollen, Puffy | 1 | 2 | 3 | 18. Difficulty Swallowing | 1 | 2 | 3 | 22. Subject to Colds, Asthma, Bronchitis | 1 | 2 | 3 |
| 15. Indigestion Soon After Meals | 1 | 2 | 3 | 19. Alternating Constipation, Diarrhea | 1 | 2 | 3 | | | | |

ARE YOUR SYMPTOMS MADE WORSE BY EMOTIONAL STRESS? Yes _____ No _____

GROUP THREE

- | | | | | | | | | | | | |
|--------------------------------|---|---|---|---|---|---|---|--|---|---|---|
| 23. Afternoon Headaches | 1 | 2 | 3 | 26. Heart Palpitates if Meals are Missed or Delayed | 1 | 2 | 3 | 28. Awaken After Few Hours of Sleep Difficult to Get Back to Sleep | 1 | 2 | 3 |
| 24. Get "Shaky" if Hungry | 1 | 2 | 3 | 27. Eat When Nervous | 1 | 2 | 3 | 29. Crave Candy or Coffee in Afternoon | 1 | 2 | 3 |
| 25. Faintness if Meals Delayed | 1 | 2 | 3 | | | | | 30. Abnormal Craving for Sweets or Snacks | 1 | 2 | 3 |

GROUP FOUR

| | | | | | | | | | | | |
|--|---|---|---|--|---|---|---|--|---|---|---|
| 31. Bruise Easily "Black and Blue" Spots | 1 | 2 | 3 | 36. Swollen Ankles, Worse at Night | 1 | 2 | 3 | 40. Hands and Feet go to Sleep Easily, Numbness | 1 | 2 | 3 |
| 32. Sigh Frequently - "Air Hunger" | 1 | 2 | 3 | 37. Muscle Cramps, Worse During Exercise | 1 | 2 | 3 | 41. Tendency to Anemia | 1 | 2 | 3 |
| 33. Aware of "Breathing Heavily" | 1 | 2 | 3 | 38. Shortness of Breath on Exertion | 1 | 2 | 3 | 42. Tension Under the Breastbone, or Feeling of "Tightness", Worse on Exertion | 1 | 2 | 3 |
| 34. Opens Window in Closed Room | 1 | 2 | 3 | 39. Dull Pain in Chest or Radiating into Left Arm, Worse on Exertion | 1 | 2 | 3 | | | | |
| 35. Susceptible to Colds and Fevers | 1 | 2 | 3 | | | | | | | | |

GROUP FIVE

| | | | | | | | | | | | |
|--|---|---|---|----------------------------------|---|---|---|--|---|---|---|
| 43. Dry Skin | 1 | 2 | 3 | 47. Biliousness | 1 | 2 | 3 | 51. Laxatives Used Often | 1 | 2 | 3 |
| 44. Skin Rashes Frequent | 1 | 2 | 3 | 48. Greasy Foods Upset Stomach | 1 | 2 | 3 | 52. History of Gallbladder Attacks or Gallstones | 1 | 2 | 3 |
| 45. Bitter Metallic Taste in Mouth in the Mornings | 1 | 2 | 3 | 49. Stools Light Colored | 1 | 2 | 3 | 53. Sneezing Attacks | 1 | 2 | 3 |
| 46. Bowel Movements Painful or Difficult | 1 | 2 | 3 | 50. Pain Between Shoulder Blades | 1 | 2 | 3 | | | | |

GROUP SIX

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|-------------------------------------|---|---|---|
| 54. Lower Bowel Gas Several Hours After Eating | 1 | 2 | 3 | 56. Coated Tongue | 1 | 2 | 3 | 58. Gas Shortly After Eating | 1 | 2 | 3 |
| 55. Burning Stomach Sensations, Eating Relieves | 1 | 2 | 3 | 57. Indigestion 1/2 to 1 Hour After Eating, may be up to 3 to 4 hours | 1 | 2 | 3 | 59. Stomach "Bloating" After Eating | 1 | 2 | 3 |

GROUP SEVEN

| | | | | | | | | | | | |
|--------------------------------------|---|---|---|---|---|---|---|--|---|---|---|
| A | | | | B | | | | C | | | |
| 60. Pulse Fast at Rest | 1 | 2 | 3 | 70. Impaired Hearing | 1 | 2 | 3 | 78. Low Blood Pressure | 1 | 2 | 3 |
| 61. Nervousness | 1 | 2 | 3 | 71. Decrease in Appetite | 1 | 2 | 3 | 79. Failing Memory | 1 | 2 | 3 |
| 62. Can't Gain Weight | 1 | 2 | 3 | 72. Ringing in Ears | 1 | 2 | 3 | 80. Increased Sex Desire | 1 | 2 | 3 |
| 63. Intolerance to Heat | 1 | 2 | 3 | 73. Constipation | 1 | 2 | 3 | 81. Headaches, "Splitting/Rendering" Type | 1 | 2 | 3 |
| 64. Highly Emotional | 1 | 2 | 3 | 74. Mental Sluggishness | 1 | 2 | 3 | 82. Decreased Sugar Tolerance | 1 | 2 | 3 |
| 65. Flush Easily | 1 | 2 | 3 | 75. Headaches Upon Arising - Wears Off During the Day | 1 | 2 | 3 | | | | |
| 66. Night Sweats | 1 | 2 | 3 | 76. Slow Pulse, Below 65 | 1 | 2 | 3 | F | | | |
| 67. Inward Trembling | 1 | 2 | 3 | 77. Increase in Weight | | | | 97. Low Blood Pressure | 1 | 2 | 3 |
| 68. Heart Palpitates | 1 | 2 | 3 | | | | | 98. Chronic Fatigue | 1 | 2 | 3 |
| 69. Insomnia | 1 | 2 | 3 | E | 1 | 2 | 3 | 99. Weakness, Fatigue | 1 | 2 | 3 |
| | | | | 91. Hot Flashes | 1 | 2 | 3 | 100. Tendency to Hives | 1 | 2 | 3 |
| D | | | | 92. Headaches | 1 | 2 | 3 | 101. Arthritic Tendencies | 1 | 2 | 3 |
| 83. Bloating of Intestines | 1 | 2 | 3 | 93. Dizziness | 1 | 2 | 3 | 102. Perspiration Increases | 1 | 2 | 3 |
| 84. Abnormal Thirst | 1 | 2 | 3 | 94. Increased Blood Pressure | 1 | 2 | 3 | 103. Crave Salt | 1 | 2 | 3 |
| 85. Weight Gain Around Hips or Waist | 1 | 2 | 3 | 95. Sugar in Urine (Not Diabetes) | 1 | 2 | 3 | 104. Brown Spots or Bronzing of Skin | 1 | 2 | 3 |
| 86. Sex Desire Reduced or Lacking | 1 | 2 | 3 | 96. Masculine Tendencies (Female) | | | | 105. Allergies - Tendency to Asthma | 1 | 2 | 3 |
| 87. Tendency to Ulcers Colitis | 1 | 2 | 3 | | | | | 106. Exhaustion - Muscular and Nervousness | 1 | 2 | 3 |
| 88. Increased Sugar Tolerance | 1 | 2 | 3 | | | | | 107. Respiratory Disorders | 1 | 2 | 3 |
| 89. Women: Menstrual Disorders | 1 | 2 | 3 | | | | | | | | |
| 90. Young Girls: Lack of Menstrual | 1 | 2 | 3 | | | | | | | | |

GROUP EIGHT

FEMALE ONLY

| | | | | | | | | | | | |
|---------------------------------------|---|---|---|--|---|---|---|-------------------------------------|---|---|---|
| 108. Painful Menses | 1 | 2 | 3 | 115. Vaginal Discharge | 1 | 2 | 3 | 122. Pain on Inside of Legs or Heel | 1 | 2 | 3 |
| 109. Premenstrual Tension | 1 | 2 | 3 | 116. Menopause, Hot Flashes, Etc. | 1 | 2 | 3 | 123. Feeling of Incomplete Bowel | 1 | 2 | 3 |
| 110. Very Easily Frustrated | 1 | 2 | 3 | 117. Menses Scanty | 1 | 2 | 3 | 124. Prostate Trouble | 1 | 2 | 3 |
| 111. Depressed Feeling Before Period | 1 | 2 | 3 | 118. Acne, Worse at Menses | 1 | 2 | 3 | 125. Leg Nervousness at Night | 1 | 2 | 3 |
| 112. Menstruation Excessive/Prolonged | 1 | 2 | 3 | 119. Tire too Easily | 1 | 2 | 3 | 126. Diminished Sex Desire | 1 | 2 | 3 |
| 113. Painful Breasts | 1 | 2 | 3 | 120. Urination Difficult | 1 | 2 | 3 | | | | |
| 114. Menstruate too Frequently | 1 | 2 | 3 | 121. Night Urination Frequent Movement | 1 | 2 | 3 | | | | |

GROUP NINE

| | | | | | | | | | | | |
|--------------------------|---|---|---|----------------------------|---|---|---|---------------------------------|---|---|---|
| 127. Chronic Cough | 1 | 2 | 3 | 131. Difficulty Breathing | 1 | 2 | 3 | 135. Infections Settle in Lungs | 1 | 2 | 3 |
| 128. Pain Around Ribs | 1 | 2 | 3 | 132. Coughing Up Phlegm | 1 | 2 | 3 | 136. Sensitive to Smog | 1 | 2 | 3 |
| 129. Shortness of Breath | 1 | 2 | 3 | 133. Coughing Up Blood | 1 | 2 | 3 | | | | |
| 130. Chest Pain | 1 | 2 | 3 | 134. Bronchitis (Frequent) | 1 | 2 | 3 | | | | |

GROUP TEN

| | | | | | | | | | | | |
|-----------------------------------|---|---|---|--|---|---|---|---|---|---|---|
| 137. Frequent Urination | 1 | 2 | 3 | 141. Cloudy Urine | 1 | 2 | 3 | 145. Urination When You Cough or Sneeze | 1 | 2 | 3 |
| 138. Rose Colored (Bloody) Urine | 1 | 2 | 3 | 142. Rarely Need to Urinate | 1 | 2 | 3 | 146. Strong Smelling Urine | 1 | 2 | 3 |
| 139. Dripping After Urination | 1 | 2 | 3 | 143. Frequent Bladder Infections | 1 | 2 | 3 | | | | |
| 140. Difficulty Passing Urine | 1 | 2 | 3 | 144. Pain / Burning When Passing Urine | 1 | 2 | 3 | | | | |

GROUP ELEVEN

| | | | | | | | | | | | |
|------------------------------------|---|---|---|---------------------------------|---|---|---|---------------------------------|---|---|---|
| A | | | | | | | | | | | |
| 147. Throat Infections | 1 | 2 | 3 | 150. Get Boils or Styes | 1 | 2 | 3 | 153. Bumpy Skin on Back of Arms | 1 | 2 | 3 |
| 148. Poor Wound Healing | 1 | 2 | 3 | 151. Swollen Lymph Glands | 1 | 2 | 3 | 154. Inflamed or Bleeding Gums | 1 | 2 | 3 |
| 149. Slow to Recover From Cold/Flu | 1 | 2 | 3 | 152. Catch Colds/Flu Too Easily | 1 | 2 | 3 | | | | |

| | | | | | | | | | | | |
|-------------------------|---|---|---|---------------------------|---|---|---|----------------------------------|---|---|---|
| B | | | | | | | | | | | |
| 155. Poor Wound Healing | 1 | 2 | 3 | 157. Swollen Lymph Glands | 1 | 2 | 3 | 159. Hyperactivity | 1 | 2 | 3 |
| 156. Post Nasal Drip | 1 | 2 | 3 | 158. Swollen Tongue | 1 | 2 | 3 | 160. Food Sensitivity or Allergy | 1 | 2 | 3 |

PLEASE LIST BELOW YOUR FOUR MAIN HEALTH COMPLAINTS IN ORDER OF IMPORTANCE:

1.

2.

3.

4.

PLEASE FILL IN BELOW:

| | | | |
|--|---------|-------------|---|
| Name: | | Phone No: | |
| Address: | | City: | State: Zip: |
| Birthdate: | Weight: | Height: | Married: Yes / No Gender: Male / Female |
| Email Address (Print Legibly): | | Occupation: | |
| History of Illnesses and Treatments: | | | |
| | | | |
| | | | |
| Operations, Accidents or Injuries: | | | |
| | | | |
| | | | |
| Present Diagnosed Illnesses: | | | |
| | | | |
| | | | |
| Please List any Family History of Illness or Disease: | | | |
| | | | |
| | | | |
| Please List any Medications or Supplements you are presently taking: | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Client Signature

Date

Technician Signature

Date

DISCLAIMER

The Qest4 system provides a completely non-invasive method for gaining valuable information about your body's vital functions. The primary objective of the screening is to disclose patterns of stress and provide feedback that will assist in developing a program to restore each system and meridian to balance.

- I understand that the Qest4 survey does not provide medical diagnosis and that my testing technician may recommend further medical testing. If I suspect I need further medical intervention, I understand I should consult MY physician. I give my permission for the testing technician to evaluate me on the Qest4. I understand in doing so my testing technician is NOT becoming my primary care physician. I understand that the testing technician will give me information about myself and make recommendations based on the Qest4 screening. I understand that the testing technician will not pass judgements on prescribed medications and it is the responsibility of my primary care physician to make any adjustments on prescribed medications. Any decision to follow through with the recommended program is my own decision and I hold the testing technician harmless.
- I understand that I am here to learn about natural health and better lifestyle practices and I will be offered information about food supplements and herbs as a guide to general health.
- I understand that I should continue to see any medical doctors I am currently under the care of, and that any prescribed medications should not be altered without first consulting the physician who recommended it.
- I fully understand that those who counsel me are not medical doctors, medical practitioners, licensed nutritionists, or licensed naturopaths. I am not here for any medical diagnostic purposes or treatment procedures.
- Information about traditional uses of supplementation that may create a healthy balance in the body may be discussed. This is not intended to be interpreted as a substitute for a licensed physician's treatment. Nothing said, done, typed, printed or reproduced by us is intended to diagnose, prescribe, treat, or take the place of a licensed physician.
- The intent is to provide educational information for the purpose of assisting you with the lifestyle changes necessary to regain and maintain an environment needed to support a well-balanced lifestyle.
- I am not on this visit, or any subsequent visit, acting as an agent for the federal, state, county, local law enforcement or news media on a mission of entrapment or investigation.
- I understand that all information and conversations will be kept confidential, and that information concerning myself can be released to another health professional only with my written consent
- I understand that the Qest4 screening will only identify energetic imbalances and does not diagnose any diseases in the body. The Balancing Item refers to the energetic signature needed to restore balance to the body. Balancing Items are defined differently from medical terms and are not a cure for any disease.
- I recognize that the Qest4 screening is an unorthodox approach to balancing my health. Being of sound mind, I have chosen this screening to assist in balancing my health of my own free will and in exercise of my constitutional right for the attainment of life, liberty and the pursuit of happiness.

 Client Signature

 Date

 Guardian Signature (if under 18 years of age)

 Relationship