Name:_____ Date:_____

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: ____-____-_____ Work:____-____-_____ Cell:____-____-_____

Occupation:_____ Hours of work per week: _____

Age: _____ Birth Date: ___/___/_____ Current weight: _____ Weight one year ago: _____

Email address: _____ Relationship status: _____

Children: _____ Ages: _____ Pets: _____

How did you hear about us? _____

Parent/Guardian Name (If applicable): _____ Contact Number: _____

Present Complaints: List your main health problems:

1._____When did it start?_____

2._____When did it start_____

3._____When did it start?_____

4._____When did it start?_____

5._____When did it start?_____

At what point in your life did you feel best?

_____

_____

What are your health goals?

_____

_____

Medications or nutritional supplements you are currently taking:

_____

_____

_____

Key: 0=No, symptom does not occur
1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occurs weekly
3=Severe symptom, occurs daily

SECTION 1 – Read each symptom and circle the number that applies.

1. 0 1 2 3 Heartburn or Acid Reflux
2. 0 1 2 3 Burping or Gas after eating
3. 0 1 2 3 Bloating after eating
4. 0 1 2 3 Bad breath
5. 0 1 2 3 Sweat has a strong odor
6. 0 1 2 3 Feel better if I don't eat
7. 0 1 2 3 Sleepy after meals
8. 0 1 2 3 Burning pain in stomach
9. 0 1 2 3 Fingernails chip, break, peel
10. 0 1 2 3 Anemia unresponsive to iron
11. 0 1 2 3 Stomach pain or cramps
12. 0 1 2 3 Diarrhea, chronic
13. 0 1 2 3 Diarrhea after meals
14. 0 1 2 3 Black or dark stool
15. 0 1 2 3 Undigested food in stool

SECTION 2 – Read each symptom and circle the number that applies.

16. 0 1 2 3 Skip days between bowel movm.
17. 0 1 2 3 Stools hard or difficult to pass
18. 0 1 2 3 Cramping on lower abdomen
19. 0 1 2 3 Blood in stool
20. 0 1 2 3 Mucus in stool
21. 0 1 2 3 IBS or colitis
22. 0 1 2 3 Yeast Infections
23. 0 1 2 3 Nail fungus or athletes foot
24. 0 1 2 3 Dark circles under eyes
25. 0 1 2 3 History of parasites
26. 0 1 2 3 Coated tongue
27. 0 1 2 3 Anus itches
28. 0 1 2 3 Constipation
29. 0 1 2 3 Stools are loose
30. 0 1 2 3 Bad smelling gas

SECTION 3 – Read each symptom and circle the number that applies.

31. 0 1 2 3 Food allergies
32. 0 1 2 3 Bloating after eating
33. 0 1 2 3 Airborne allergies
34. 0 1 2 3 Wheat or gluten sensitivity
35. 0 1 2 3 Dairy sensitivity
36. 0 1 2 3 Sinus congestion
37. 0 1 2 3 Craves bread and pasta
38. 0 1 2 3 Pulse speeds after eating
39. 0 1 2 3 Nightmares
40. 0 1 2 3 Feel spacy or unreal
41. 0 1 2 3 Alternating diarrhea/ constipation
42. 0 1 2 3 Hives

Key: 0=no, symptom does not occur
1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occurs weekly
3=Severe symptom, occurs daily

SECTION 4 – Read each symptom and circle the number that applies.

43. 0 1 2 3 Nausea
44. 0 1 2 3 Pain between shoulder blades
45. 0 1 2 3 Skin rashes, acne, eczema, etc.
46. 0 1 2 3 Age or "Liver" spots
47. 0 1 2 3 Greasy foods upset stomach
48. 0 1 2 3 Gallbladder attacks or stones
49. 0 1 2 3 Motion sickness
50. 0 1 2 3 Headache over eyes
51. 0 1 2 3 Easily intoxicated
52. 0 1 2 3 Hemorrhoids or varicose veins
53. 0 1 2 3 Sensitivity to perfumes or chemicals, etc...
54. 0 1 2 3 Pain under right rib cage
55. 0 1 2 3 Insomnia

SECTION 5 – Read each symptom and circle the number that applies.

56. 0 1 2 3 Carpal Tunnel Syndrome
57. 0 1 2 3 Osteoporosis or Osteopenia
58. 0 1 2 3 Legs or foot cramps at rest
59. 0 1 2 3 Pain or swelling in joints
60. 0 1 2 3 Bursitis or tendonitis
61. 0 1 2 3 Joints pop or crack
62. 0 1 2 3 White spots on fingernails
63. 0 1 2 3 Decreased taste or smell

SECTION 6 – Read each symptom and circle the number that applies.

64. 0 1 2 3 Intense Fatigue
65. 0 1 2 3 Brain Fog
66. 0 1 2 3 Memory loss short/long term
67. 0 1 2 3 Pain or swelling in joints
68. 0 1 2 3 Stiff joints in morning
69. 0 1 2 3 Muscle twitching
70. 0 1 2 3 Unexplained fevers
71. 0 1 2 3 Headaches/Migraines
72. 0 1 2 3 Poor concentration
73. 0 1 2 3 Sore soles of feet in morning

SECTION 7 – Read each symptom and circle the number that applies

74. 0 1 2 3 Body jerks as falling asleep
75. 0 1 2 3 Restless leg syndrome
76. 0 1 2 3 Small bumps on back of arms
77. 0 1 2 3 Heart races
78. 0 1 2 3 Worrier, anxious
79. 0 1 2 3 Nosebleeds
80. 0 1 2 3 Bruise easily
81. 0 1 2 3 Gums bleed easily
82. 0 1 2 3 Depressed regularly
83. 0 1 2 3 Numbness or tingling in body
84. 0 1 2 3 Loss of muscle tone

Key: 0=no, symptom does not occur
1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occur
3=Severe symptom, occurs daily

SECTION 8 – Read each symptom and circle the number that applies.

85. 0 1 2 3 Difficulty falling asleep
86. 0 1 2 3 Slow starter in the morning
87. 0 1 2 3 Suddenly dizzy when standing
88. 0 1 2 3 Difficulty holding chiropractic adjustments
89. 0 1 2 3 Arthritis
90. 0 1 2 3 Crave salty food
91. 0 1 2 3 Headache after exercise
92. 0 1 2 3 Chronic low back pain
93. 0 1 2 3 Clench or grind teeth
94. 0 1 2 3 Perspire too easily
95. 0 1 2 3 Hives
96. 0 1 2 3 Bright light hurts eyes
97. 0 1 2 3 Slow recovery from stress

SECTION 9 – Read each symptom and circle the number that applies.

98. 0 1 2 3 Difficulty losing weight
99. 0 1 2 3 Loss of outer 1/3 eyebrows
100. 0 1 2 3 Mentally sluggish
101. 0 1 2 3 Cold hands and feet
102. 0 1 2 3 Hair loss
103. 0 1 2 3 Easily fatigued
104. 0 1 2 3 Seasonal sadness
105. 0 1 2 3 Low body temperature
106. 0 1 2 3 Sensitive to iodine
107. 0 1 2 3 Fast pulse at rest
108. 0 1 2 3 Nervousness
109. 0 1 2 3 Sensitivity to cold
110. 0 1 2 3 Intolerant to heat
111. 0 1 2 3 Flush easily
112. 0 1 2 3 Heart palpitations

SECTION 10 - Read each symptom and circle the number that applies.

113. 0 1 2 3 Crave sweets
114. 0 1 2 3 Awaken during night, hard to fall back asleep
115. 0 1 2 3 Excessive appetite
116. 0 1 2 3 Crave coffee or sugar in afternoon
117. 0 1 2 3 Headache if meals are delayed
118. 0 1 2 3 Get shaky or weak if hungry
119. 0 1 2 3 Sleepy in afternoon
120. 0 1 2 3 Fatigue relieved by eating
121. 0 1 2 3 Afternoon headaches
122. 0 1 2 3 Irritable before meals

SECTION 11 – *Men Only* - Read each symptom and circle the number that applies

138. 0 1 2 3 Prostate problems
139. 0 1 2 3 Decreased libido
140. 0 1 2 3 Urination difficult
141. 0 1 2 3 Pain or burning with urination
142. 0 1 2 3 Fatigue
143. 0 1 2 3 Pain on inside of legs or heels
144. 0 1 2 3 Feeling of incomplete bowel elimination

Key: 0=no, symptom does not occur
1=Yes, mild symptom, rarely occurs
2=Moderate symptom, occur
3=Severe symptom, occurs daily

SECTION 12 - *Women Only* – Read each symptom and circle the number that applies.

123. 0 1 2 3 Painful menstrual cycle
124. 0 1 2 3 Mood swings around cycle
125. 0 1 2 3 Painful breasts at cycle
126. 0 1 2 3 Irregular cycles
127. 0 1 2 3 Heavy menstrual flow
128. 0 1 2 3 Acne at menstrual cycle
129. 0 1 2 3 Yeast Infections
130. 0 1 2 3 Endometriosis
131. 0 1 2 3 Uterine fibroids
132. 0 1 2 3 Fibrocystic breasts
133. 0 1 2 3 Hot flashes
134. 0 1 2 3 Vaginal itchiness
135. 0 1 2 3 Vaginal discharge
136. 0 1 2 3 Night sweats
137. 0 1 2 3 Menopausal symptoms

SECTION 13 – Read each symptom and circle the number that applies.

145. 0 1 2 3 Shortness of breath with moderate exertion
146. 0 1 2 3 Opens windows in closed room
147. 0 1 2 3 Sigh frequently
148. 0 1 2 3 Bruise easily
149. 0 1 2 3 Muscle cramps during exercise
150. 0 1 2 3 Hands and feet go to sleep
151. 0 1 2 3 Dull pain in chest, worse on exertion

SECTION 14 - Read each symptom and circle the number that applies.

152. 0 1 2 3 Pain upon urination
153. 0 1 2 3 Frequent bladder infections
154. 0 1 2 3 Cloudy, bloody, or dark urine
155. 0 1 2 3 Urine has strong odor
156. 0 1 2 3 History of kidney stones
157. 0 1 2 3 Pain in low back
158. 0 1 2 3 Puffy eyes or dark circles under eyes regularly

SECTION 15 - Read each symptom and circle the number that applies

159. 0 1 2 3 Catch colds/flu easily
160. 0 1 2 3 Runny or drippy nose
161. 0 1 2 3 Swollen lymph nodes
162. 0 1 2 3 Gets boils, cysts, styes
163. 0 1 2 3 Poor wound healing
164. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles or Chronic Fatigue

Key: 0= Never 2=Weekly 1=Occasionally 3=Daily

SECTION 16 - Read each symptom and circle the number that applies

165. 0 1 2 3 Use of pesticides in home
166. 0 1 2 3 Use of strong chemicals (bleach, polish, floor wax, window cleaner,etc)
167. 0 1 2 3 Exposed to tobacco, moth balls, incense, varnish, or dust
168. 0 1 2 3 Treat home for insects
169. 0 1 2 3 Use of perfumes, hairspray, cosmetics, nail polish, etc.
170. 0 1 2 3 Exposed to diesel fumes, exhaust fumes, or gasoline fumes

Rate your overall stress level on a scale of 1 to 10. (10= high, 1= low)

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What is affecting your stress level the most?

What do you enjoy most in your life?

What do you worry about most in your life?

When it comes to FULLY committing to your desire to be healthy, what is getting in the way?

Who will sincerely support you consistently with the beneficial lifestyle changes you will be making?

_____

_____

_____

_____

List any emotional or personal conflicts that you are exposed to repeatedly:

_____

_____

_____

How is your diet:

☐ Coffee:	_____ cups per:	☐ Day	☐ Week	☐ Month
☐ Soft drinks:	_____ cans per:	☐ Day	☐ Week	☐ Month
☐ Diet soda:	_____ cans per:	☐ Day	☐ Week	☐ Month
☐ Candy:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Chocolate:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Alcohol:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Fast Food:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Milk/cheese:	_____ times per:	☐ Day	☐ Week	☐ Month
☐ Fried foods:	_____ times per:	☐ Day	☐ Week	☐ Month

Current Diet Information: Give examples of what foods you typically eat daily:

Breakfast: _____

Lunch: _____

Snacks:_____

Dinner: _____

Liquids: _____

How many meals do you eat per day? _____ What meals do you skip? _____

Do you cook? _____ What percentage of your meals are home-cooked? _____

Sleep

How much sleep do you get on average per night:

☐ 1 – 3 hours ☐ 4 – 5 hours ☐ 6 – 7 hours ☐ 7+ hours

Health History:

List any major illnesses/diagnosed conditions with approximate dates:

Illness:	Date:	Recovered?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Health History:

☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Other: _____

Specify what type: _____

Please list any surgeries, operations, traumas, car accidents, etc…

_____

_____

What are your hobbies: _____

_____

Commitment Level to your health: How serious are you about improving your health?

☐ Very serious ☐ Serious ☐ Moderately interested ☐ Other:_____

I Will Commit to Do the Following, if necessary:

□ Change my diet

□ Use supplements

□ Do detoxification recommendations using sauna/other therapies

□ Whatever it takes!

□ Depends on the scan results