

EFFECTS/ SYMPTOMS

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

___ Worrysome

___ 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: _____