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
___ 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_____________________

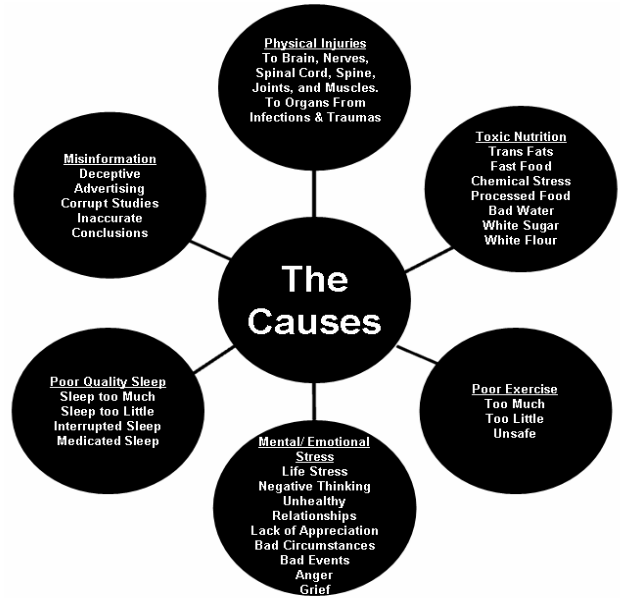
For Doctor's Use
___ Frenular Cyst
___ Cracks in Tongue
___ Allergy Patches Tongue
___ Geographic Tongue
___ Red Spots Tongue
___ Swollen Tongue
___ Color Tongue________________
___ Dark Veins Tongue
___ Coated Tongue (mild/mod/severe)
___ Ear Creases (Rt/ Lt) mild/mod/severe)
Weight ____(+/-___lbs) overall(+/-___)
Height_______
Pulse______BP:(_____/_____)
saliva pH_______ Urine pH_______
Allergies_____________________
Current Meds:___________________

CAUSES

<u>For Re-exams-</u>checkmark causes since last exam.

PHYSICAL

___ birth trauma
___ c-section
___ forceps
___ computer work hours per day _____
___ repetive stress activiites_________________
___ Over Exercise
___ Under Exercise
___ Poor Quality Sleep
___ sprains/strains_______________________
___ concussions
___ car accidents (please list below)
___ falls (please list below)
___ sports injuries (please list below)
___ broken bones (please list below)
___ surgeries (please list below)
___ stitches
___ other_____________________________



List all recent accidents, falls, & injuries <u>since last exam:</u>

	Date:	Describe:
1)		
2)		
3)		
4)		
5)		

List all hospitalizations, surgeries, broken bones, stiches since last exam:

	Date:	Describe:
1)		
2)		
3)		
4)		
5)		

EMOTIONAL STRESSORS

___ work
___ home
___ negative thinker
___ divorce
___ death of a close family
___ job loss
___ diagnosed with disease
___ finacial stress
___ difficult childhood
___ family issues/conflict
___ Hours watch T.V per day______
___ Guilt/ Remorse/ Regret

NUTRITIONAL TOXICITIES/ DEFIECIENCIES

___ white sugar
___ white flour
___ coffee
___ sodas
___ trans fats
___ Eat fried foods
___ Eat fast foods
___ Overeating
___ Stressed eating
___ Undereating

CHEMICAL TOXICITIES

___ Medications ___________________________
___ vaccinations
___ toxic cleaners
___ pesticides
___ fertilizers
___ work place chemicals
___ Shower/ Swim in Chlorine Water
___ Substance Abuse
___ prescrip. & OTC drugs (please list below)

List all current prescribed medications:

1) ______
2) ______
3) ______
4) ______
5) ______
6) ______
7)
8) ______
9) ______
10) ______

List all current "over the counter" medications:

1) ______
2) ______
3) ______
4) ______
5) ______
6) ______
7) ______
8) ______
9) ______
10) ______

Wellness Actions

For Re-exams-checkmark wellness actions you are currently doing.

REST & RELAXATION

___ Engage in activities to Destress your body
___ Get 8 hours good quality sleep regularly
___ Take breaks throughout the day
___ Use a special pillow
___ Use a special mattress
___ Use black out curtains
___ Cover all light sources including clocks
___ Stop watching TV at least 2 hours before bed
___ Turn off Computer at least 2 hours before bed
___ Decrease lighting 2 hours before bedtime
___ Other:________________________

MIND & EMOTIONS

___ Actively Think Positively Daily
___ Express Gratitude Daily
___ Pray
___ Meditate
___ Journal
___ Emotional Freedom Technique
___ Emotional CPR
___ Other:________________________

NERVOUS SYSTEM & BODY WORK

___ Chiropractic
___ Massage
___ Physical Therapy
___ Accupuncture
___ Other:________________________

EXERCISE

___ Stretching
___ Small motor movements train
___ Weight train
___ Endurance train
___ Wear orthotics
___ Floss your teeth
___ Other:________________________

NUTRITION

___ Eat Vegetables Daily
___ Eat Fruits Daily
___ Eat Animal Protein Daily
___ Drink bottled or filtered water daily
___ Make and Drink Fresh Juices
___ Avoid Trans Fats
___ Avoid MSG
___ Avoid Artificial Sugar
___ Avoid Refined Flour
___ Avoid Refined Sugar
___ Are you on any special diet?
If yes please name or describe below:

____

____

Other:________________________

List current Nutritional Supplements, NOT prescribed by your LEWC doctor:

____
____
____
____
____
____
____
____
____
____
____
____

Wellness Actions

Nervous System Care
Spinal Adjustments
Cranial Adjustments
Extremity Adjustments
C1 Therapy

Customized Clinical Nutrition
Eat Veggies & Fruit (Organic)
Buy Free Range Proteins
Use Customized Organ Specific Supplements

Exercise & Rehabilitation
Weight Training
Interval Training
Workout 20-140 Minutes Per Week
Specific Training & Rehab

Mind & Emotions
Express Gratitude
Lower Stress
3 Secure Relationships
Pray
Natural Emotional Therapies-EFT
E-CPR

Rest & Sleep
Good Mattress
A Dark Room
Comfortable Temperature
No Computer
No TV

Empowerment Education
Get True Information
Attend Classes
Learn Forever!

Doctor's Notes
____
____
____
____
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____

Wellness: A higher quality human experience resulting from specific choices and actions, which create an increasingly organized process of health and vitality in any dimension of life.