

# Center for Well Being

3601 Minnesota Drive, #160  
Edina, MN 55435  
Tel: 952-885-0822

Today's Date: \_\_\_\_\_

## ADULT MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

|   |  |                                  |  |                         |  |
|---|--|----------------------------------|--|-------------------------|--|
| First Name: _____   |  | Middle Name: _____               |  | Last Name: _____        |  |
| Address: _____  |  | City: _____                      |  | State: _____ ZIP: _____ |  |
| Home Phone: (_____) _____ - _____   |  | Birth Date: ____/____/____       |  | Age: _____              |  |
|   |  | month day year                   |  |                         |  |
| Work Phone: (_____) _____ - _____   |  | Email: _____                     |  |                         |  |
| Cell Phone: (_____) _____ - _____   |  |                                  |  |                         |  |
| Living Status: S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Partner <input type="checkbox"/> |  | Place of Birth: _____            |  |                         |  |
| Occupation: _____   |  | City or town & country if not US |  |                         |  |
| Referred by: _____  |  | Height: ___' ___" Weight: _____  |  | Sex: _____              |  |

1. Please check appropriate box(es):

- |   |                                    |  |                                |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic  | <input type="checkbox"/> Mediterranean     | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American  | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

## CREDIT CARD INFORMATION

Patient \_\_\_\_\_ Date \_\_\_\_\_

DOB \_\_\_\_\_

Preferred Method of Payment (*please circle one*): Cash / Check / Credit Card

Credit Card Type (*please circle one*): VISA MASTERCARD DISCOVER

Name on Card \_\_\_\_\_

Card Type  Visa  MasterCard  Discover

Account Number \_\_\_\_\_

Expiration Date (mm/yy) \_\_\_\_\_

CVV# \_\_\_\_\_

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

| DESCRIBE PROBLEM                | MILD/<br>MODERATE/<br>SEVERE | TREATMENT<br>APPROACH | SUCCESS  |
|---------------------------------|------------------------------|-----------------------|----------|
| <b>Example:</b> Post Nasal Drip | Moderate                     | Elimination Diet      | Moderate |
| a.                              |                              |                       |          |
| b.                              |                              |                       |          |
| c.                              |                              |                       |          |
| d.                              |                              |                       |          |
| e.                              |                              |                       |          |
| f.                              |                              |                       |          |
| g.                              |                              |                       |          |

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)

Example: Wendy, age 7, sister

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Do you have any pets or farm animals? Yes\_\_\_\_ No\_\_\_\_

If yes, where do they live? 1. \_\_\_\_\_ indoors 2. \_\_\_\_\_ outdoors 3. \_\_\_\_\_ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes\_\_\_\_ No\_\_\_\_

If so, when and where? \_\_\_\_\_  
 \_\_\_\_\_

6. Have you or your family recently experienced any major life changes? Yes\_\_\_\_ No\_\_\_\_  
 If yes, please comment: \_\_\_\_\_  
 \_\_\_\_\_

7. Have you experienced any major losses in life? Yes\_\_\_\_ No\_\_\_\_  
 If so, please comment: \_\_\_\_\_  
 \_\_\_\_\_

8. How important is religion (or spirituality) for you and your family's life?  
 a. \_\_\_\_ not at all important  
 b. \_\_\_\_ somewhat important  
 c. \_\_\_\_ extremely important

9. How much time have you lost from work or school in the past year?  
 a. \_\_\_\_ 0-2 days  
 b. \_\_\_\_ 3 -14 days  
 c. \_\_\_\_ > 15 days

10. Previous jobs: \_\_\_\_\_  
 \_\_\_\_\_

11. Recent Medical Physician: \_\_\_\_\_ Date: \_\_\_\_\_

12. Recent Chiropractic Physician \_\_\_\_\_ Date: \_\_\_\_\_

13. Past Medical and Surgical History:

| ILLNESSES                                       | WHEN | COMMENTS |
|---|------|----------|
| a. Anemia                                       |      |          |
| b. Arthritis                                    |      |          |
| c. Asthma                                       |      |          |
| d. Bronchitis                                   |      |          |
| e. Cancer                                       |      |          |
| f. Chronic Fatigue Syndrome                     |      |          |
| g. Crohn's Disease or Ulcerative Colitis        |      |          |
| h. Diabetes                                     |      |          |
| i. Emphysema                                    |      |          |
| j. Epilepsy, convulsions, or seizures           |      |          |
| k. Gallstones                                   |      |          |
| l. Gout   |      |          |
| ILLNESSES                                       | WHEN | COMMENTS |
| m. Heart attack/Angina                          |      |          |
| n. Heart failure                                |      |          |
| o. Hepatitis                                    |      |          |
| p. High blood fats (cholesterol, triglycerides) |      |          |

|     |                                    |             |                 |
|-----|------------------------------------|-------------|-----------------|
| q.  | High blood pressure (hypertension) |             |                 |
| r.  | Irritable bowel                    |             |                 |
| s.  | Kidney stones                      |             |                 |
| t.  | Mononucleosis                      |             |                 |
| u.  | Pneumonia                          |             |                 |
| v.  | Rheumatic fever                    |             |                 |
| w.  | Sinusitis                          |             |                 |
| x.  | Sleep apnea                        |             |                 |
| y.  | Stroke                             |             |                 |
| z.  | Thyroid disease                    |             |                 |
| aa. | Other (describe)                   |             |                 |
|     | <b>INJURIES</b>                    | <b>WHEN</b> | <b>COMMENTS</b> |
| ab. | Back injury                        |             |                 |
| ac. | Broken (describe)                  |             |                 |
| ad. | Head injury                        |             |                 |
| ae. | Neck injury                        |             |                 |
| af. | Other (describe)                   |             |                 |
|     | <b>DIAGNOSTIC STUDIES</b>          | <b>WHEN</b> | <b>COMMENTS</b> |
| ag. | Barium Enema                       |             |                 |
| ah. | Bone Scan                          |             |                 |
| ai. | CAT Scan of Abdomen                |             |                 |
| aj. | CAT Scan of Brain                  |             |                 |
| ak. | CAT Scan of Spine                  |             |                 |
| al. | Chest X-ray                        |             |                 |
| am. | Colonoscopy                        |             |                 |
| an. | EKG                                |             |                 |
| ao. | Liver scan                         |             |                 |
| ap. | Neck X-ray                         |             |                 |
| aq. | NMR/MRI                            |             |                 |
| ar. | Sigmoidoscopy                      |             |                 |
| as. | Upper GI Series                    |             |                 |
| at. | Other (describe)                   |             |                 |
|     | <b>OPERATIONS</b>                  | <b>WHEN</b> | <b>COMMENTS</b> |
| au. | Appendectomy                       |             |                 |
| av. | Dental Surgery                     |             |                 |
| aw. | Gall Bladder                       |             |                 |
| ax. | Hernia                             |             |                 |
| ay. | Hysterectomy                       |             |                 |
| az. | Tonsillectomy                      |             |                 |
| ba. | Other (describe)                   |             |                 |
| bb. | Other (describe)                   |             |                 |

14. Hospitalizations:

| WHERE HOSPITALIZED | WHEN | FOR WHAT REASON |
|--------------------|------|-----------------|
| a.                 |      |                 |
| b.                 |      |                 |
| c.                 |      |                 |
| d.                 |      |                 |
| e.                 |      |                 |

15. How often have you have taken antibiotics?

|                    | < 5 times | > 5 times |
|--------------------|-----------|-----------|
| Infancy/ Childhood |           |           |
| Teen               |           |           |
| Adulthood          |           |           |

16. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

|                    | < 5 times | > 5 times |
|--------------------|-----------|-----------|
| Infancy/ Childhood |           |           |
| Teen               |           |           |
| Adulthood          |           |           |

17. What medications are you taking now? Include non-prescription drugs.

| Medication Name | Date started | Dosage |
|-----------------|--------------|--------|
| 1.              |              |        |
| 2.              |              |        |
| 3.              |              |        |
| 4.              |              |        |
| 5.              |              |        |
| 6.              |              |        |
| 7.              |              |        |
| 8.              |              |        |

Are you allergic to any medications?

Yes \_\_\_ No \_\_\_

If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_

18. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

| Vitamin/Mineral/Supplement Name | Date started | Dosage |
|---------------------------------|--------------|--------|
| 1.                              |              |        |
| 2.                              |              |        |
| 3.                              |              |        |
| 4.                              |              |        |
| 5.                              |              |        |
| 6.                              |              |        |
| 7.                              |              |        |
| 8.                              |              |        |

19. Childhood:

| Question   | Yes | No | Don't Know | Comment |
|--|-----|----|------------|---------|
| 1. Were you a full term baby?                          |     |    |            |         |
| a. A preemie?  |     |    |            |         |
| b. Breast fed?   |     |    |            |         |
| c. Bottle fed?   |     |    |            |         |
| 2. As a child did you eat a lot of sugar and/or candy? |     |    |            |         |

20. As a child, were there any foods that you had to avoid because they gave you symptoms?

Yes \_\_\_\_ No \_\_\_\_

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

21. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

|    |                        |   |    |                     |   |    |                     |   |
|----|------------------------|---|----|---------------------|---|----|---------------------|---|
|    | <b>Usual Breakfast</b> | √ |    | <b>Usual Lunch</b>  | √ |    | <b>Usual Dinner</b> | √ |
| a. | None                   |   | a. | None                |   | a. | None                |   |
| b. | Bacon/Sausage          |   | b. | Butter              |   | b. | Beans (legumes)     |   |
| c. | Bagel                  |   | c. | Coffee              |   | c. | Brown rice          |   |
| d. | Butter                 |   | d. | Eat in a cafeteria  |   | d. | Butter              |   |
| e. | Cereal                 |   | e. | Eat in restaurant   |   | e. | Carrots             |   |
| f. | Coffee                 |   | f. | Fish sandwich       |   | f. | Coffee              |   |
| g. | Donut                  |   | g. | Juice               |   | g. | Fish                |   |
| h. | Eggs                   |   | h. | Leftovers           |   | h. | Green vegetables    |   |
| i. | Fruit                  |   | i. | Lettuce             |   | i. | Juice               |   |
| j. | Juice                  |   | j. | Margarine           |   | j. | Margarine           |   |
| k. | Margarine              |   | k. | Mayo                |   | k. | Milk                |   |
| l. | Milk                   |   | l. | Meat sandwich       |   | l. | Pasta               |   |
| m. | Oat bran               |   | m. | Milk                |   | m. | Potato              |   |
| n. | Sugar                  |   | n. | Salad               |   | n. | Poultry             |   |
|    | <b>Usual Breakfast</b> | √ |    | <b>Usual Lunch</b>  | √ |    | <b>Usual Dinner</b> | √ |
| o. | Sweet roll             |   | o. | Salad dressing      |   | o. | Red meat            |   |
| p. | Sweetener              |   | p. | Soda                |   | p. | Rice                |   |
| q. | Tea                    |   | q. | Soup                |   | q. | Salad               |   |
| r. | Toast                  |   | r. | Sugar               |   | r. | Salad dressing      |   |
| s. | Water                  |   | s. | Sweetener           |   | s. | Soda                |   |
| t. | Wheat bran             |   | t. | Tea                 |   | t. | Sugar               |   |
| u. | Yogurt                 |   | u. | Tomato              |   | u. | Sweetener           |   |
| v. | Other: (List below)    |   | v. | Water               |   | v. | Tea                 |   |
|    |                        |   | w. | Yogurt              |   | w. | Water               |   |
|    |                        |   | x. | Other: (List below) |   | x. | Yellow vegetables   |   |
|    |                        |   |    |                     |   | y. | Other: (List below) |   |
|    |                        |   |    |                     |   |    |                     |   |
|    |                        |   |    |                     |   |    |                     |   |

22. How much of the following do you consume each week?

|   |  |
|---|--|
| a. Candy                                |  |
| b. Cheese                               |  |
| c. Chocolate                            |  |
| d. Cups of coffee containing caffeine   |  |
| e. Cups of decaffeinated coffee or tea  |  |
| f. Cups of hot chocolate                |  |
| g. Cups of tea containing caffeine      |  |
| h. Diet sodas                           |  |
| i. Ice cream                            |  |
| j. Salty foods                          |  |
| k. Slices of white bread (rolls/bagels) |  |
| l. Sodas with caffeine                  |  |
| m. Sodas without caffeine               |  |

23. Are you on a special diet?

\_\_\_\_\_ ovo-lacto

\_\_\_\_\_ diabetic

\_\_\_\_\_ dairy restricted

\_\_\_\_\_ vegetarian

\_\_\_\_\_ vegan

\_\_\_\_\_ blood type diet

Yes\_\_\_\_ No\_\_\_\_

\_\_\_\_\_ other (describe):

\_\_\_\_\_

\_\_\_\_\_

24. Is there anything special about your diet that we should know?

Yes\_\_\_\_ No\_\_\_\_

If yes, please explain:

\_\_\_\_\_

25. a. Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.?

Yes\_\_\_\_ No\_\_\_\_

b. If yes, are these symptoms associated with any particular food or supplement(s)?

Yes\_\_\_\_ No\_\_\_\_

c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

\_\_\_\_\_

26. Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes\_\_\_\_ No\_\_\_\_

27. Do you feel much **worse** when you eat a lot of :

\_\_\_\_\_ high fat foods

\_\_\_\_\_ high protein foods

\_\_\_\_\_ high carbohydrate foods

(breads, pastas, potatoes)

\_\_\_\_\_ refined sugar (junk food)

\_\_\_\_\_ fried foods

\_\_\_\_\_ 1 or 2 alcoholic drinks

\_\_\_\_\_ other \_\_\_\_\_

28. Do you feel much **better** when you eat a lot of :

\_\_\_\_\_ high fat foods

\_\_\_\_\_ high protein foods

\_\_\_\_\_ high carbohydrate foods

(breads, pastas, potatoes)

\_\_\_\_\_ refined sugar (junk food)

\_\_\_\_\_ fried foods

\_\_\_\_\_ 1 or 2 alcoholic drinks

\_\_\_\_\_ other \_\_\_\_\_

29. Does skipping a meal greatly affect your symptoms?

Yes\_\_\_\_ No\_\_\_\_

30. Have you ever had a food that you craved or really "binged" on over a period of time?

Food craving may be an indicator that you may be allergic to that food.

Yes\_\_\_\_ No\_\_\_\_

If yes, what food(s)? \_\_\_\_\_

\_\_\_\_\_

31. Do you have an aversion to certain foods?

Yes\_\_\_\_ No\_\_\_\_

If yes, what foods? \_\_\_\_\_

32. Please fill in the chart below with information about your bowel movements:

|   |   |                           |   |
|---|---|---------------------------|---|
| a. Frequency                              | √ | b. Color                  | √ |
| More than 3x/day                          |   | Medium brown consistently |   |
| 1-3x/day                                  |   | Very dark or black        |   |
| 4-6x/week                                 |   | Greenish color            |   |
| 2-3x/week                                 |   | Blood is visible.         |   |
| 1 or fewer x/week                         |   | Varies a lot.             |   |
|   |   | Dark brown consistently   |   |
| b. Consistency                            |   | Yellow, light brown       |   |
| Soft and well formed                      |   | Greasy, shiny appearance  |   |
| Often float                               |   |                           |   |
| Difficult to pass                         |   |                           |   |
| Diarrhea                                  |   |                           |   |
| Thin, long or narrow                      |   |                           |   |
| Small and hard                            |   |                           |   |
| Loose but not watery                      |   |                           |   |
| Alternating between hard and loose/watery |   |                           |   |

33. Intestinal gas: \_\_\_\_\_ Daily \_\_\_\_\_ Present with pain  
 \_\_\_\_\_ Occasionally \_\_\_\_\_ Foul smelling  
 \_\_\_\_\_ Excessive \_\_\_\_\_ Little odor

34. a. Have you ever used alcohol? Yes\_\_\_\_ No\_\_\_\_

b. If yes, how often do you now drink alcohol? \_\_\_\_\_ No longer drinking alcohol  
 \_\_\_\_\_ Average 1-3 drinks per week  
 \_\_\_\_\_ Average 4-6 drinks per week  
 \_\_\_\_\_ Average 7-10 drinks per week  
 \_\_\_\_\_ Average >10 drinks per week

c. Have you ever had a problem with alcohol? Yes\_\_\_\_ No\_\_\_\_  
 If yes, please indicate time period (month/year): from \_\_\_\_\_ to \_\_\_\_\_.

35. Have you ever used tobacco? Yes\_\_\_\_ No\_\_\_\_

If yes, number of years as a nicotine user \_\_\_\_\_. Amount per day \_\_\_\_\_. Year quit \_\_\_\_\_.

If yes, what type of nicotine have you used? \_\_\_\_\_ Cigarette \_\_\_\_\_ Smokeless  
 \_\_\_\_\_ Cigar \_\_\_\_\_ Pipe \_\_\_\_\_ Patch/Gum

36. Are you exposed to second hand smoke regularly? Yes\_\_\_\_ No\_\_\_\_

37. Do you have mercury (“silver”) amalgam fillings? Yes\_\_\_\_ No\_\_\_\_

38. Do you have any artificial joints or implants? Yes\_\_\_\_ No\_\_\_\_

39. Do you feel worse at certain times of the year? Yes\_\_\_\_ No\_\_\_\_

If yes, when? \_\_\_\_\_spring \_\_\_\_\_fall  
 \_\_\_\_\_summer \_\_\_\_\_winter

40. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes\_\_\_\_ No\_\_\_\_  
If yes, which one(s)? \_\_\_\_\_lead \_\_\_\_\_cadmium \_\_\_\_\_aluminum  
\_\_\_\_\_arsenic \_\_\_\_\_mercury

41. Do odors affect you? Yes\_\_\_\_ No\_\_\_\_

Currently? \_\_\_\_\_ Previously? \_\_\_\_\_ If previously, from \_\_\_\_\_ to \_\_\_\_\_.

What kind? \_\_\_\_\_

Comments: \_\_\_\_\_

42. Are you currently, or have you ever been, married? Yes\_\_\_\_ No\_\_\_\_

If so, when were you married? \_\_\_\_\_ Spouse's occupation \_\_\_\_\_

When were you separated? \_\_\_\_\_ Never \_\_\_\_\_ (partner)

When were you divorced? \_\_\_\_\_ Never \_\_\_\_\_

When were you remarried? \_\_\_\_\_ Never \_\_\_\_\_ Spouse's occupation \_\_\_\_\_

Comments: \_\_\_\_\_

43. Hobbies and leisure activities: \_\_\_\_\_

44. Do you exercise regularly? Yes\_\_\_\_ No\_\_\_\_

If so, how many times a week?

1. \_\_\_\_\_ 1x

2. \_\_\_\_\_ 2x

3. \_\_\_\_\_ 3x

4. \_\_\_\_\_ 4x or more

When you exercise, how long is each session?

1. \_\_\_\_\_ ≤15 min

2. \_\_\_\_\_ 16-30 min

3. \_\_\_\_\_ 31-45 min

4. \_\_\_\_\_ > 45 min

What type of exercise is it?

\_\_\_\_\_ jogging/walking

\_\_\_\_\_ basketball

\_\_\_\_\_ home aerobics

\_\_\_\_\_ tennis

\_\_\_\_\_ water sports

\_\_\_\_\_ other \_\_\_\_\_

# MSQ – MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps track your child's progress over time. Rate each of the following symptoms based upon your child's health profile for the past 30 days. If you are taking after the first time, record your child's symptoms for the last 48 hours ONLY.

## POINTS SCALE

0 = Never or almost never have the symptom

1 = Occasionally have it, effect is not severe

2 = Occasionally have, effect is severe

3 = Frequently have it, effect is not severe

4 = Frequently have it, effect is severe

## DIGESTIVE TRACT

- Nausea or vomiting
- Diarrhea
- Constipation
- Bloating feeling
- Belching, or passing gas
- Heartburn
- Intestinal/Stomach pain

Total \_\_\_\_\_

## EARS

- Itchy ears Total
- Earaches, ear infections
- Drainage from ear
- Ringing in ears, hearing loss

Total \_\_\_\_\_

## EMOTIONS

- Mood swings
- Anxiety, fear or Nervousness
- Anger, irritability, or aggressiveness
- Depression

Total \_\_\_\_\_

## ENERGY/ACTIVITY

- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness

Total \_\_\_\_\_

## EYES

- Watery or itchy eyes
- Swollen, reddened or sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel vision (does not include near-or far-sightedness)

Total \_\_\_\_\_

## HEAD

- Headaches
- Faintness
- Dizziness
- Insomnia

Total \_\_\_\_\_

## HEART

- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

Total \_\_\_\_\_

## JOINTS/MUSCLES

- Pain or aches in joints
- Arthritis
- Stiffness or limitation of movement
- Pain or aches in muscles
- Feeling of weakness or tiredness

Total \_\_\_\_\_

## LUNGS

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficult breathing

Total \_\_\_\_\_

## MIND

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical coordination
- Difficulty in making decisions
- Stuttering or stammering
- Slurred speech
- Learning disabilities

Total \_\_\_\_\_

## MOUTH/THROAT

- Chronic coughing
- Gagging, frequent need to clear throat
- Sore throat, hoarseness, loss of voice
- Swollen/discolored tongue, gum, lips
- Canker sores

Total \_\_\_\_\_

## NOSE

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation

Total \_\_\_\_\_

## SKIN

- Acne
- Hives, rashes, or dry skin
- Hair loss
- Flushing or hot flushes
- Excessive sweating

Total \_\_\_\_\_

## WEIGHT

- Binge eating/drinking
- Craving certain foods
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

Total \_\_\_\_\_

## OTHER

- Frequent illness
- Frequent or urgent urination
- Genital itch or discharge

Total \_\_\_\_\_

## GRAND

TOTAL \_\_\_\_\_

Please check if these symptoms occur presently **or** have occurred in the past 6 months.

| <b>GENERAL:</b>               | <b>Mild</b> | <b>Mod-<br/>erate</b> | <b>Severe</b> |
|-------------------------------|-------------|-----------------------|---------------|
| Cold hands & feet             |             |                       |               |
| Cold intolerance              |             |                       |               |
| Daytime sleepiness            |             |                       |               |
| Difficulty falling asleep     |             |                       |               |
| Early waking                  |             |                       |               |
| Fatigue                       |             |                       |               |
| Fever                         |             |                       |               |
| Flushing                      |             |                       |               |
| Heat intolerance              |             |                       |               |
| Night waking                  |             |                       |               |
| Nightmares                    |             |                       |               |
| No dream recall               |             |                       |               |
| <b>HEAD, EYES &amp; EARS:</b> |             |                       |               |
| Conjunctivitis                |             |                       |               |
| Distorted sense of smell      |             |                       |               |
| Distorted taste               |             |                       |               |
| Ear fullness                  |             |                       |               |
| Ear noises                    |             |                       |               |
| Ear pain                      |             |                       |               |
| Ear ringing/buzzing           |             |                       |               |
| Eye crusting                  |             |                       |               |
| Eye pain                      |             |                       |               |
| Headache                      |             |                       |               |
| Hearing loss                  |             |                       |               |
| Hearing problems              |             |                       |               |
| Lid margin redness            |             |                       |               |
| Migraine                      |             |                       |               |
| Sensitivity to loud noises    |             |                       |               |
| Vision problems               |             |                       |               |

| <b>MUSCULOSKELETAL:</b> | <b>Mild</b> | <b>Mod-<br/>erate</b> | <b>Severe</b> |
|-------------------------|-------------|-----------------------|---------------|
| Back muscle spasm       |             |                       |               |

|                                 |             |                       |               |
|---------------------------------|-------------|-----------------------|---------------|
| Calf cramps                     |             |                       |               |
| Chest tightness                 |             |                       |               |
| Foot cramps                     |             |                       |               |
| Joint deformity                 |             |                       |               |
| Joint pain                      |             |                       |               |
| Joint redness                   |             |                       |               |
| Joint stiffness                 |             |                       |               |
| Muscle pain                     |             |                       |               |
| Muscle spasms                   |             |                       |               |
| Muscle stiffness                |             |                       |               |
| Muscle twitches:<br>Around eyes |             |                       |               |
| Arms or legs                    |             |                       |               |
| Muscle weakness                 |             |                       |               |
| Neck muscle spasm               |             |                       |               |
| Tendonitis                      |             |                       |               |
| Tension headache                |             |                       |               |
| TMJ problems                    |             |                       |               |
| <b>MOOD/NERVES:</b>             |             |                       |               |
| Agoraphobia                     |             |                       |               |
| Anxiety                         |             |                       |               |
| Auditory hallucinations         |             |                       |               |
| Black-out                       |             |                       |               |
| Depression                      |             |                       |               |
| Difficulty:<br>Concentrating    |             |                       |               |
| With balance                    |             |                       |               |
| With thinking                   |             |                       |               |
| With judgment                   |             |                       |               |
| With speech                     |             |                       |               |
| With memory                     |             |                       |               |
| Dizziness (spinning)            |             |                       |               |
| Fainting                        |             |                       |               |
| Fearfulness                     |             |                       |               |
| Irritability                    |             |                       |               |
| Light-headedness                |             |                       |               |
| <b>MOOD/NERVES,<br/>Cont'd:</b> | <b>Mild</b> | <b>Mod-<br/>erate</b> | <b>Severe</b> |
| Numbness                        |             |                       |               |

|                            |             |                       |               |
|----------------------------|-------------|-----------------------|---------------|
| Other Phobias              |             |                       |               |
| Panic attacks              |             |                       |               |
| Paranoia                   |             |                       |               |
| Seizures                   |             |                       |               |
| Suicidal thoughts          |             |                       |               |
| Tingling                   |             |                       |               |
| Tremor/trembling           |             |                       |               |
| Visual hallucinations      |             |                       |               |
| <b>EATING:</b>             |             |                       |               |
| Binge eating               |             |                       |               |
| Bulimia                    |             |                       |               |
| Can't gain weight          |             |                       |               |
| Can't lose weight          |             |                       |               |
| Carbohydrate craving       |             |                       |               |
| Carbohydrate intolerance   |             |                       |               |
| Poor appetite              |             |                       |               |
| Salt craving               |             |                       |               |
| <b>DIGESTION:</b>          |             |                       |               |
| Anal spasms                |             |                       |               |
| Bad teeth                  |             |                       |               |
| Bleeding gums              |             |                       |               |
| Bloating of:               |             |                       |               |
| Lower abdomen              |             |                       |               |
| Whole abdomen              |             |                       |               |
| Blood in stools            |             |                       |               |
| Burping                    |             |                       |               |
| Canker sores               |             |                       |               |
| Cold sores                 |             |                       |               |
| Constipation               |             |                       |               |
| Cracking at corner of lips |             |                       |               |
| Dentures w/poor chewing    |             |                       |               |
| Diarrhea                   |             |                       |               |
| Difficulty swallowing      |             |                       |               |
| Dry mouth                  |             |                       |               |
| Farting                    |             |                       |               |
| <b>DIGESTION, Cont'd:</b>  | <b>Mild</b> | <b>Mod-<br/>erate</b> | <b>Severe</b> |
| Fissures                   |             |                       |               |
| Foods "repeat" (reflux)    |             |                       |               |

|   |  |  |  |
|---|--|--|--|
| Heartburn                                       |  |  |  |
| Hemorrhoids                                     |  |  |  |
| Intolerance to:                                 |  |  |  |
| Lactose   |  |  |  |
| All milk products                               |  |  |  |
| Intolerance to:                                 |  |  |  |
| Gluten (wheat)                                  |  |  |  |
| Corn  |  |  |  |
| Eggs  |  |  |  |
| Fatty foods                                     |  |  |  |
| Yeast   |  |  |  |
| Liver disease/jaundice<br>(yellow eyes or skin) |  |  |  |
| Lower abdominal pain                            |  |  |  |
| Mucus in stools                                 |  |  |  |
| Nausea  |  |  |  |
| Periodontal disease                             |  |  |  |
| Sore tongue                                     |  |  |  |
| Strong stool odor                               |  |  |  |
| Undigested food in stools                       |  |  |  |
| Upper abdominal pain                            |  |  |  |
| Vomiting  |  |  |  |
| <b>SKIN PROBLEMS:</b>                           |  |  |  |
| Acne on back                                    |  |  |  |
| Acne on chest                                   |  |  |  |
| Acne on face                                    |  |  |  |
| Acne on shoulders                               |  |  |  |
| Athlete's foot                                  |  |  |  |
| Bumps on back of upper<br>arms                  |  |  |  |
| Cellulite                                       |  |  |  |
| Dark circles under eyes                         |  |  |  |
| Ears get red                                    |  |  |  |
| Easy bruising                                   |  |  |  |

| <b>SKIN PROBLEMS,<br/>Cont'd:</b> | <b>Mild</b> | <b>Mod-<br/>erate</b> | <b>Severe</b> |
|-----------------------------------|-------------|-----------------------|---------------|
| Eczema                            |             |                       |               |
| Herpes - genital                  |             |                       |               |
| Hives                             |             |                       |               |
| Jock itch                         |             |                       |               |
| Lackluster skin                   |             |                       |               |
| Moles w color/size<br>change      |             |                       |               |
| Oily skin                         |             |                       |               |
| Pale skin                         |             |                       |               |
| Patchy dullness                   |             |                       |               |
| Psoriasis                         |             |                       |               |
| Rash                              |             |                       |               |
| Red face                          |             |                       |               |
| Sensitive to bites                |             |                       |               |
| Sensitive to poison<br>ivy/oak    |             |                       |               |
| Shingles                          |             |                       |               |
| Skin cancer                       |             |                       |               |
| Skin darkening                    |             |                       |               |
| Strong body odor                  |             |                       |               |
| Thick calluses                    |             |                       |               |
| Vitiligo                          |             |                       |               |
| <b>SKIN, ITCHING:</b>             |             |                       |               |
| Anus                              |             |                       |               |
| Arms                              |             |                       |               |
| Ear canals                        |             |                       |               |
| Eyes                              |             |                       |               |
| Feet                              |             |                       |               |
| Hands                             |             |                       |               |
| Legs                              |             |                       |               |
| Nipples                           |             |                       |               |
| Nose                              |             |                       |               |
| Penis                             |             |                       |               |
| Roof of mouth                     |             |                       |               |
| Scalp                             |             |                       |               |
| Skin in general                   |             |                       |               |
| Throat                            |             |                       |               |

| <b>SKIN, DRYNESS OF:</b>             | <b>Mild</b> | <b>Mod-<br/>erate</b> | <b>Severe</b> |
|--------------------------------------|-------------|-----------------------|---------------|
| Eyes                                 |             |                       |               |
| Feet                                 |             |                       |               |
| Any cracking?                        |             |                       |               |
| Any peeling?                         |             |                       |               |
| Hair                                 |             |                       |               |
| And unmanageable?                    |             |                       |               |
| Hands                                |             |                       |               |
| Any cracking?                        |             |                       |               |
| Any peeling?                         |             |                       |               |
| Mouth/throat                         |             |                       |               |
| Scalp                                |             |                       |               |
| Any dandruff?                        |             |                       |               |
| Skin in general                      |             |                       |               |
| <b>LYMPH NODES:</b>                  |             |                       |               |
| Enlarged/neck                        |             |                       |               |
| Tender/neck                          |             |                       |               |
| Other enlarged/tender<br>lymph nodes |             |                       |               |
| <b>NAILS:</b>                        |             |                       |               |
| Bitten                               |             |                       |               |
| Brittle                              |             |                       |               |
| Curve up                             |             |                       |               |
| Frayed                               |             |                       |               |
| Fungus - fingers                     |             |                       |               |
| Fungus - toes                        |             |                       |               |
| Pitting                              |             |                       |               |
| Ragged cuticles                      |             |                       |               |
| Ridges                               |             |                       |               |
| Soft                                 |             |                       |               |
| Thickening of:<br>Finger nails       |             |                       |               |
| Toenails                             |             |                       |               |
| White spots/lines                    |             |                       |               |

| <b>RESPIRATORY:</b>    | <b>Mild</b> | <b>Mod-<br/>erate</b> | <b>Severe</b> |
|------------------------|-------------|-----------------------|---------------|
| Bad breath             |             |                       |               |
| Bad odor in nose       |             |                       |               |
| Cough - dry            |             |                       |               |
| Cough - productive     |             |                       |               |
| Hay fever : Spring     |             |                       |               |
| Summer                 |             |                       |               |
| Fall                   |             |                       |               |
| Change of season       |             |                       |               |
| Hoarseness             |             |                       |               |
| Nasal stuffiness       |             |                       |               |
| Nose bleeds            |             |                       |               |
| Post nasal drip        |             |                       |               |
| Sinus fullness         |             |                       |               |
| Sinus infection        |             |                       |               |
| Snoring                |             |                       |               |
| Sore throat            |             |                       |               |
| Wheezing               |             |                       |               |
| Winter stuffiness      |             |                       |               |
| <b>CARDIOVASCULAR:</b> |             |                       |               |
| Angina/chest pain      |             |                       |               |
| Breathlessness         |             |                       |               |
| Heart attack           |             |                       |               |
| Heart murmur           |             |                       |               |
| High blood pressure    |             |                       |               |
| Irregular pulse        |             |                       |               |
| Mitral valve prolapse  |             |                       |               |
| Palpitations           |             |                       |               |
| Phlebitis              |             |                       |               |
| Swollen ankles/feet    |             |                       |               |
| Varicose veins         |             |                       |               |

| <b>URINARY:</b>                 | <b>Mild</b> | <b>Mod-<br/>erate</b> | <b>Severe</b> |
|---------------------------------|-------------|-----------------------|---------------|
| Bed wetting                     |             |                       |               |
| Hesitancy                       |             |                       |               |
| Infection                       |             |                       |               |
| Kidney disease                  |             |                       |               |
| Kidney stone                    |             |                       |               |
| Leaking/incontinence            |             |                       |               |
| Pain/burning                    |             |                       |               |
| Prostate enlargement            |             |                       |               |
| Prostate infection              |             |                       |               |
| Urgency                         |             |                       |               |
| <b>MALE<br/>REPRODUCTIVE:</b>   |             |                       |               |
| Discharge from penis            |             |                       |               |
| Ejaculation problem             |             |                       |               |
| Genital pain                    |             |                       |               |
| Impotence                       |             |                       |               |
| Infection                       |             |                       |               |
| Lumps in testicles              |             |                       |               |
| Poor libido (sex drive)         |             |                       |               |
| <b>FEMALE<br/>REPRODUCTIVE:</b> |             |                       |               |
| Breast cysts                    |             |                       |               |
| Breast lumps                    |             |                       |               |
| Breast tenderness               |             |                       |               |
| Ovarian cyst                    |             |                       |               |
| Poor libido (sex drive)         |             |                       |               |
| Endometriosis                   |             |                       |               |
| Fibroids                        |             |                       |               |
| Infertility                     |             |                       |               |
| Vaginal discharge               |             |                       |               |
| Vaginal odor                    |             |                       |               |
| Vaginal itch                    |             |                       |               |
| Vaginal pain                    |             |                       |               |

| <b>FEMALE<br/>REPRODUCTIVE,<br/>Cont'd:</b> | <b>Mild</b> | <b>Mod-<br/>erate</b> | <b>Severe</b> |
|---|-------------|-----------------------|---------------|
| <u>Premenstrual:</u>                        |             |                       |               |
| Bloating                                    |             |                       |               |
| Breast tenderness                           |             |                       |               |
| Carbohydrate craving                        |             |                       |               |
| Chocolate craving                           |             |                       |               |
| Constipation                                |             |                       |               |
| Decreased sleep                             |             |                       |               |
| Diarrhea                                    |             |                       |               |
| Fatigue                                     |             |                       |               |
| Increased sleep                             |             |                       |               |
| Irritability                                |             |                       |               |
| <u>Menstrual:</u>                           |             |                       |               |
| Cramps                                      |             |                       |               |
| Heavy periods                               |             |                       |               |
| Irregular periods                           |             |                       |               |
| No periods                                  |             |                       |               |
| Scanty periods                              |             |                       |               |
| Spotting between                            |             |                       |               |