New Patient Information

Personal Information

Full Name:			D.O.B: (MM/DD/YY)
Street Address:			
City, State, Zip:			
Email:			
Home Phone:			Cell Phone:
Age:	Height:	Weight:	Occupation:
Marital Status: S M D W			Name of spouse:
Describe health of spouse:			Number of children if any:
Referred By:			
Emergency Contact Information:			

Primary Health Concerns

List Your Health Concerns According To Severity	Rate Of Severity 1= Minimal 10= Unbearable	When Did It Begin?	Have You Ever Had This Before?	% of the Day That Symptoms Are Present?	Better? Worse? Same?
1)					
2)					
3)					
4)					
5)					

Received a Diagnosis For <u>Any</u> Condition By Another Health Care Provider? Y N

If Yes, What Was The Diagnosis? _____

Who Provided The Diagnosis? _____

Health Goals (what are your health goals for the next 6-12 months?)

_____

_____

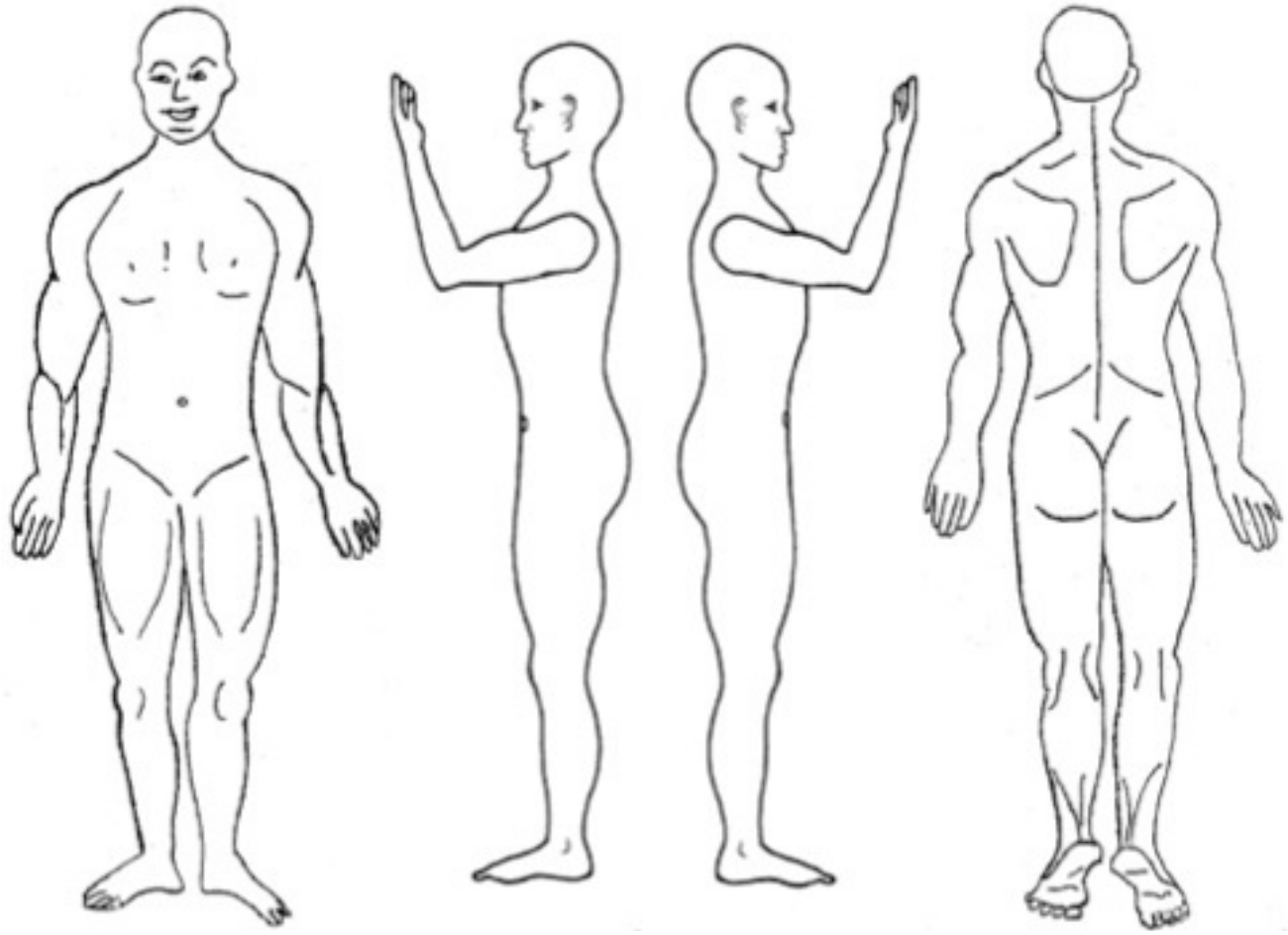
_____

_____

_____

_____

SCAR / TRAUMA CHART



Directions (Please READ)

All Scars: Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, vasectomies, etc.
All Trauma Areas: Please put a red"X" where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.
Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects, such as surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.
Date of injury and type of injury: Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988")

Do you have weight loss goals? Y N **How many pounds would you like to lose? _____**

Do you smoke, drink coffee or alcohol? (if yes, indicate how much)

Cigarettes_____ **Coffee_____** **Alcohol_____**

MEDICATIONS AND SUPPLEMENTS

Please list ALL medications and supplements that you are taking, the reason you are taking them, and the person that prescribed them to you (including yourself). This includes over the counter, prescription, recreational, vitamins, herbs, etc.

MEDICATIONS	PRESCRIPTION?	WHO PRESCRIBED?	REASON
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		

SUPPLEMENTS	REASON

HEALTH HISTORY

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

Is there anything else in your medical history that you consider to be relevant? (Even from childhood)

_____

_____

_____

_____

What is your employment history? Please provide a brief summary including dates if possible.

_____

_____

_____

_____

Please list past or present allergies, including allergies to medications.

_____

_____

_____

Please list all surgeries and the condition each surgery was for, including dates.

_____

_____

_____

Please explain your housing history (type of homes, where and when).

_____

_____

_____

_____

How did you hear about our wellness program?

_____

_____

_____

Neurotoxic Questionnaire

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

Mercury

☐ Yes	☐ No	Do you have amalgam (silver) fillings in your teeth? If yes, How many? _____
☐ Yes	☐ No	Have you ever had an amalgam removed? If Yes, How many_____
☐ Yes	☐ No	If you had amalgams removed, was it done by a biological dentist using a safe protocol?
☐ Yes	☐ No	Did your mother have amalgam when pregnant with you?
☐ Yes	☐ No	Have you ever worked in a dental office? If so, how long? _____
☐ Yes	☐ No	Have you had any dental crowns? If yes, how many_____
☐ Yes	☐ No	Have you had any bridges?
☐ Yes	☐ No	Have you had any root canals?
☐ Yes	☐ No	Have you had any tooth extractions?
☐ Yes	☐ No	Do you have any dental implants, retainers or other metal in your mouth? Explain:_____
☐ Yes	☐ No	Did you wear contact lenses during the 1980's or early 1990's?
☐ Yes	☐ No	Did you take oral contraceptives during the 1980's or early 1990's?
☐ Yes	☐ No	Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
☐ Yes	☐ No	Have you noticed any adverse reactions to these shots?
☐ Yes	☐ No	Do you have any tattoos with red ink?
☐ Yes	☐ No	Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

Lead

☐ Yes	☐ No	Does your occupation involve soldering or metal salvage?
☐ Yes	☐ No	Have you done any old home repair or sandblasting? If so, When_____
☐ Yes	☐ No	Do you do a lot of painting?
☐ Yes	☐ No	Was your home built before 1978?
☐ Yes	☐ No	Have you ever worn cosmetics containing kohl? (make-up with dark black or deep red pigment)
☐ Yes	☐ No	Are you around a lot of fake leather, or vinyl?
☐ Yes	☐ No	Do you get stomach aches in the morning?

General Toxicity

☐ Yes ☐ No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain. _____

☐ Yes ☐ No Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)

☐ Yes ☐ No Do you have your house sprayed with pesticides for pest control?

☐ Yes ☐ No Do you spray herbicide (weed killers) in or around your home?

☐ Yes ☐ No Do you use conventional insect repellants on your self or family?

☐ Yes ☐ No Do you use conventional sunscreen?

☐ Yes ☐ No Do you use conventional perfume or cologne every day?

☐ Yes ☐ No Do you get your hair colored? If so, is it on the scalp?

☐ Yes ☐ No Do you use aerosol hairspray?

☐ Yes ☐ No Do you get your nails done? If so, how often? _____

☐ Yes ☐ No Do you use air freshener in your house, work or car?

☐ Yes ☐ No Do you drink filtered water? If so, what type of filter do you have?_____

☐ Yes ☐ No Do you drink bottle water if so what kind? _____

☐ Yes ☐ No Do you have a water filtration system for your entire house or shower filtration? If so, what type?_____

☐ Yes ☐ No Does your spouse or other family members work around chemicals?

☐ Yes ☐ No Can you think of any other toxic exposures you may have had?

Mold

How old is the house you are living in? _____ How long have you lived there? _____

Have you noticed any new symptoms since moving in?_____ If so, what?_____

☐ Yes ☐ No Do you see mold growing at home, work or school?

☐ Yes ☐ No Have you ever had water damage at home, work or school?

☐ Yes ☐ No Does your home, workplace or school have a damp or mildew smell?

☐ Yes ☐ No Does spending time in your basement cause or worsen your symptoms?

☐ Yes ☐ No Does your basement ever get wet?

☐ Yes ☐ No Do you have a crawl space?

☐ Yes ☐ No Does your basement or crawl space have a sump pump?

☐ Yes ☐ No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?

☐ Yes ☐ No Does your car have a mildew smell?

☐ Yes ☐ No Does anyone in your home have asthma like symptoms?

☐ Yes ☐ No Does anyone in your family have chronic sinus infections or irritations?

Lyme Disease

☐ Yes	☐ No	Have you ever been diagnosed with Lyme Disease?
☐ Yes	☐ No	Have you had dry sockets or infected tooth extractions?
☐ Yes	☐ No	Do you have small joint pain?
☐ Yes	☐ No	Have you ever been bitten by a tick or recluse spider?
☐ Yes	☐ No	Have you ever seen a bulls-eye rash appear on any part of your body?
☐ Yes	☐ No	Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?
☐ Yes	☐ No	Was your mother ever diagnosed with Lyme Disease?
☐ Yes	☐ No	Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

Health History

☐ Yes	☐ No	Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
☐ Yes	☐ No	Does anyone in your family experience similar symptoms to yours?
		What is your birth order (i.e. first born, second, third, etc.)? _____.
☐ Yes	☐ No	Do you have any history of kidney dysfunction?
☐ Yes	☐ No	Do you or any immediate family member have a history with cancer?
☐ Yes	☐ No	Do you have any history of heart disease, myocardial infarction (heart attack), etc.?
☐ Yes	☐ No	Are you currently having any thoughts of suicide?
☐ Yes	☐ No	Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?
☐ Yes	☐ No	Do you have a history of strokes?
☐ Yes	☐ No	Have you ever been diagnosed with diabetes, thyroiditis, or heart disease?
☐ Yes	☐ No	Have you ever been in an auto accident, fallen or received a major physical injury?
☐ Yes	☐ No	Are you in menopause?

Microbiome Health

☐ Yes	☐ No	Do you get foul or sulfur smelling gas (distention, bloating, belching, feeling full and a noisy gut) after eating carbohydrates (ie. grains and vegetables) or fermented foods and/or probiotics?
☐ Yes	☐ No	Do you often have gas that has a sulfur or foul smell?
☐ Yes	☐ No	Are you sensitive to supplements?
☐ Yes	☐ No	Have you ever been vegan or vegetarian for any length of time?
☐ Yes	☐ No	Can you tolerate Meat?
☐ Yes	☐ No	Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?
☐ Yes	☐ No	Have you taken birth control or Hormone replacement therapy for any length of time?
☐ Yes	☐ No	If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?
☐ Yes	☐ No	Have been on antibiotics for any extended period of time or often as a child or adult?
☐ Yes	☐ No	Were you caesarian delivered?
☐ Yes	☐ No	Were you breast fed? If so, How long _____
☐ Yes	☐ No	Does your gut temporarily feel better after a round of antibiotics?
		How many times a day are you having a bowel movement? _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

0 = Never had the symptom
1 = Occasionally have it, mild effect
2 = Occasionally have it, severe effect
3 = Frequently have it, mild effect
4 = Frequently have it, severe effect

Column #1

	Anxiety
	Mood Swings
	Enraged behavior or anger for no reason
	Excessive shyness, timidity, social phobia (not your typical personality)
	Irritability
	Low body temperature (below 97.5º)
	Insomnia (can't get to sleep or return to sleep)
	Dizziness
	Sound in ears (ringing or hearing your heart beat)
	Psychological symptoms, even thoughts of suicide
	Sensitivity to sound

	Indecisiveness
	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in mouth
	Floaters, shadows or swimmers when you read or look into the sky
	Dyslexia or loss of place while reading, even as a child
	Swelling eyelids
	Peeling on top layer of skin (hands, feet)
	Dry skin
	Heart pain (angina) and you are under 45 years old
	Depression
	Gout (arthritic pain, especially in big toes)
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muslces
	Hair falls out (not normal male pattern baldness)

Column #2

	Sensitivity to light
	Fatigue after exercising (feeling worse)
	Bad night vision or seeing halos around lights
	Shortness of breath, with very little effort
	Excessive thirst and/or frequent urination
	Red eyes or tearing
	Blurred vision at times
	Morning stiffness
	Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Chronic fatigue or weakness
	Non-restful sleep

	Receive static shock more often and w/ more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
	Trouble processing new information
	Word reversal or trouble finding words
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry non-productive cough
	Muscle twitching
	Excessive sweating, especially at night
	Joint pain-not necessarily true arthritis-can move from joint to joint
	Difficulty losing weight regardless of diet or exercise
	Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
	Frequent illness, prolonged illness or sick days
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing numbers in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Frequent muscle aches, cramps, unusual sharp sudden pains
	Rashes or rosacea
	Cold extremities (hands and feet)

Total Columns 1 & 2

Permission & Authorization Form

Regarding the Use of

Applied Kinesiology Testing

Please Read Before Signing:

I specifically authorize the natural health practitioners at Larsen Wellness Center to perform an Applied Kinesiology* health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, chiropractic adjustments, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **Applied Kinesiology is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Applied Kinesiology is not a method for "diagnosing" or "treatment" of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Applied Kinesiology or any natural health, nutritional or dietary programs recommended, but rather I understand that Applied Kinesiology is a means by which the body's natural organ and neurological responses can be used as an aid to determining possible nutritional and physical imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Print Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____- _____

Signed: _____

(If minor, signature of parent or guardian required)

Witness: _____

* The term Applied Kinesiology includes other techniques such as Nutrition Response Testing, Quantum Reflex Analysis and other forms of manual techniques designed to obtain information about the body used by Dr. Larsen and Larsen Wellness Center.

Name: _____ Birthdate: _____ Constitution : _____

Circle the answer that best reflects the intensity of each symptom at this time.

0 = Never 1 = Seldom 2 = Occasional 3 = Often

Unit I: DIGESTION

Part A: LOW ACIDITY

1. Indigestion 0 1 2 3
2. Abdominal Bloating 0 1 2 3
3. Feel too full after eating 0 1 2 3
4. Constipation 0 1 2 3
5. Belching/Burping 0 1 2 3
6. Diminished appetite 0 1 2 3
7. Stomach growls/ gurgles 0 1 2 3
8. Any known food allergies? 0 1 2 3

Part B: HIGH ACIDITY

1. Stomach pains just before or after meals 0 1 2 3
2. Stomach pains with no apparent reason 0 1 2 3
3. Stomach pain relieved by carbonated drinks 0 1 2 3
4. Stomach pain relieved by milk / cream 0 1 2 3
5. Emotional upset causes stomach pain 0 1 2 3
6. Heartburn immediately after meals 0 1 2 3
7. Constant need for antacids 0 1 2 3
8. "Butterfly feeling" in stomach 0 1 2 3
9. Family history of ulcer / gastritis? No Yes
10. Ulcer in the past year? No Yes
11. Current ulcer? No Yes
12. Very dark or black stool? No Yes
13. Hot / spicy food cause stomach irritation? No Yes

Unit II: ASSIMILATION

Part A: SMALL INTESTINE

1. Stomach cramps 0 1 2 3
2. Indigestion immediately after eating 0 1 2 3
3. Feel tired after meals 0 1 2 3
4. Flatulence (gas) 0 1 2 3
5. Constipation / diarrhea (alternating) 0 1 2 3
6. Fiber rich diet won't stop constipation 0 1 2 3
7. Loose stool 0 1 2 3
8. Presence of mucus in stool 0 1 2 3
9. Stool poorly formed 0 1 2 3
10. Four or more large stools daily 0 1 2 3
11. Stools have foul odor 0 1 2 3
12. Pain in left side of abdomen 0 1 2 3
13. History of pimples, skin eruption? No Yes
14. Any known food allergies? No Yes

Part B: LARGE INTESTINE

1. Diarrhea 0 1 2 3
2. Recurrent infections / colds 0 1 2 3
3. History of kidney and/or bladder infection 0 1 2 3
4. Yeast infection (including vaginal) 0 1 2 3
5. Frequent abdominal cramps 0 1 2 3
6. Fingernail and/or toenail fungus 0 1 2 3
7. Diarrhea and constipation (alternating) 0 1 2 3
8. Chronic constipation 0 1 2 3
9. Use of antibiotics in past year? No Yes
10. Meat eater? No Yes
11. Vision deteriorating rapidly? No Yes

Unit III: PANCREAS

Part A: LOW BLOOD SUGAR

1. Dizziness / dimmed vision when standing up suddenly 0 1 2 3
2. Strong desire / craving for sweets 0 1 2 3
3. Sweets / alcohol promptly relieve headaches 0 1 2 3
4. Irritable if a meal is missed or delayed 0 1 2 3
5. Hungry most of the time 0 1 2 3
6. Constantly anxious, nervous, worrisome 0 1 2 3
7. Frequently drowsy, impatient, moody 0 1 2 3
8. Need for caffeine to get going 0 1 2 3
9. Rapid heartbeat after eating sweets 0 1 2 3
10. Hungry 1-3 hours after eating 0 1 2 3
11. Restless, poor concentration 0 1 2 3
12. Forgetful; poor memory 0 1 2 3
13. Feel shaky, weak, or fatigued 0 1 2 3
14. Feel better / calmer after eating? No Yes
15. Low protein / high carbohydrate diet? No Yes

Part B: HIGH BLOOD SUGAR

1. Decreased resistance to infection 0 1 2 3
2. Slow healing cuts, wounds, etc. 0 1 2 3
3. Night sweats 0 1 2 3
4. Heightened thirst 0 1 2 3
5. Increased appetite 0 1 2 3
6. Eating sweets does not alleviate cravings 0 1 2 3
7. Fatigue, mental confusion 0 1 2 3
8. Poor, deteriorating eyesight 0 1 2 3
9. Itchy skin, boils and/or leg sores 0 1 2 3
10. History of diabetes in family? No Yes
11. Sugar (glucose) detected in urine? No Yes
12. Low protein / high carbohydrate diet? No Yes
13. Overweight? No Yes

Unit IV: LIVER / GALLBLADDER

Part A-1: LIVER / GALLBLADDER

1. Abdominal pain after eating fatty foods 0 1 2 3
2. Pain in the side under right rib cage 0 1 2 3
3. Pain or tender big toe 0 1 2 3
4. Hard / dry stool (painful to pass) 0 1 2 3
5. Stool color is grayish (light in color) 0 1 2 3
6. Stool has foul odor 0 1 2 3
7. Less than one daily bowel movement 0 1 2 3
8. History of constipation 0 1 2 3
9. Gray colored skin 0 1 2 3
10. Headaches following meals 0 1 2 3
11. Recurring sour, bitter taste in mouth 0 1 2 3
12. Red blood in stool? No Yes

Part A-2: LIVER / GALLBLADDER

1. Yellow sclera (white of the eyes) 0 1 2 3
2. Bad breath or body odor 0 1 2 3
3. Tired / sleepy after meals 0 1 2 3
4. Dandruff 0 1 2 3
5. Retain water 0 1 2 3
6. Dry skin and/or hair 0 1 2 3
7. Eat at fast food restaurants 0 1 2 3
8. Impatient, impulsive, easy to anger 0 1 2 3

Part A-2: LIVER / GALLBLADDER (cont)

9. Vision problems / red or dry eyes? No Yes
10. Have had jaundice or hepatitis? No Yes
11. High blood cholesterol and/or low HDL? No Yes

Unit V: URINARY SYSTEM

Part A: KIDNEY / BLADDER

1. Constant feeling of a full bladder 0 1 2 3
2. Loss of control holding urine 0 1 2 3
3. Drip / dribble after urination 0 1 2 3
4. Blood or pus in urine (in any amount) 0 1 2 3
5. Hazy or cloudy urine 0 1 2 3
6. Urine has odor / strong smell 0 1 2 3
7. Long intervals between urination 0 1 2 3
8. Straining to urinate with scant passage 0 1 2 3
9. Awaken in middle of night to urinate 0 1 2 3
10. Feeling of fear / insecurity 0 1 2 3
11. Dark circles under eyes 0 1 2 3
12. Pain or pressure in middle of back 0 1 2 3
13. Intermittent pain in urethra 0 1 2 3
14. History of bladder infection / cystitis? No Yes
15. Recent use of antibiotics – kidney/bladder infections? No Yes
16. Recent bladder surgery (including A/P repair) No Yes

Unit VI: THYROID

Part A-1: THYROID

1. Sensitivity to cold / wet weather 0 1 2 3
2. Hands and feet are cold 0 1 2 3
3. Constantly tired / fatigued 0 1 2 3
4. Lack of stamina for daily chores 0 1 2 3
5. Diagnosis of attention deficit disorder (ADD) 0 1 2 3
6. Eyes appear bulging or swollen 0 1 2 3
7. Skin is dry (lacks moisture) 0 1 2 3
8. Difficulty waking up in the morning 0 1 2 3
9. Depressed, apathetic, lethargic 0 1 2 3
10. Lack of or diminished sex drive 0 1 2 3
11. Irritability / mood swings when eating sweets 0 1 2 3

Part A-2: THYROID

12. Constipation? 0 1 2 3
13. Gain weight easily? No Yes
14. Basal / armpit temperature less than normal? No Yes
15. Slow reflexes / reaction time? No Yes
16. Infertility / impotency? No Yes
    For women only:
17. Heavy / profuse menstrual bleeding 0 1 2 3
18. Premenstrual tension / stress 0 1 2 3

Unit VII: ADRENAL

Part A: ADRENAL

1. Unable to tolerate much exercise 0 1 2 3
2. Catch colds or get sick easily 0 1 2 3
3. Sensitive to air pollutants, chemicals, smoke 0 1 2 3
4. Breathing is labored / difficult 0 1 2 3
5. Feelings of weakness / shakiness 0 1 2 3
6. Moments of depression 0 1 2 3
7. Rapid mood swings 0 1 2 3
8. Energy lag in morning to mid-afternoon 0 1 2 3
9. Need for caffeine to get going 0 1 2 3
10. Intermittent constipation 0 1 2 3
11. Dark circles beneath the eyes 0 1 2 3
12. Dizzy / light headed upon standing 0 1 2 3
13. Lack of mental alertness (mental fog) 0 1 2 3

Part A: ADRENAL (cont)

14. Retain Water 0 1 2 3
15. Insomnia 0 1 2 3
16. Eyes sensitive to bright / direct light 0 1 2 3
17. Use cortisone, prednisone, steroids No Yes

Unit VIII: FEMALE

Part A: SYMPTONS DURING MENSTRUATION

1. Monthly weight gain 0 1 2 3
2. Feeling of depression / anxiety 0 1 2 3
3. Moodiness / irritability / anger 0 1 2 3
4. Bloating / swelling 0 1 2 3
5. Nausea / vomiting 0 1 2 3
6. Tenderness in breast area 0 1 2 3
7. Leg cramps / tenderness 0 1 2 3
8. Lower back ache 0 1 2 3
9. Headaches 0 1 2 3
10. Easily distracted 0 1 2 3
11. Asthma / bronchitis attacks? No Yes
12. Suicidal feelings? No Yes

Part B: AMENORRHEA(ABSENCE OF MENSTRUATION)

1. Vaginal itching / discharge 0 1 2 3
2. Missed periods 0 1 2 3
3. Crave sweets or additional food 0 1 2 3
4. More than 1 cycle per month 0 1 2 3
5. Low or no desire for sex? No Yes
6. Pain during intercourse? No Yes
7. Menstruation started after age 15? No Yes
8. Unable to get pregnant? No Yes
9. Number of miscarriages (if any) 0 1 2 3+
10. Number of abortions (if any) 0 1 2 3+

Part C: DYSMENORRHEA (PAINFUL MENSTRUATION)

1. Anxiety about arrival of menstrual cycle 0 1 2 3
2. Low abdominal pain 0 1 2 3
3. Dull pain radiation to lower back or legs 0 1 2 3
4. Menstrual pain 0 1 2 3
5. Menstrual pain becomes progressively worse 0 1 2 3
6. Pain and cramps without blood flow 0 1 2 3
7. Light, sparse blood flow 0 1 2 3
8. Heavy menstrual bleeding 0 1 2 3
9. Nausea / vomiting prior to or during periods 0 1 2 3
10. Need to lie down first 1 or 2 days of period 0 1 2 3
11. Increased urinary frequency 0 1 2 3
12. Pelvic soreness 0 1 2 3
13. Diarrhea associated with menstruation 0 1 2 3
14. Headache during periods 0 1 2 3
15. Abdominal bloating 0 1 2 3
16. Craving for sweets (especially chocolate) 0 1 2 3

Part D: FIBROUS TISSUE AND CYSTS

1. Irregularities / soreness / lumps in vaginal area 0 1 2 3
2. Pain in ovaries 0 1 2 3
3. Retain water 0 1 2 3
4. Swollen feeling 0 1 2 3
5. Premenstrual breast pain or discomfort 0 1 2 3
6. Breast lumps? No Yes
7. Recent abnormal pap smear? No Yes
8. Family history of breast cancer? No Yes
9. Ovarian / uterine cyst? No Yes
10. Recent use of hormones? No Yes
11. Recent use of birth control device / medication? No Yes

Part E: CHANGE OF LIFE (AGE 35 AND OVER)

1. Sweating throughout the day 0 1 2 3
2. Night sweats 0 1 2 3
3. Hot flashes 0 1 2 3
4. Mood swings 0 1 2 3
5. Insomnia / light sleeper 0 1 2 3
6. Craving for sweets (especially chocolate) 0 1 2 3
7. Heavy bleeding two weeks at a time 0 1 2 3
8. Dryness of pubic hair and vaginal area 0 1 2 3
9. Vaginal pain / itching 0 1 2 3
10. Painful intercourse 0 1 2 3
11. Hysterectomy? No Yes
12. Osteoporosis? No Yes

Unit IX: MALE

Part A: PROSTATE

1. Weakened urinary flow 0 1 2 3
2. Burning / painful urination 0 1 2 3
3. Bladder feels full 0 1 2 3
4. Blood / pus in urine (any amount) 0 1 2 3
5. Awakening to urinate during the night 0 1 2 3
6. Drip / dribble after urination 0 1 2 3
7. Fatigue in legs or lower back 0 1 2 3
8. Decreased libido / sex drive 0 1 2 3
9. Pain or discomfort upon ejaculation 0 1 2 3

Part B: MALE REPRODUCTION

1. Coldness / pain in genital area 0 1 2 3
2. Difficulty in maintaining an erection 0 1 2 3
3. Fear / anxiety about sexual intimacy 0 1 2 3
4. Premature ejaculation 0 1 2 3
5. Weak knew / lower back 0 1 2 3
6. Infertility? No Yes
7. Varicose veins on scrotum? No Yes
8. Sperm count low? No Yes
9. Lack of / diminished sex drive? No Yes

Part C: GENITAL INFECTION

1. Genitals swollen and/or tender 0 1 2 3
2. Groin area swollen / inflamed 0 1 2 3
3. Multiple sexual partners 0 1 2 3
4. Discharge from penis? No Yes
5. Rash on penis / pubic area? No Yes
6. Current venereal disease? No Yes
7. Venereal disease in the past? No Yes

Unit X: CIRCULATORY SYSTEM

Part A: HEART

1. Nervous / jittery for no apparent reason 0 1 2 3
2. Calf muscles cramp when walking 0 1 2 3
3. Arrhythmia / chest pain when walking 0 1 2 3
4. Shortness of breath during minor activity 0 1 2 3
5. Rapid heartbeat during minor activity 0 1 2 3
6. Palpitations / erratic heartbeat 0 1 2 3
7. Numbness / pain in left arm 0 1 2 3
8. Heaviness in legs 0 1 2 3
9. Edema / swelling of feet and ankles 0 1 2 3
10. Regular exercise? 0 1 2 3
11. Frequent aerobic exercise? No Yes
12. Red, swollen nose? No Yes
13. Usual resting heart rate Slow Norm. Fast

Part B: CIRCULATION

1. Get angry / excited easily 0 1 2 3
2. Headaches / migraines for no apparent reason 0 1 2 3
3. Poor concentration / foggy brain 0 1 2 3
4. Ringing in ears 0 1 2 3
5. Cold extremities (hands / feet) 0 1 2 3
6. Numbness in extremities (hands / feet) 0 1 2 3
7. Blushing for no apparent reason 0 1 2 3
8. Speech slurred / sloppy 0 1 2 3
9. Calf muscles cramp when walking 0 1 2 3
10. Poor circulation 0 1 2 3
11. Systolic and diastolic pressures widely separated? No Yes
12. Lower ear lobe has vertical crease? No Yes
13. Heart attack? No Yes
14. History of stroke? No Yes
15. Resting blood pressure Low Norm High

Part C: HIGH BLOOD PRESSURE

1. Pain in back of head upon arising in the AM 0 1 2 3
2. Dizziness / lightheadedness / vertigo 0 1 2 3
3. Rapid pulse / shortness of breath 0 1 2 3
4. Easily tired by minor exertion 0 1 2 3
5. Visual disturbance 0 1 2 3
6. Exercise regularly? No Yes
7. Blood pressure higher than it should be? No Yes
8. Systolic and diastolic pressures close to each other? No Yes

Part D: LYMPHATIC

1. Need to clear throat, particularly in AM 0 1 2 3
2. Swelling in throat / neck 0 1 2 3
3. Skin irritation / rash 0 1 2 3
4. Pressure / congestion in or behind ears 0 1 2 3
5. Do you exercise regularly? No Yes

For women only:

6. Nodules or tenderness in breasts 0 1 2 3
7. Swelling in feet / ankles upon waking in AM 0 1 2 3
8. Puffiness beneath eyes in the morning 0 1 2 3

Unit XI: RESPIRATORY SYSTEM

Part A: RESPIRATORY SYSTEM

1. Shortness of breath / labored breathing 0 1 2 3
2. Chest tightness / pain 0 1 2 3
3. Recurring / chronic cough 0 1 2 3
4. Coughing up phlegm or blood 0 1 2 3
5. Chest colds 0 1 2 3
6. Sensitive to smog / perfumes, etc 0 1 2 3
7. Live / work with people who smoke 0 1 2 3
8. Smoker – currently or in past 3 years? No Yes
9. Chronic lung infections? No Yes
10. Exposure to chemicals, pesticides or radiation? No Yes

Unit XII: IMMUNE SYSTEM

Part A: LOW-FUNCTION (HYPO IMMUNITY)

1. Bleeding or sensitive gums 0 1 2 3
2. Runny / sniffy nose 0 1 2 3
3. Nose bleeds for no apparent cause 0 1 2 3
4. Loss of sense of smell or taste 0 1 2 3
5. Chest and throat infections 0 1 2 3
6. Fever blisters, cold sores 0 1 2 3
7. Wounds heal slowly 0 1 2 3
8. Hair thinning / falling out / slow growing 0 1 2 3
9. Ear infection / congestion 0 1 2 3
10. Slow recovery from cold or flu 0 1 2 3

Part A: LOW-FUNCTION (HYPO IMMUNITY)(cont)

11. Catch colds / flu easily, despite precautions 0 1 2 3
12. Skin on back of arms is rough / bumpy 0 1 2 3
13. Lymph glands swell? No Yes

Part B-1: EXCESSIVE FUNCTION (HYPER IMMUNITY)

1. Known food sensitivity / allergy 0 1 2 3
2. Some foods cause illness / anxiety / depression 0 1 2 3
3. Stomach pain / G.I. tract discomfort 0 1 2 3
4. Swallowing tablets is difficult 0 1 2 3
5. Skin disorder / rashes? No Yes
6. Bronchitis / asthma / chronic lung problems? No Yes
7. Recurring migraine headaches? No Yes
8. Mucus in throat / chest 0 1 2 3
9. Low grade fever from time to time 0 1 2 3
10. Swollen / inflamed joints, body aches 0 1 2 3
11. Swollen or sore tongue 0 1 2 3
12. Eye itch / puffiness / discharge? No Yes
13. Ear stuffy / congested 0 1 2 3
14. Sinus infection 0 1 2 3

Part B-2: EXCESSIVE FUNCTION (HYPER IMMUNITY)

15. Runny nose / post nasal drip 0 1 2 3
16. Alternating diarrhea and constipation 0 1 2 3
17. Bed wetting? No Yes
18. Attention deficit / hyperactivity? No Yes
19. Use aspirin, Tylenol, ibuprofen? No Yes
20. Use cortisone, prednisone, steroids? No Yes
21. Mouth breather? No Yes

Unit XIII: BONE

Part A: BONE INTEGRITY

1. Cavities / dental weaknesses 0 1 2 3
2. Bones sore / painful 0 1 2 3
3. Pain in joints / extremities 0 1 2 3
4. Eat meat at most meals? No Yes
5. 3+ cups/day of carbonated beverages? No Yes
6. Gingivitis / gum sensitivity? No Yes
7. Use antacids at least once a day? No Yes
8. Presently wear dentures? No Yes
9. Any known bone deformities? No Yes
10. Diagnosed with arthritis / rheumatism? No Yes
11. Diagnosed with osteoporosis? No Yes
12. Recent bone fracture (past 2 years)? No Yes

For women only:

13. Post menopausal? No Yes

Unit XIV: SOFT TISSUE

Part A: MUSCLE

1. Muscle cramps 0 1 2 3
2. Muscle spasms 0 1 2 3
3. Tension in shoulder muscles 0 1 2 3
4. Pain in neck (fibronalgia) 0 1 2 3
5. Unable to sit for long periods 0 1 2 3
6. Still upon awakening 0 1 2 3
7. Pain / cramps in arms, legs, hands and feet 0 1 2 3
8. Fibromyalgia? No Yes

Part B: CONNECTIVE TISSUE

1. Injured tendons / ligaments 0 1 2 3
2. Double jointed 0 1 2 3
3. Aching joints 0 1 2 3
4. Back pain 0 1 2 3
5. Tendonitis 0 1 2 3
6. Knees / elbows swollen 0 1 2 3

Part B: CONNECTIVE TISSUE (cont)

7. Bursitis 0 1 2 3
8. Slipped / herniated disc? No Yes
9. Height loss? No Yes
10. Bruise / injure easily? No Yes

Unit XV: NERVIOUS SYSTEM

Part A: NERVOUS SYSTEM

1. Tingling sensation under the skin 0 1 2 3
2. Noises / ringing in ears 0 1 2 3
3. Loss of balance / vertigo 0 1 2 3
4. Abnormally exhausted 0 1 2 3
5. Light headedness / dizziness 0 1 2 3
6. Nervousness / restlessness 0 1 2 3
7. Grip strength weaker than usual 0 1 2 3
8. Arms and legs feel heavy 0 1 2 3
9. Numbness in hands and feet 0 1 2 3
10. Heavy headed feeling 0 1 2 3
11. Tremor in hands 0 1 2 3
12. Clumsiness / bad coordination 0 1 2 3
13. Convulsions / seizures? No Yes
14. Have shingles / herpes? No Yes
15. Accident prone? No Yes
16. Need for 10 or more hours of sleep? No Yes
17. Noticeable loss of muscle mass? No Yes

Unit XVI: SLEEP

Part A: SLEEP PATTERNS

1. Nightmares / intense dreams 0 1 2 3
2. Insomnia 0 1 2 3
3. “Toss and turn” sleeper 0 1 2 3
4. Restless legs when laying down 0 1 2 3
5. Currently using a sleep aid? No Yes
6. Wake up frequently during the night? No Yes
7. Wake early, can’t fall back to sleep? No Yes
8. Sleep walk / talks in sleep? No Yes