HEALTH ASSESSMENT FORM

ABOUT YOU

NAME:		
ADDRESS:		
CITY:	**STATE/ZIP CODE:**	
HOME PHONE:	**CELL PHONE:**	
EMAIL ADDRESS:		
DATE OF BIRTH:	**AGE:**	**GENDER:**
MARITAL STATUS:	**CHILDREN:**	
WHOM MAY WE THANK FOR REFERRING YOU?		
EMPLOYER NAME:		
WORK PHONE:	POSITION TITLE:	

OFFICE USE ONLY

REASON FOR THIS VISIT

Please list your 3 main health concerns in order of importance.

1.

2.

3.

HOW FREQUENTLY DO YOUR SYMPTOMS OCCUR?

DO YOUR SYMPTOMS INTERFERE WITH YOUR LIFE IN ANY WAY?

WHAT (if anything) HAVE YOU DONE TO ADDRESS YOUR CONCERNS?

RESULTS:

GOALS FOR YOUR CARE

MEDICATIONS

INSTRUCTIONS: *Please list all medications (current and previous) and as much information as possible. This includes over-the-counter an prescription. If more room is needed, please include on additional piece of paper.*

MEDICATION	Dosage	Duration	Reason
Example: *Armour*	*30 mg / daily*	*2000 to Present*	*Hypothyroid*

APPROXIMATE MONTHLY out-of-pocket COST:

SUPPLEMENTS

INSTRUCTIONS: *Please list all current supplements If more room is needed, please include on additional piece of paper.*

SUPPLEMENT	Dosage	Reason

FOR WOMEN ONLY:
MOST RECENT MENSTRUAL CYCLE?
ARE YOU PREGNANT? ❑ NO ❑ YES
ARE YOU NURSING? ❑ NO ❑ YES

PREVIOUS MEDICAL CONDITIONS

INSTRUCTIONS: *Please list every condition or disease that you now have **or have had in the past**, (approximate) age you were diagnosed or it was discovered, how long you were treated or troubled by condition, any and all symptoms and treatments. Please use additional paper if needed.*

CONDITION	Age	Duration	Your Symptoms	Treatment Received
Example: *Kidney Stones*	*44 & 50*	*1 week & 3 months*	*Severe pain, vomiting, fever, blood in urine*	*Blood test, X-rays, Surgery*

******** TO BE COMPLETED BY DOCTOR IN OFFICE ********

BLOOD PRESSURE:

Supine _____/ _____ Standing _____/ _____

BLOOD PRESSURE:

Supine _____/ _____ Standing _____/ _____

HEIGHT:					NAILS				
WEIGHT:					EYES				
PULSE:					TONGUE				
RESPIRATION:					pH				

HEALTH ASSESSMENT FORM

DIRECTIONS:

Please read each description and circle the number which best describes the frequency of your symptoms within the past year. If you do not understand a symptom, put a ? *before* the symptom's number.

KEY: 0 = Never 1 = Mild 2 = Moderate 3 = Severe

PATIENT NAME:

CATEGORY I

SECTION A				
1. Bad breath, halitosis	0	1	2	3
2. Loss of taste for high protein foods (meat)	0	1	2	3
3. Burning or nervous stomach relieved by eating	0	1	2	3
4. Gas shortly after eating	0	1	2	3
5. Indigestion 30-60 min after eating, may last 3-4 hours	0	1	2	3
6a. Difficulty digesting fruits and/or veggies	0	1	2	3
6b. Undigested foods found in stools	0	1	2	3
7. Acid or spicy food upsets stomach	0	1	2	3
SECTION B				
8. Lower bowel gas/bloating several hours after eating	0	1	2	3
9. Burning feet	0	1	2	3
10. "whites" of eyes (sclera) yellowing	0	1	2	3
11. Dry skin, itchy feet and/or skin peels on feet	0	1	2	3
12. Brown spots or bronzing of skin	0	1	2	3
13. Bitter metallic taste in mouth	0	1	2	3
14. Blurred vision	0	1	2	3
15. Headaches over eyes	0	1	2	3
16. Feel nauseous, queasy or gag easily	0	1	2	3
17. Color of stools light brown or yellow	0	1	2	3
18. Greasy or high fat foods cause distress	0	1	2	3
19. Pain between shoulder blades	0	1	2	3
20. Dark circles under eyes	0	1	2	3
21. "Acid" breath	0	1	2	3
22. Appetite reduced	0	1	2	3
23. History of gallbladder attacks/stones or removed GB	NO		YES	
SECTION C				
24. Coated tongue or "fuzzy" debris on tongue	0	1	2	3
25. Pass large amounts of foul smelling gas	0	1	2	3
26. Irritable bowel or mucous colitis	0	1	2	3
27. Constipation, diarrhea or alternating or stools	0	1	2	3
28. Burning or itching anus	0	1	2	3
29. Bowel mvmts painful or difficult, constipated or use laxatives	0	1	2	3

CATEGORY II

30. Head congestion / sinus "fullness"	0	1	2	3
31. Sneezing attacks	0	1	2	3
32. Dreaming, nightmare-like bad dreams	0	1	2	3
33. Milk and/or wheat products cause distress	0	1	2	3
34. Eyes and nose watery	0	1	2	3
35. Eyes get swollen and puffy	0	1	2	3
36. Pulse speeds after meals and/or heart pounds at rest	0	1	2	3

CATEGORY III

SECTION A				
37. Crave sweets or coffee in afternoon or mid-morning	0	1	2	3
38. Hungry between meals or excessive appetite	0	1	2	3
39. Overeating sweets upsets	0	1	2	3
40. Eat when nervous	0	1	2	3
41. Irritable before meals	0	1	2	3
42. Get "shaky" or light-headed if meals delayed	0	1	2	3
43. Fatigue, eating relieves	0	1	2	3
44. Heart palpitates if meals missed or delayed	0	1	2	3
45. Awaken few hours after sleep, hard to get back to sleep	0	1	2	3
SECTION B				
46. Muscle soreness after moderate exercise	0	1	2	3
47. Vulnerability to insect bites—Especially fleas & mosquito	0	1	2	3
48. Loss of muscle tone or "heaviness" in arms or legs	0	1	2	3
49. Enlarged heart and/or heart failure	0	1	2	3
50. Worrier, feel insecure and/or highly emotional	0	1	2	3
51. Pulse slow/below 65 or irregular pulse	NO		YES	

FEMALE ONLY

135. Premenstrual tension	0	1	2	3
136. Painful menses (cramping, etc)	0	1	2	3
137. Excessive flow or prolonged menstruation	0	1	2	3
138. Painful / tender breasts	0	1	2	3
139. Menstruate too frequently	0	1	2	3
140. Acne, worse at menses	0	1	2	3
141. Depressed feelings before menstruation	0	1	2	3
142. Vaginal discharge	0	1	2	3
143. Menses scanty or missed	0	1	2	3
144. Hysterectomy / ovaries removed	NO		YES	
145. Menopausal hot flashes	0	1	2	3
146. Depression	0	1	2	3

MALE ONLY

147. Prostate trouble	0	1	2	3
148. Urination difficult or dribbling	0	1	2	3
149. Frequent night urination	0	1	2	3
150. Pain on inside of legs or heels	0	1	2	3
151. Feeling of incomplete bowel evacuation	0	1	2	3
152. Leg nervousness at night	0	1	2	3
153. Tire easily / avoid activity	0	1	2	3
154. Reduced sex drive	0	1	2	3
155. Depression	0	1	2	3
156. Migrating aches and pain	0	1	2	3

CATEGORY IV

SECTION A				
52. Sex drive increased	0	1	2	3
53. "Splitting" type headaches	0	1	2	3
54. Memory failing	0	1	2	3
55. Tolerance for sugar reduced	0	1	2	3
SECTION B				
56. Sex drive reduced or absent	0	1	2	3
57. Abnormal thirst	0	1	2	3
58. Weight gain around hips or waist	0	1	2	3
59. Tendency to ulcers or colitis	0	1	2	3
60. Increased ability to eat sugar without symptoms	0	1	2	3
61. Menstrual disorders (women)	0	1	2	3
62. Lack of menstruation (young girls)	0	1	2	3
SECTION C				
63. Difficulty gaining weight, even if large appetite	0	1	2	3
64. Heart palpitations	0	1	2	3
65. Nervous, emotional, and/or can't work under pressure	0	1	2	3
66. Insomnia	0	1	2	3
67. Inward trembling	0	1	2	3
68. Night sweats	0	1	2	3
69. Fast pulse at rest	0	1	2	3
70. Intolerant to high temperatures	0	1	2	3
71. Easily flushed	0	1	2	3
SECTION D				
72. Difficulty losing weight	0	1	2	3
73. Reduced initiative and/or mental sluggishness	0	1	2	3
74. Easily fatigued, sleepy during the day	0	1	2	3
75. Sensitive to cold, poor circulation (cold hands and feet)	0	1	2	3
76. Dry or scaly skin	0	1	2	3
77. "Ringing" in ears/noises in head	0	1	2	3
78. Hearing impaired	0	1	2	3
79. Constipation	0	1	2	3
80. Excessive falling hair and/or coarse hair	0	1	2	3
81. Headaches when waking that wear off during the day	0	1	2	3

SECTION E				
82. Blood pressure increased	0	1	2	3
83. Headaches	0	1	2	3
84. Hot flashes	0	1	2	3
85. WOMEN ONLY: Hair growth on face or body	0	1	2	3
86. WOMEN ONLY: Masculine tendencies	0	1	2	3
SECTION F				
87. Blood pressure low	0	1	2	3
88. Crave salt	0	1	2	3
89. Chronic fatigue / get drowsy	0	1	2	3
90. Afternoon yawning	0	1	2	3
91. Weakness / dizziness	0	1	2	3
92. Weakness after colds / slow recovery	0	1	2	3
93. Circulation poor	0	1	2	3
94. Muscular and / or neurological exhaustion	0	1	2	3
95. Subject to colds, asthma, bronchitis, respiratory issues	0	1	2	3
96. Allergies and / or hives	0	1	2	3
97. Difficulty maintaining or holding adjustments	0	1	2	3
98. Arthritic tendencies	0	1	2	3
99. Nails weak or ridged	0	1	2	3
100. Perspire easily	0	1	2	3
101. Slow starter in the morning	0	1	2	3
102. Afternoon headaches	0	1	2	3

CATEGORY V

103. Frequent skin rashes and/or hives	0	1	2	3
104. Muscle-leg-toe cramping at rest and/or while sleeping	0	1	2	3
105. Fever easily raised / fevers common	0	1	2	3
106. Crave chocolate	0	1	2	3
107. Feet have bad odor	0	1	2	3
108. Hoarseness frequent	0	1	2	3
109. Difficulty swallowing	0	1	2	3
110. Joint stiffness after rising	0	1	2	3
111. Vomit frequently	0	1	2	3
112. Tendency to anemia	0	1	2	3
113. "whites" of eyes (sclera) blue	0	1	2	3
114. "Lump" in throat	0	1	2	3
115. Dry mouth, eyes, and/or nose	0	1	2	3
116. White spots on finger nails	0	1	2	3
117. Cuts heal slowly and/or scar easily	0	1	2	3
118. Reduced or "lost" sense of taste and/or smell	0	1	2	3
119. Susceptible to colds, fevers, and/or infections	0	1	2	3
120. Strong light irritates eyes	0	1	2	3
121. Noises in head or ringing in ears	0	1	2	3
122. Burning sensations in mouth	0	1	2	3
123. Numbness in hands and feet (extremities "go to sleep")	0	1	2	3
124. Intolerant to MSG (monosodium glutamate)	NO			YES
125. Cannot recall dreams	0	1	2	3
126. Nose bleeds frequent	0	1	2	3
127. Bruise easily, "black and blue" spots	0	1	2	3
128. Muscle cramps, worse with exercise ("charley horses")	0	1	2	3

CATEGORY II

129. Aware of heavy and/or irregular breathing	0	1	2	3
130. Discomfort in high altitudes	0	1	2	3
131. "Air hunger" / sigh frequently	0	1	2	3
132. Swollen ankles (worse at night)	0	1	2	3
133. Shortness of breath with exertion	0	1	2	3
134. Dull pain in chest and/or pain radiating into left arm	0	1	2	3
134. High blood pressure (with or without medication)	0	1	2	3

How often do you have a bowel movement?

Please describe consistency, color, etc.