



Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient's Health Professional: \_\_\_\_\_

## PART I

Circle any of the following medications you are taking:

- |                         |                                 |                       |                            |
|-------------------------|---------------------------------|-----------------------|----------------------------|
| • Antacids              | • Chemotherapy                  | • Hormones            | • Relaxants/Sleeping Pills |
| • Antibiotic/Antifungal | • Cortisone Anti-Inflammatories | • Laxatives           | • Recreational Drugs       |
| • Antidepressants       | • Diuretics                     | • Lithium             | Specify _____              |
| • Antidiabetic/Insulin  | • Heart Medications             | • Oral Contraceptives | • Thyroid                  |
| • Aspirin/Tylenol       | • High Blood Pressure           | • Radiation           | • Ulcer Medications        |
|                         |                                 |                       | • Other _____              |

Circle if you eat, drink, or use:

- |                        |                                      |                         |                       |
|------------------------|--------------------------------------|-------------------------|-----------------------|
| • Alcohol              | • Distilled Water                    | • Luncheon Meats        | • Non-Herbal Teas     |
| • Candy                | • Fluoridated/Chlorinated Water      | • Margarine             | • Chew Tobacco        |
| • Carbonated Beverages | • At fast food restaurants regularly | • Refined Sugars        | • Vitamins & Minerals |
| • Cigarettes           | • Fried Foods                        | • Milk Products         | • Specify _____       |
| • Coffee               | • Refined (White) Flour Products     | • Artificial Sweeteners |                       |

Circle if you:

- |                             |                                     |                                    |
|-----------------------------|-------------------------------------|------------------------------------|
| • Diet often                | • Exercise less than 3 times weekly | • Are exposed to chemicals at work |
| • Salt food without tasting | • Are under excessive stress        | • Are exposed to cigarette smoke   |

### DIRECTIONS:

Please read each description and darken 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  
 (Occurs once a month or less)                      (Occurs several times monthly)                      (Aware of it almost constantly)

## PART II

### IMPORTANT

Dear Patient, Please list your five major health concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### 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 alternating or stools alternate from soft to watery | .....0 | 1 | 2 | 3 |
| 28. Bowel movements painful or difficult, constipation, and/or laxatives used  | .....0 | 1 | 2 | 3 |
| 29. Burning or itching anus  | .....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 products and/or wheat products cause distress          | .....0 | 1 | 2 | 3 |
| 34. Eyes and nose watery  | .....0 | 1 | 2 | 3 |
| 35. Eyes swollen and puffy                                      | .....0 | 1 | 2 | 3 |
| 35. Pulse speeds after meals and/or heart pounds after retiring | .....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 delay                | .....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 a 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 and mosquitoes) | .....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                          | .....YES | NO |   |   |

## PART III

### CATEGORY I

#### Section A:

- |  |        |   |   |   |
|--|--------|---|---|---|
| 1. Bad breath, halitosis   | .....0 | 1 | 2 | 3 |
| 2. Loss of taste for high protein foods (meat, etc.)                           | .....0 | 1 | 2 | 3 |
| 3. Burning ("acid") or nervous stomach, eating relieves                        | .....0 | 1 | 2 | 3 |
| 4. Gas shortly after eating  | .....0 | 1 | 2 | 3 |
| 5. Indigestion 1/2 to 1 hour after eating, may last 3-4 hours                  | .....0 | 1 | 2 | 3 |
| 6. Difficulty digesting fruits or vegetables; undigested foods found in stools | .....0 | 1 | 2 | 3 |
| 7. Acid or spicy foods upset stomach   | .....0 | 1 | 2 | 3 |

#### Section B:

- |   |          |    |   |   |
|---|----------|----|---|---|
| 8. Lower bowel gas and or bloating several hours after eating           | .....0   | 1  | 2 | 3 |
| 9. Feet burn  | .....0   | 1  | 2 | 3 |
| 10. "Whites" of eyes (sclera) yellow                                    | .....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. Headache 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. History of gallbladder attacks or gallstones OR gallbladder removed | .....YES | NO |   |   |
| 23. Appetite reduced  | .....0   | 1  | 2 | 3 |

**PART III (Continued)**

**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 awaken/wear off during 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. Hair growth on face or body (Question to females) .....	0	1	2	3
86. Masculine tendencies (Question to females) .....	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 nervous exhaustion .....	0	1	2	3
95. Subject to colds, asthma, bronchitis (respiratory disorders) .....	0	1	2	3
96. Allergies and/or hives .....	0	1	2	3
97. Difficulty maintaining manipulative correction .....	0	1	2	3
98. Arthritic tendencies .....	0	1	2	3
99. Nails weak, ridged .....	0	1	2	3
100. Perspire easily .....	0	1	2	3
101. Slow starter in morning .....	0	1	2	3
102. Afternoon headaches .....	0	1	2	3

**CATEGORY V**

**Section A:**

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. Vomiting frequent .....	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-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 monosodium glutamate (MSG) .....	YES	NO		
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 VI**

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, worse on exertion .....	0	1	2	3

**CATEGORY VII**

**Female Only**

135. Premenstrual tension .....	0	1	2	3
136. Painful menses (cramping, etc.) .....	0	1	2	3
137. Menstruation excessive or prolonged .....	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 .....	YES	NO		
145. Menopausal hot flashes .....	0	1	2	3
146. Depression .....	0	1	2	3

**CATEGORY VIII**

**Male Only**

147. Prostate trouble .....	0	1	2	3
148. Urination difficult or dribbling .....	0	1	2	3
149. Night urination frequent .....	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 pains .....	0	1	2	3