



Rehab / Disc Therapy
Acupuncture
Posture Correction
Nutrition & Wellness
Brain Health /
Amino Acid Therapy

Dr. Robert Wright DC,CBCN

10059 S. Roberts Rd.
Palos Hills

(708) 598-9144
www.PalosChiro.com

Dear Patient:

WELCOME ! and thank you for choosing Dr. Wright as one of your health care providers.

HOW THE PROCESS WORKS:

STEP 1:

Your Initial Examination will include:

- A thorough review of your health history, including current issues / challenges.
- Extensive testing of all body systems (digestive, hormonal, etc.), including testing for food sensitivities
- Lab tests may be recommended for your specific health issues.

STEP 2:

Upon your Follow-up Consultation:

- Dr. Wright will discuss an individualized Wellness/Therapeutic Program for you, which can include: diet changes, nutritional supplements, specific exercises, lifestyle & stress management advice.
- If lab tests were ordered, Dr. Wright will explain your test results, and incorporate their findings into your above Wellness/Therapeutic Program.

STEP 3:

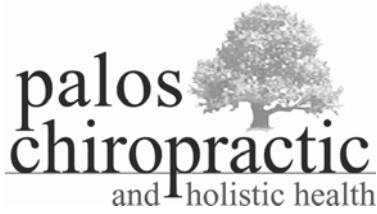
Subsequent Follow-up Consults:

Follow-up Consults will be scheduled to monitor your progress. Initially, follow-up consults may be weekly, and then reduced to every two weeks, then monthly as your progress continues.

Please feel free to contact us via email or phone should you have any questions during the course of your treatment. Our office hours are: Monday, Tuesday, Wednesday, and Friday from 8:30 – 6:00 pm. Nutrition & Wellness patients are seen on Tuesdays.

**We look forward to assisting you in achieving your current wellness goals
and guiding you in maintaining wellness throughout your life.**

In Health, Dr. Wright and Health Staff



Rehab / Disc Therapy
 Acupuncture
 Posture Correction
 Nutrition & Wellness
 Brain Health /
 Amino Acid Therapy

10059 S. Roberts Rd.
 Palos Hills

(708) 598-9144
 www.PalosChiro.com

Please note: We must receive your completed paperwork at least one (1) day prior to your appointment or phone consultation. Please mail back / fax / or drop off your completed paperwork to our office. Thank you!

Nutrition & Wellness Patient Paperwork

Name:			Date:		
Address:				Country:	
City:		State:		Zip/Postal Code:	
Home Phone:		Work Phone:		Fax:	
E-mail:			Cell Phone:		
Please mark your preference for occasional follow up communication from our office: <input type="checkbox"/> Email <input type="checkbox"/> Phone					
Age:	Birth date:	Sex: M F	Status: M S W D	No.: Children:	
Occupation:		Employer:		Years Employed:	
Spouse's Name:		Occupation:			
Person responsible for this account:			Referred by:		
What is your major complaint?					
Other complaints?					
What are your overall health goals once your complaints are resolved?					
How long has it been since you really felt good?					

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Palos Chiropractic & Holistic Health to release my personal medical information to me.

Patient's Signature: _____

Date: _____



Rehab / Disc Therapy
 Acupuncture
 Posture Correction
 Nutrition & Wellness
 Brain Health /
 Amino Acid Therapy

10059 S. Roberts Rd.
 Palos Hills

(708) 598-9144
 www.PalosChiro.com

**PLEASE ANSWER ALL QUESTIONS FRANKLY, TO THE BEST OF YOUR KNOWLEDGE.
 ALL INFORMATION IS CONFIDENTIAL.**

Weight _____ **Height** _____ **Blood Pressure** (if known) _____ **% Body Fat** (if known) _____

1. Are you presently taking any medications, nutritional supplements or vitamins? _____
please list (attach sheet if necessary)

2. In the past, have you used **birth control pills** **for how long:** _____
 antibiotics? **for how long:** _____

3. If you have fillings, are they: **amalgam (metals)** **composite**
Explain if combination of both: _____

4. Do you presently, or have you ever had any of these conditions? (circle)

- | | | |
|---------------------------|---------------------|---------------------------|
| Anemia | Frequent Headaches | Skin condition |
| Arthritis | Heartburn | Thyroid condition |
| Asthma | High blood pressure | Unexplained weight change |
| Chest pains | High cholesterol | |
| Chronic cold/flu symptoms | Hypoglycemia | |
| Chronic fatigue | Kidney problems | |
| Depression | Liver problems | |
| Diabetes | Osteoporosis | |

5. How much sleep do you get each night on average? _____

6. Do you have any food allergies, sensitivities or restrictions? _____

7. Do you: **smoke** **drink alcohol** **use recreational drugs**

a. How much, how often? _____

b. How much / how often do you drink caffeinated beverages? _____



Rehab / Disc Therapy
Acupuncture
Posture Correction
Nutrition & Wellness
Brain Health /
Amino Acid Therapy

10059 S. Roberts Rd.
Palos Hills

(708) 598-9144
www.PalosChiro.com

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.): _____

9. Are there foods that you eat on a daily basis, almost daily basis? _____

a. Do you “miss”/crave these foods if you do not eat them? YES NO

10. Write briefly about your weight gain/loss history: _____

a. What do you feel triggers your weight fluctuation? (circle) heredity stress eating habits boredom

b. Is your weight gain/loss: (circle) sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity: _____

12. What methods have you tried to lose/gain weight? _____

13. How is your energy level? (0 = no energy 10 = high energy) _____

a. Are there times in the day that you feel best? _____ worst? _____

14. Are you happy in your life right now? _____

15. What are your main sources of stress? _____

16. How do you deal with your stress? _____

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes _____ No _____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes _____ No _____



Rehab / Disc Therapy
 Acupuncture
 Posture Correction
 Nutrition & Wellness
 Brain Health /
 Amino Acid Therapy

10059 S. Roberts Rd.
 Palos Hills

(708) 598-9144
 www.PalosChiro.com

- c. I get tired and/or hungry in the mid-afternoon. Yes _____ No _____
- d. I get a sleepy, almost “drugged” feeling after eating a meal containing bread, pasta or dessert. Yes _____ No _____
- e. Now and then I think I am a secret eater. Yes _____ No _____
- f. At a restaurant, I almost always eat too much bread before the meal is served. Yes _____ No _____
- g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes _____ No _____
- h. I experience cravings for sugar, breads, pasta and baked goods. Yes _____ No _____
- i. I feel shaky if I don’t eat on time or if I don’t snack. Yes _____ No _____
- j. I often find myself irritable or angry. Yes _____ No _____

18. Check off any of the following that have applied to you within the last 30 days:

- | | |
|---|---|
| <input type="checkbox"/> Do you feel nauseous? | <input type="checkbox"/> Do you have abdominal/intestinal pain? |
| <input type="checkbox"/> Do you have bloating? | <input type="checkbox"/> Do you get bloated after meals? |
| <input type="checkbox"/> Do you get heartburn? | <input type="checkbox"/> Do you have diarrhea? |
| <input type="checkbox"/> Do you have constipation? | <input type="checkbox"/> Do you travel outside of the U.S.? |
| <input type="checkbox"/> Do you have gas? | <input type="checkbox"/> Are your stools compact/hard to pass? |
| <input type="checkbox"/> Do you belch following meals? | <input type="checkbox"/> Do you have gurgles in your stomach? |
| <input type="checkbox"/> Do your bowel movements alternate between constipation and diarrhea? | |

24. In your estimation, how physically fit are you right now?

Unfit _____ Below average _____ Average _____ Above average _____ Very fit _____

25. How often do you exercise? _____

a. What is your regime? _____



Rehab / Disc Therapy
 Acupuncture
 Posture Correction
 Nutrition & Wellness
 Brain Health /
 Amino Acid Therapy

10059 S. Roberts Rd.
 Palos Hills

(708) 598-9144
 www.PalosChiro.com

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past? _____

27. What are your fitness goals? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> General fitness endurance | <input type="checkbox"/> Muscle toning |
| <input type="checkbox"/> Weight loss/maintain weight | <input type="checkbox"/> Muscle strengthening |
| <input type="checkbox"/> Osteoporosis prevention | <input type="checkbox"/> Muscular coordination/balance |
| <input type="checkbox"/> Specific sport enhancement _____ | Other _____ |
| <input type="checkbox"/> Flexibility | _____ |

28. Surgeries, starting with most recent: _____

29. Hospitalizations: _____

30. Briefly describe where you have lived since childhood: _____

31. What is your heritage? (Polish, African American, Latin, etc.) _____

32. Circle NOW or PAST for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:

- Now Past **Satisfactory**
 Now Past **Boring**
 Now Past **Demanding**
 Now Past **Unsatisfactory**

Do you often:

- Now Past **Feel depressed**
 Now Past **Have anxiety**

Do you often:

- Now Past **Have irrational fears**



Rehab / Disc Therapy
Acupuncture
Posture Correction
Nutrition & Wellness
Brain Health /
Amino Acid Therapy

10059 S. Roberts Rd.
Palos Hills

(708) 598-9144
www.PalosChiro.com

Do you worry over:

Now Past **Home life**
Now Past **Marriage**
Now Past **Children**
Now Past **Job**
Now Past **Income**
Now Past **Money problems**

Now Past **Feel upset**
Now Past **Feel things go wrong**
Now Past **Feel shy**
Now Past **Cry**
Now Past **Feel inferior**

Have you:

Now Past **Seriously considered suicide**
Now Past **Attempted suicide**



Rehab / Disc Therapy
Acupuncture
Posture Correction
Nutrition & Wellness
Brain Health /
Amino Acid Therapy

10059 S. Roberts Rd.
Palos Hills

(708) 598-9144
www.PalosChiro.com

POLICIES AND PROCEDURES

(PATIENT: PLEASE RETAIN THIS PAGE FOR YOUR RECORDS)

Nutrition & Wellness Fee Schedule

Initial Consultation: (45 minutes - 1 hour)	\$100.00
Follow-Up Visits (15-20 minutes)	\$ 35.00

- Payment is due at time of visit
- Methods of payment are: Cash, Personal Check / Money Order, Visa, MasterCard, American Express or *CareCredit
- * CareCredit: A revolving open line of credit for health/dental/vision/veterinary care (Inquire at Front Desk on 3, 6 & 9 month programs @ 0%)

Appointments

- As a courtesy to you, our office will call you to confirm your appointment one day in advance.

Cancellations

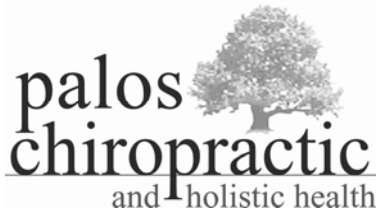
- If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you may be charged for that appointment.

Lab Tests

- If Lab Tests have been ordered, the results of your lab test(s) will be sent directly to Dr. Wright 2 to 4 weeks after mailing your specimens to the lab. After Dr. Wright has evaluated your results, you will be contacted to schedule a follow-up appointment.

Returned Products

- Pre-approval is required by Dr. Wright on all returns.
- Refrigerated items CANNOT be returned
- No supplement returns will be accepted after 30 days on all regularly stocked items. Special orders CANNOT be returned!
- Prepaid tests can be returned for credit within one year of purchase.



Rehab / Disc Therapy
Acupuncture
Posture Correction
Nutrition & Wellness
Brain Health /
Amino Acid Therapy

10059 S. Roberts Rd.
Palos Hills

(708) 598-9144
www.PalosChiro.com

I have read and understood Palos Chiropractic & Holistic Health's Policy & Procedures.

Date: _____

Printed Name: _____

Signature: _____

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ Date _____

DIRECTIONS

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

0 = No or Rarely—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

1 = Occasionally—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = Often—Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Some questions require a YES or NO response: 0 = NO 8 = YES

PART I

SECTION A

- | | No/Rarely | Occasionally | Often | Frequently |
|--|-----------|--------------|-------|------------|
| 1. Indigestion, food repeats on you after you eat | 0 | 1 | 4 | 8 |
| 2. Excessive burping, belching and/or bloating following meals | 0 | 1 | 4 | 8 |
| 3. Stomach spasms and cramping during or after eating | 0 | 1 | 4 | 8 |
| 4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal | 0 | 1 | 4 | 8 |
| 5. Bad taste in your mouth | 0 | 1 | 4 | 8 |
| 6. Small amounts of food fill you up immediately | 0 | 1 | 4 | 8 |
| 7. Skip meals or eat erratically because you have no appetite | 0 | 1 | 4 | 8 |

Total points

SECTION B

- | | | | | |
|--|-------|---|---|--------|
| 1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt | 0 | 1 | 4 | 8 |
| 2. Feel hungry an hour or two after eating a good-sized meal | 0 | 1 | 4 | 8 |
| 3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating | 0 | 1 | 4 | 8 |
| 4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids | 0 | 1 | 4 | 8 |
| 5. Burning sensation in the lower part of your chest, especially when lying down or bending forward | 0 | 1 | 4 | 8 |
| 6. Digestive problems that subside with rest and relaxation | (0)No | | | (8)Yes |
| 7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache | 0 | 1 | 4 | 8 |
| 8. Feel a sense of nausea when you eat | 0 | 1 | 4 | 8 |
| 9. Difficulty or pain when swallowing food or beverage | 0 | 1 | 4 | 8 |

Total points

SECTION C

- | | | | | |
|--|---|---|---|---|
| 1. When massaging under your rib cage <i>on your left side</i> , there is pain, tenderness or soreness | 0 | 1 | 4 | 8 |
| 2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal | 0 | 1 | 4 | 8 |
| 3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement | 0 | 1 | 4 | 8 |
| 4. Specific foods/beverages aggravate indigestion | 0 | 1 | 4 | 8 |
| 5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day | 0 | 1 | 4 | 8 |

SECTION C (cont.)

- | | No/Rarely | Occasionally | Often | Frequently |
|---|-----------|--------------|-------|------------|
| 6. Stool odor is embarrassing | 0 | 1 | 4 | 8 |
| 7. Undigested food in your stool | 0 | 1 | 4 | 8 |
| 8. Three or more large bowel movements daily | 0 | 1 | 4 | 8 |
| 9. Diarrhea (frequent loose, watery stool) | 0 | 1 | 4 | 8 |
| 10. Bowel movement shortly after eating (within 1 hour) | 0 | 1 | 4 | 8 |

Total points

SECTION D

- | | | | | |
|--|-------|---|---|--------|
| 1. Discomfort, pain or cramps in your colon (lower abdominal area) | 0 | 1 | 4 | 8 |
| 2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas | 0 | 1 | 4 | 8 |
| 3. Generally constipated (or straining during bowel movements) | 0 | 1 | 4 | 8 |
| 4. Stool is small, hard and dry | 0 | 1 | 4 | 8 |
| 5. Pass mucus in your stool | 0 | 1 | 4 | 8 |
| 6. Alternate between constipation and diarrhea | 0 | 1 | 4 | 8 |
| 7. Rectal pain, itching or cramping | 0 | 1 | 4 | 8 |
| 8. No urge to have a bowel movement | (0)No | | | (8)Yes |
| 9. An almost continual need to have a bowel movement | (0)No | | | (8)Yes |

Total points

PART II

- | | | | | |
|---|---|---|---|---|
| 1. When massaging under your rib cage <i>on your right side</i> , there is pain, tenderness or soreness | 0 | 1 | 4 | 8 |
| 2. Abdominal pain worsens with deep breathing | 0 | 1 | 4 | 8 |
| 3. Pain at night that may move to your back or right shoulder | 0 | 1 | 4 | 8 |
| 4. Bitter fluid repeats after eating | 0 | 1 | 4 | 8 |
| 5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods | 0 | 1 | 4 | 8 |
| 6. Throbbing temples and/or dull pain in forehead associated with overeating | 0 | 1 | 4 | 8 |
| 7. Unexplained itchy skin that's worse at night | 0 | 1 | 4 | 8 |
| 8. Stool color alternates from clay colored to normal brown | 0 | 1 | 4 | 8 |
| 9. General feeling of poor health | 0 | 1 | 4 | 8 |

PART II

	No/Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise	0	1	4	8
11. Retain fluid and feel swollen around the abdominal area	0	1	4	8
12. Reddened skin, especially palms	0	1	4	8
13. Very strong body odor	0	1	4	8
14. Are you embarrassed by your breath?	0	1	4	8
15. Bruise easily	(0)No	(8)Yes		
16. Yellowish cast to eyes	(0)No	(8)Yes		

Total points **PART III****SECTION A**

1. Feel cold or chilled—hands, feet or all over—for no apparent reason	0	1	4	8
2. Your upper eyelids look swollen	0	1	4	8
3. Muscles are weak, cramp and/or tremble	0	1	4	8
4. Are you forgetful?	0	1	4	8
5. Do you feel like your heart beats slowly?	0	1	4	8
6. Reaction time seems slowed down	0	1	4	8
7. In general, are you disinterested in sex because your desire is low?	0	1	4	8
8. Feel slow-moving, sluggish	0	1	4	8
9. Constipation	0	1	4	8
10. Dryness, discoloration of skin and/or hair	(0)No	(8)Yes		
11. Have you noticed recently that your voice is deepening?	(0)No	(8)Yes		
12. Thick, brittle nails	(0)No	(8)Yes		
13. Weight gain for no apparent reason	(0)No	(8)Yes		
14. Outer third of your eyebrow is thinning or disappearing	(0)No	(8)Yes		
15. Swelling of the neck	(0)No	(8)Yes		

Total points **SECTION B**

1. Lingering mild fatigue after exertion or stress	0	1	4	8
2. Do you find that you get tired and exhaust easily?	0	1	4	8
3. Craving for salty foods	0	1	4	8
4. Sensitive to minor changes in weather and surroundings	0	1	4	8
5. Dizzy when rising or standing up from a kneeling position	0	1	4	8
6. Dark bluish or black circles under your eyes	0	1	4	8
7. Have bouts of nausea with or without vomiting	0	1	4	8
8. Catch colds or infections easily	(0)No	(8)Yes		
9. Wounds heal slowly	(0)No	(8)Yes		
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful	0	1	4	8
11. Feel puffy and swollen all over your body	0	1	4	8
12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements	(0)No	(8)Yes		

Total points **PART IV**

	No/Rarely	Occasionally	Often	Frequently
--	-----------	--------------	-------	------------

SECTION A**When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?**

1. A sense of weakness	0	1	4	8
2. A sudden sense of anxiety when you get hungry	0	1	4	8
3. Tingling sensation in your hands	0	1	4	8
4. A sensation of your heart beating too quickly or forcefully	0	1	4	8
5. Shaky, jittery, hands trembling	0	1	4	8
6. Sudden profuse sweating and/or your skin feels clammy	0	1	4	8
7. Nightmares possibly associated with going to bed on an empty stomach	0	1	4	8
8. Wake up at night feeling restless	0	1	4	8
9. Agitation, easily upset, nervous	0	1	4	8
10. Poor memory, forgetful	0	1	4	8
11. Confused or disoriented	0	1	4	8
12. Dizzy, faint	0	1	4	8
13. Cold or numb	0	1	4	8
14. Mild headaches or head pounding	0	1	4	8
15. Blurred vision or double vision	0	1	4	8
16. Feel clumsy and uncoordinated	0	1	4	8

Total points **SECTION B**

1. Frequent urination during the day and night	0	1	4	8
2. Unusual thirst—feeling like you can't drink enough water	0	1	4	8
3. Unusual hunger—eating all the time	0	1	4	8
4. Vision blurs	0	1	4	8
5. Feel itchy all over	0	1	4	8
6. Tingling or numbness in your feet	0	1	4	8
7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	0	1	4	8
8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing weight	(0)No	(8)Yes		
9. Sores heal slowly	(0)No	(8)Yes		
10. Loss of hair on your legs	(0)No	(8)Yes		

Total points **PART V****SECTION A**

1. Feel jittery	0	1	4	8
2. First effort of the day causes pain, pressure, tightness or heaviness around the chest	0	1	4	8
3. Exhaustion with minor exertion	0	1	4	8
4. Heavy sweating (no exertion, no hot flashes)	0	1	4	8
5. Difficulty catching breath, especially during exercise	0	1	4	8
6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly	0	1	4	8
7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason	0	1	4	8

Total points

PART V (cont.)**SECTION B**

	No/Rarely	Occasionally	Often	Frequently
1. Muscle pain at rest	0	1	4	8
2. Cramp-like pains in your ankles, calves or legs	0	1	4	8
3. Numbness, tingling and prickling sensation in hands and feet	0	1	4	8
4. Cold feet and/or toes appear blue	0	1	4	8
5. Brief moments of hearing loss	0	1	4	8
6. Nausea comes and goes quickly (unrelated to eating)	0	1	4	8
7. Feel worse standing: legs get heavy and fatigued	0	1	4	8
8. Leg discomfort or fatigue relieved by elevating legs	0	1	4	8
9. Fingers and toes get numb in cold weather even when protected	0	1	4	8
10. Notice changes in your ability to feel pain or differentiate between sensations of hot or cold	(0)No		(8)Yes	
11. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared	(0)No		(8)Yes	
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?	(0)No		(8)Yes	

Total points**PART VI****SECTION A**

1. Family, friends, work, hobbies or activities you hold dear are no longer of interest	0	1	4	8
2. Do you cry?	0	1	4	8
3. Does life look entirely hopeless?	0	1	4	8
4. Would you describe yourself as feeling miserable and sad, unhappy or blue?	0	1	4	8
5. Do you find it hard to make the best of difficult situations?	0	1	4	8
6. Sleep problems—too much or too little sleep	0	1	4	8
7. Changes in your appetite and weight	(0)No		(8)Yes	
8. Lately you've noticed an inability to think clearly or concentrate	(0)No		(8)Yes	
9. Difficulty making decisions and/or clarifying and achieving your goals	(0)No		(8)Yes	

Total points**SECTION B**

1. Does worrying get you down?	0	1	4	8
2. Does every little thing get on your nerves and wear you out?	0	1	4	8
3. Would you consider yourself a nervous person?	0	1	4	8
4. Do you feel easily agitated?	0	1	4	8
5. Do you shake and tremble?	0	1	4	8
6. Are you keyed up and jittery?	0	1	4	8
7. Do you tremble or feel weak when someone shouts at you?	0	1	4	8
8. Do you become scared at sudden movements or noises at night?	0	1	4	8
9. Do you find yourself sighing a lot?	0	1	4	8
10. Are you awakened out of your sleep by frightening dreams?	0	1	4	8
11. Do frightening thoughts keep coming back in your mind?	0	1	4	8

SECTION B (cont.)

12. Do you become suddenly scared for no reason?	0	1	4	8
13. Do you break out in a cold sweat?	0	1	4	8
14. "Butterflies in your stomach," nausea and/or diarrhea	0	1	4	8

Total points**SECTION C**

1. Do you feel pent up and ready to explode?	0	1	4	8
2. Are you prone to noisy and emotional outbursts?	0	1	4	8
3. Do you do things on impulse?	0	1	4	8
4. Are you easily upset or irritated?	0	1	4	8
5. Do you go to pieces if you don't control yourself?	0	1	4	8
6. Do little annoyances get on your nerves and make you angry?	0	1	4	8
7. Does it make you angry to have anyone tell you what to do?	0	1	4	8
8. Do you flare up in anger if you can't have what you want right away?	0	1	4	8

Total points**PART VII**

1. Eyes water or tear	0	1	4	8
2. Mucus discharge from the eyes	0	1	4	8
3. Ears ache, itch, feel congested or sore	0	1	4	8
4. Discharge from ears	0	1	4	8
5. Is your nose continually congested?	0	1	4	8
6. Are you prone to loud snoring?	(0)No		(8)Yes	
7. Does your nose run?	0	1	4	8
8. Nosebleeds	(0)No		(8)Yes	
9. Hoarse voice	0	1	4	8
10. Do you have to clear your throat?	0	1	4	8
11. Do you feel a choking lump in your throat?	0	1	4	8
12. Do you suffer from severe colds?	(0)No		(8)Yes	
13. Do frequent colds keep you miserable all winter?	(0)No		(8)Yes	
14. Flu symptoms last longer than 5 days	(0)No		(8)Yes	
15. Do infections settle in your lungs?	(0)No		(8)Yes	
16. Chest discomfort or pain	0	1	4	8
17. Do you experience sudden breathing difficulties?	0	1	4	8
18. Do you struggle with shortness of breath?	0	1	4	8
19. Difficulty exhaling (breathing out)	0	1	4	8
20. Breathlessness followed by coughing during exertion, no matter how slight	0	1	4	8
21. Inability to breathe comfortably while lying down	0	1	4	8
22. Do you cough up lots of phlegm?	0	1	4	8
23. Can you hear noisy rattling sounds when breathing in and out?	0	1	4	8
24. Are you troubled with coughing?	0	1	4	8
25. Do you wheeze?	0	1	4	8
26. Do you have severe soaking sweats at night?	0	1	4	8
27. Do your lips and/or nails have a bluish hue?	0	1	4	8
28. Are you sleepy during the day?	0	1	4	8

PART VII (cont.)

	No/Rarely	Occasionally	Often	Frequently
29. Do you have difficulty concentrating?	0	1	4	8
30. Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products	(0)No		(8)Yes	
31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal changes	(0)No		(8)Yes	
Total points				

PART VIII

1. Involuntary loss of urine when you cough, lift something or strain during an activity	0	1	4	8
2. Mild lower back ache or pain	0	1	4	8
3. Abdominal achiness or pain	0	1	4	8
4. Pain or burning when urinating	0	1	4	8
5. Rarely feel the urge to urinate	0	1	4	8
6. Feel the need to urinate less than every two hours during the day or night	0	1	4	8
7. Strong smelling urine	0	1	4	8
8. Back or leg pains are associated with dripping after urination	0	1	4	8
9. Sore or painful genitals	0	1	4	8
10. Urine is a rose color	0	1	4	8
11. Sudden urge to void causes involuntary loss of urine	0	1	4	8
12. Generalized sense of water retention throughout your body	0	1	4	8
Total points				

PART IX**SECTION A**

1. Bones throughout your entire body ache, feel tender or sore	0	1	4	8
2. Localized bone pain	0	1	4	8
3. Hands, feet or throat get tight, spasm or feel numb	0	1	4	8
4. Difficulty sitting straight	0	1	4	8
5. Upper back pain	0	1	4	8
6. Lower back pain	0	1	4	8
7. Pain when sitting down or walking	0	1	4	8
8. Find yourself limping or favoring one leg	0	1	4	8
9. Shins hurt during or after exercise	0	1	4	8
Total points				

SECTION B

1. Are you stiff in the morning when you wake up?	0	1	4	8
2. Difficulty bending down and picking up clothing or anything from the floor	0	1	4	8
3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees or ankles)	0	1	4	8
4. Joints hurt when moving or when carrying weight	0	1	4	8
5. A routine exercise program, like daily walking, causes your knees to swell or hurt	0	1	4	8
6. Difficulty opening jars that were previously easy to open	0	1	4	8
7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm	0	1	4	8

SECTION B (cont.)

	No/Rarely	Occasionally	Often	Frequently
8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	0	1	4	8
9. Difficulty chewing food or opening mouth	0	1	4	8
10. Difficulty standing up from a sitting position	0	1	4	8
11. Shooting, aching, tingling pain down the back of leg	0	1	4	8
12. Is it difficult to reach up and get a 5-pound object like a bag of flour from just above your head?	(0)No		(8)Yes	
13. Injure, strain or sprain easily	(0)No		(8)Yes	
Total points				

SECTION C

1. Muscles stiff, sore, tense and/or achy	0	1	4	8
2. Burning, throbbing, shooting or stabbing muscle pain	0	1	4	8
3. Muscle cramps or spasms (involuntary or after exertion/exercise)	0	1	4	8
4. Is muscle pain or stiffness greater in the morning than other times of the day?	0	1	4	8
5. Specific points on body feel sore when pressed	0	1	4	8
6. Feel unrefreshed upon awakening	0	1	4	8
7. Headaches	0	1	4	8
8. Pain at the sides of your head or in your face especially when awakening	0	1	4	8
9. Your jaw clicks or pops	0	1	4	8
10. Muscle twitch or tremor—eyelids, thumb, calf muscle	0	1	4	8
11. Irresistible urge to move legs	0	1	4	8
12. Legs move during sleep	0	1	4	8
13. Unpleasant crawling sensation inside calves when lying down	0	1	4	8
14. Hand and wrist numbness or pain (e.g., interferes with writing or with buttoning or unbuttoning your clothes)	0	1	4	8
15. Feeling of "pins and needles" in your thumb and first three fingers	0	1	4	8
16. Pain in forearm and sometimes in shoulder	0	1	4	8
Total points				

PART X**SECTION A**

1. Head feels heavy	0	1	4	8
2. Dizziness	0	1	4	8
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side	0	1	4	8
4. Your hands tremble, ever so slightly, for no apparent reason	0	1	4	8
5. You feel like you're wearing heavy weights on your feet when walking	0	1	4	8
6. Bump into things, trip, stumble and feel clumsy	0	1	4	8
7. Difficulty breathing	0	1	4	8
8. Difficulty swallowing	0	1	4	8
9. People tell you to speak up because they have trouble hearing you	0	1	4	8
10. Speaking and forming words does not feel automatic	0	1	4	8
11. Need 10-12 hours of sleep to feel rested	0	1	4	8

PART X (cont.)

SECTION A (cont.)

- | | No/Rarely | Occasionally | Often | Frequently |
|--|-----------|--------------|--------|------------|
| 12. Lack strength (your grip is weak, holding your head or picking your arms up takes effort) | 0 | 1 | 4 | 8 |
| 13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be | (0)No | | (8)Yes | |
| 14. Muscles in arms and legs seem softer and smaller | (0)No | | (8)Yes | |
| 15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be? | (0)No | | (8)Yes | |
| 16. Do you find yourself moving slower than you used to? | (0)No | | (8)Yes | |

Total points

SECTION B

- | | | | | |
|--|---|---|---|---|
| 1. Difficulty absorbing new information | 0 | 1 | 4 | 8 |
| 2. Tend to forget things | 0 | 1 | 4 | 8 |
| 3. Trouble thinking or concentrating | 0 | 1 | 4 | 8 |
| 4. Easily distracted | 0 | 1 | 4 | 8 |
| 5. Do you have a tendency to become frustrated quickly? | 0 | 1 | 4 | 8 |
| 6. Inability to sit still for any length of time, even at mealtime | 0 | 1 | 4 | 8 |
| 7. Finishing tasks is easier said than done | 0 | 1 | 4 | 8 |
| 8. Do you have more trouble solving problems or managing your time than usual? | 0 | 1 | 4 | 8 |
| 9. Low tolerance for stress and otherwise ordinary problems | 0 | 1 | 4 | 8 |

Total points

PART XI

Men Only

- | | | | | |
|--|---|---|---|---|
| 1. Sensation of not emptying your bladder completely | 0 | 1 | 4 | 8 |
| 2. Need to urinate less than 2 hours after you have finished urinating | 0 | 1 | 4 | 8 |
| 3. Find yourself needing to stop and start again several times while urinating | 0 | 1 | 4 | 8 |
| 4. Find it difficult to postpone urination | 0 | 1 | 4 | 8 |
| 5. Have a weak urinary stream | 0 | 1 | 4 | 8 |
| 6. Need to push or strain to begin urinating | 0 | 1 | 4 | 8 |
| 7. Dripping after urination | 0 | 1 | 4 | 8 |
| 8. Urge to urinate several times a night | 0 | 1 | 4 | 8 |

Total points

PART XII

Women Only

(Menopausal women should skip to Sections E and F)

SECTION A

Do you persistently experience any of these symptoms within three days to two weeks prior to menstruation?

[A]

- | | | |
|--|-------|--------|
| 1. Anxious, irritable or restless | (0)No | (8)Yes |
| 2. Numbness, tingling in hands and feet | (0)No | (8)Yes |
| 3. Easy to anger, resentful | (0)No | (8)Yes |
| 4. Aggressive or hostile toward family/friends | (0)No | (8)Yes |

Total points

SECTION A (cont.)

[B]

- | | | |
|---|-------|--------|
| 5. Abdominal bloating, feeling swollen (e.g., feet) | (0)No | (8)Yes |
| 6. Temporary weight gain | (0)No | (8)Yes |
| 7. Breast tenderness, swelling | (0)No | (8)Yes |
| 8. Appearance of breast lumps | (0)No | (8)Yes |
| 9. Discharge from nipples | (0)No | (8)Yes |
| 10. Nausea and/or vomiting | (0)No | (8)Yes |
| 11. Diarrhea or constipation | (0)No | (8)Yes |
| 12. Aches and pains (back, joints, etc.) | (0)No | (8)Yes |

[C]

- | | | |
|---|-------|--------|
| 13. Craving for sweets | (0)No | (8)Yes |
| 14. Increased appetite or binge eating | (0)No | (8)Yes |
| 15. Headaches | (0)No | (8)Yes |
| 16. Being easily overwhelmed, shaky or clumsy | (0)No | (8)Yes |
| 17. Heart pounding | (0)No | (8)Yes |
| 18. Dizziness or fainting | (0)No | (8)Yes |

[D]

- | | | |
|--|-------|--------|
| 19. Confused and forgetful to the point that work suffers | (0)No | (8)Yes |
| 20. Overwhelmed with feelings of sadness and worthlessness | (0)No | (8)Yes |
| 21. Difficulty sleeping or falling asleep | (0)No | (8)Yes |
| 22. Engaging in self-destructive behavior | (0)No | (8)Yes |

Total points

SECTION B

Do you experience any of these symptoms during your period?

- | | | |
|--|-------|--------|
| 1. Cramping in lower abdomen or pelvic area | (0)No | (8)Yes |
| 2. Lower abdominal pain is sharp and/or dull or intermittent | (0)No | (8)Yes |
| 3. Bloating and sense of abdominal fullness | (0)No | (8)Yes |
| 4. Diarrhea or constipation | (0)No | (8)Yes |
| 5. Nausea and/or vomiting | (0)No | (8)Yes |
| 6. Low back and/or legs ache | (0)No | (8)Yes |
| 7. Headaches | (0)No | (8)Yes |
| 8. Unusual fatigue (take naps) resulting in missed work | (0)No | (8)Yes |
| 9. Painful and/or swollen breasts | (0)No | (8)Yes |
| 10. Scanty blood flow | (0)No | (8)Yes |

Total points

SECTION C

- | | | | | |
|--|-------|--------|---|---|
| 1. Painful or difficult sexual intercourse | 0 | 1 | 4 | 8 |
| 2. Low abdominal, back and vaginal pain throughout the month | 0 | 1 | 4 | 8 |
| 3. Pelvic pressure or pain while sitting down or standing up, relieved by lying down | 0 | 1 | 4 | 8 |
| 4. Vaginal bleeding other than during your period | 0 | 1 | 4 | 8 |
| 5. Painful bowel movements | 0 | 1 | 4 | 8 |
| 6. Difficult (straining) urination | 0 | 1 | 4 | 8 |
| 7. Abnormal vaginal discharge | 0 | 1 | 4 | 8 |
| 8. Offensive vaginal discharge | 0 | 1 | 4 | 8 |
| 9. Vaginal itching or burning with or without intercourse | 0 | 1 | 4 | 8 |
| 10. Pain during periods is getting progressively worse | (0)No | (8)Yes | | |
| 11. Profuse or prolonged menstrual bleeding | (0)No | (8)Yes | | |
| 12. Unable to get pregnant | (0)No | (8)Yes | | |

Total points

PART XII (cont.)

SECTION D

	No/Rarely	Occasionally	Often	Frequently
1. Absence of periods for six months or longer	(0)No	(8)Yes		
2. Periods occur irregularly (e.g., 3 to 6 times a year)	(0)No	(8)Yes		
3. Profuse heavy bleeding during periods	0	1	4	8
4. Menstrual blood contains clots and tissue	0	1	4	8
5. Bleeding between periods can occur anytime	0	1	4	8
6. Periods occur greater than every 35 days	(0)No	(8)Yes		
7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)	0	1	4	8
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)	0	1	4	8
9. Monthly abdominal pain without bleeding	0	1	4	8
10. Abundant cervical mucus	0	1	4	8
11. Acne and/or oily skin	0	1	4	8
12. Overwhelming urges for sexual intercourse	0	1	4	8
13. Aggressive feelings	0	1	4	8
14. Increased growth of dark facial and/or body hair	(0)No	(8)Yes		
15. Poor sense of smell	(0)No	(8)Yes		
16. Voice is becoming deeper	(0)No	(8)Yes		
17. Breasts seem to be getting smaller	(0)No	(8)Yes		
18. Receding hairline	(0)No	(8)Yes		

Total points

SECTION E

1. Vaginal discharge	0	1	4	8
2. Vaginal secretions are watery and thin	0	1	4	8
3. Vaginal dryness	0	1	4	8
4. Sexual intercourse is uncomfortable	0	1	4	8

SECTION E (cont.)

	No/Rarely	Occasionally	Often	Frequently
5. Interest in having sex is low	0	1	4	8
6. Engorged breasts	0	1	4	8
7. Breast tenderness, soreness	0	1	4	8
8. Difficulty with orgasm	0	1	4	8
9. Vaginal bleeding after sexual intercourse	0	1	4	8
10. Do you skip periods?	(0)No	(8)Yes		
11. The length (number of days) of your period varies month to month, with the number of days of bleeding getting fewer	(0)No	(8)Yes		

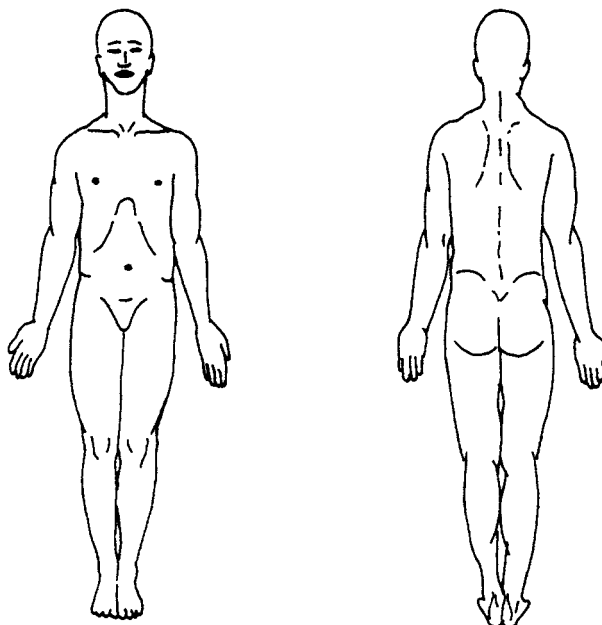
Total points

SECTION F

1. Sense of well-being fluctuates throughout the day for no apparent reason	0	1	4	8
2. Sudden hot flashes	0	1	4	8
3. Spontaneous sweating	0	1	4	8
4. Chills	0	1	4	8
5. Cold hands and feet	0	1	4	8
6. Heart beats rapidly or feels like it is fluttering	0	1	4	8
7. Numbness, tingling or prickling sensations	0	1	4	8
8. Dizziness	0	1	4	8
9. Mental foginess, forgetful or distracted	0	1	4	8
10. Inability to concentrate	0	1	4	8
11. Depression, anxiety, nervousness and/or irritability	0	1	4	8
12. Difficulty sleeping	0	1	4	8
13. Conscious of new feelings of anger and frustration	0	1	4	8
14. Skin, hair, vagina and/or eyes feel dry	0	1	4	8
15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding	(0)No	(8)Yes		

Total points

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.



HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date began: _____

List current health problems for which you are being treated: _____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

- diet modification fasting vitamins/minerals herbs homeopathy chiropractic acupuncture conventional drugs
 other _____

Do you experience any of these general symptoms EVERY DAY?

- | | | | | |
|--|--|-----------------------------------|---|--|
| <input type="checkbox"/> Debilitating fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic pain/inflammation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Nausea | <input type="checkbox"/> Fecal incontinence | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Disinterest in sex | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Disinterest in eating | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low grade fever | <input type="checkbox"/> Itching/rash |

Current medications (prescription or over-the-counter): _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): _____

Outcome _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)? _____

What are your current health goals: _____

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Date of last GYN exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Age of first period _____
- Date - last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
- Surgical menopause
- Menopause

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
- Cigarettes: #/day _____
- Cigars: #/day _____
- Alcohol:
- Wine: #glasses/d or wk _____
- Liquor: #ounces/d or wk _____
- Beer: #glasses/d or wk _____
- Caffeine:
- Coffee: #6 oz cups/d _____
- Tea: #6 oz cups/d _____
- Soda w/caffeine: #cans/d _____
- Other sources _____
- Water: #glasses/d _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk - #days/wk _____
- Run, jog, other aerobic - #days/wk _____
- Weight lift - #days/wk _____
- Stretch - #days/wk _____
- Other _____

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
- dairy wheat eggs
- soy corn all gluten
- Other _____

Food Frequency

- Number of servings per day:
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip meals - which ones _____
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals (Ensure)
- Others _____

I Would Like To:

- ENERGY - VITALITY
- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive
- BODY COMPOSITION
- Loose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible
- STRESS, MENTAL, EMOTIONAL
- Learn how to reduce stress
- Think more clearly and be more-focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated
- LIFE ENRICHMENT
- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle

NUTRITION & IMMUNE STATUS

Physical assessment of common markers of malnutrition, maldigestion, malabsorption, hypermetabolic stress syndrome and protein calorie malnutrition. Exam to be conducted by a healthcare professional.

General Appearance:

- Undernourished, skinny (especially the temporal muscles)

Hair:

- Dull, dry
- Thin, fine, straight
- Easily plucked
- Areas of lighter or darker spots
- Hair loss

Face:

- Pale complexion
- Generalized swelling
- Dark areas on cheeks
- Dark circles under eyes
- Lumpy or flaky skin around the nose and mouth
- Enlarged parotid glands

Eyes:

- Difficulty adjusting to the dark
- Dull appearance
- Dry and either pale or red membranes
- Triangular, shiny gray spots on conjunctivas
- Red and fissured eyelid corners
- Bloodshot ring around cornea

Lips:

- Red and swollen, especially at corners
- Cheilosis (fissures and chapping of lips)

Tongue:

- Swollen
- Purple and raw-looking with sores and abnormal papillae

Teeth:

- Missing, or emerging abnormally
- Visible cavities or dark spots
- Bleeding gums

Nails:

- Spoon-shaped
- Brittle
- Ridged

Neck:

- Swollen thyroid gland

Skin:

- Dry, flaky
- Swollen, with lighter and darker spots, some resembling bruises
- Tight and drawn, with poor turgor (elasticity)
- Dermatitis
- Retarded wound healing
- Skin lesions

Smell and Taste:

- Partial loss of taste
- Partial loss of smell

Musculoskeletal System:

- Muscle wasting
- Muscle weakness
- Muscle atrophy
- Knock-knee or bowlegs
- Bumps on ribs
- Swollen joints
- Musculoskeletal hemorrhages
- Stunted growth, loss of height
- Dowager's hump
- Tetany (muscle twitches and/or cramps)

Cardiovascular System:

- Heart rate above 100 beats/minute
- Arrhythmias
- Elevated blood pressure

Abdomen:

- Enlarged liver and spleen

Reproductive System:

- Decreased libido
- Amenorrhea
- Retarded development of the reproductive system

Nervous System:

- Irritability
- Mental confusion
- Abnormal behavior
- Depression
- Paresthesias (tingling) in hands and feet
- Loss of proprioception (unable to maintain balance with eyes closed)
- Decreased ankle and knee reflexes
- Paralysis (no spinal cord injury)
- Tremor

Consider blood deficiency (pernicious anemia) with the following clinical picture:

- Considerable weight loss without apparent cause
- Burning tongue
- General weakness, malaise and fatigue
- Numbness and tingling in the extremities
- Alternating constipation and diarrhea
- Abdominal pain
- Nausea and vomiting
- Bleeding gums
- Ataxia (incoordination and irregularity of voluntary, purposeful movements)
- Diplopia (double vision) and blurred vision
- Irritability
- Headache

Ethnic Background:

- White (non-Hispanic origin)
- Hispanic
- African American
- Asian
- Pacific Islander
- Native North American
- East Indian