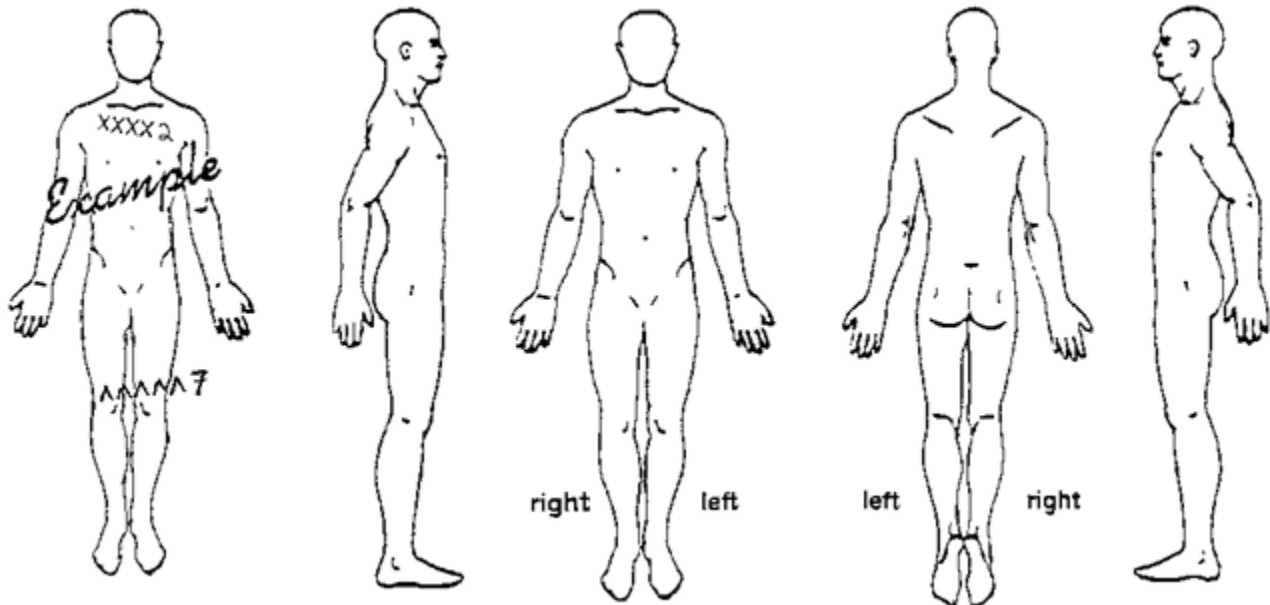


Please show us where you are experiencing symptoms...

Indicate your degree of pain using a scale of 1 (minor discomfort) to 10 (extreme pain):

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	0 0 0 0 0 0	^ ^ ^ ^ ^	X X X X	/ / / / / / / /



Has your condition caused you to lose enjoyment in (Circle all that apply)

Hobbies Personal Activities Sports Work

Has your condition caused you duress in work or school? YES NO

Has your condition caused you duress in your household duties? YES NO

If you have lost time from school or work due to this condition, how much? _____

Activities of Daily Living

Please circle any of the following that you are not doing as well as you feel you should.

- | | | | | | | |
|-----------------------|------------------|---------------------------|---------------------|------------------|-------------------|-------------------|
| Bathing | driving | getting in and out of car | caring for children | lifting children | | |
| Playing with children | computer | dressing | eating | feeding self | grooming | |
| Cleaning | cooking | dishes | laundry | yard work | managing finances | |
| Managing medications | oral care | paperwork | caring for pet/s | phone | | |
| Reading | religious events | sex | shopping | sitting | sleeping | social activities |
| Stairs | standing | toileting | walking | working | writing | |
| Other | _____ | | | | | |

For each of the above that you have circled, please place a number next to it indicating how severe

1 mild 2 mild to moderate 3 moderate 4 moderate to severe 5 severe

Medications currently taking (we are happy to make a copy of any list that you carry☺)

Please list any **herbs, vitamins, home remedies, homeopathic remedies** _____

Alcohol Use (How much?)

Beer	_____	a day	a week	a month	a year
Wine	_____	a day	a week	a month	a year
Liquor	_____	a day	a week	a month	a year

Tobacco Use (How much?) N/A_____ Cigarettes _____ Cigars_____ Chewing tobacco_____ Pipe_____

Liquids Consumed (how much per day?)

Water _____	Reg. Coffee _____	Decaf. Coffee _____	Energy Drinks _____
Tea, Black _____	Tea, Decaf. _____	Tea, Green _____	Tea Herbal _____
Diet Soda _____	Regular Soda _____		

Recreational interests _____

Hobbies _____

On a typical day, **what do you eat** for the following meals

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

How many hours do you typically **sleep** each night _____

Exercise routine including hours per week _____

Constitution: lack of appetite fatigue fever weight stable weight loss weight gain

Eyes/Head: blurred vision corrective lenses dizziness double vision eye discharge eye pain headache lightheaded visual changes visual disturbance other _____

ENT/Upper respiratory: allergy bad breath bridges dental implants dentures difficulty swallowing ear pain ear infection ear discharge ears ringing goiter hearing loss lightheaded mouth pain mouth sore nose discharge nosebleed sinus congestion sinus issues sinus pain snoring sore throat loss of teeth other _____

Cardiovascular: asthma chest pain cough difficulty breathing difficulty lying flat fainting spells heart problems history of heart disease mucus with color murmur palpitations problems with cholesterol levels shortness of breath with exertion swelling/edema in extremities swollen ankles varicose veins other _____

Respiratory: bronchitis chills cough coughing blood emphysema lung disease smoking wheezing other_____

Gastrointestinal: abdominal pain bloody stool change in BMs constipation diarrhea heartburn/reflux hemorrhoids hernia indigestion jaundice nausea vomiting other_____

Genitourinary: abnormal discharge bladder infection bladder leakage childbirth discharge from penis hysterectomy incontinence jaundice kidney infection kidney pain kidney stones miscarriage pregnancy abnormal pregnancy prostate enlarged prostate symptoms STDs urinate more than twice a night unusual discharge or bleeding frequent urination loss of control of urination painful urination Blood in urine urine clear urine yellow other_____

Musculoskeletal: arthritis backache cramps headaches joint pain limited motion muscle pain muscle weakness neck pain sore muscles sports injuries muscle stiffness swelling in joints other_____

Skin and Breast: acne breast discharge breast lumps breast painful change in skin color change in hair change in nails change in skin texture dermatitis dryness eczema fungal infection growths itchiness lumps pimples psoriasis rashes shingles sores suspicious moles warts yeast infection other_____

Neurological: concussion convulsions diabetes dizziness fainting head trauma headaches memory loss multiple sclerosis neuropathy numbness paralysis Parkinson's disease pins & needles restless legs seizures tingling tremors unable to move parts of body vertigo visual disturbances weakness other_____

Mental: anger issues anxiety confusion depression difficult sleeping memory loss mental illness mood swings nervousness sadness tension other_____

Do you want us to help you naturally with this condition YES NO

Endocrine: ankle swelling diabetes excessive appetite excessive hunger excessive thirst excessive urination fatigue hair loss heat/cold intolerance hysterectomy postmenopausal early signs of menopause significant weight change skin changes thyroid issues weakness Other_____

Hematologic/Lymphatic: anemia blood clots B12 deficiency easy bruising enlarged glands problems with cholesterol levels sore lymph nodes swelling in extremities other_____

Allergic/Immunologic: environmental allergies food allergies frequent infections hay fever HIV/AIDS hives lupus medication allergies pet allergy rheumatoid arthritis other_____