Outline Procedure for New Patients

Step One: All new patients are requested to fill out a personal health questionnaire prior to their appointment.

Step Two: Your consultation with a doctor to discuss your health problems.

Step Three: Diagnostic chiropractic, orthopedic, and neurological examination procedures to determine if Chiropractic care is appropriate for your condition.

Step Four: You will be advised if there is the need of any additional procedures such as X-rays, MRI, & CAT Scan.

Step Five: If your case requires immediate attention, treatment will be administered.

Step Six: You will be advised as to a time you can return for your “Report of Findings” so that the Doctor will inform you as to your examination results and whether or not your case has been accepted. You will be informed of specific recommendations in regards to your condition.

Step Seven: If appropriate, your treatment plan will begin following your “Report of Findings.”

Confidential Patient Information

Name _____ SS# _____ Date of Birth _____

Home Phone # _____ Cellular Phone # _____

Address _____ City _____ State ___ Zip _____

E-mail _____ May we send you newsletters and promotions via email? Yes____ No____

Marital Status ___ Name of Spouse _____ # of Children _____

Occupation _____ Employer _____ Work Phone _____

In case of emergency, please contact: Name _____ Phone # _____

How were you referred to our office? _____

Purpose of this appointment _____

Is your injury work related, and auto accident or personal injury? [ ] Yes [ ] No

If your injury is related to work, an auto accident or any other injury involving a claim, please advise the office staff.

Name of person responsible for payment _____ Insurance Company _____

Group # _____ ID # _____ Phone # _____

Name of the Insured _____ Birth Date of Insured _____ SS# of Insured _____

Financial Policy

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Foothill Chiropractic** will gladly prepare any necessary reports and forms to assist me in making collection from my primary insurance carrier. If I am paying by cash, check or credit card or if I have insurance co-pay and/or deductible, payment is expected at the time of service. If I have insurance, I hereby authorize and direct my insurance carrier to pay benefits, which may be due to me, according to my policy, directly to, and payable to **Foothill Chiropractic** to be applied to my account. I understand and agree that all fees for services rendered on my behalf are my personal responsibility and are due and payable at time of service.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE. IF MY TREATMENT REQUIRES INSURANCE BILLING, I HEREBY AUTHORIZE AND DIRECT **FOOTHILL CHIROPRACTIC** TO RELEASE ALL MEDICAL INFORMATION NECESSARY TO PROCESS THESE CLAIMS.

Signed _____ Date _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved to avoid future relapses (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible in order to optimize their physical and emotional well-being (**Comprehensive Care**).

Foothill Chiropractic and Wellness Center stresses that it is always ***YOUR*** choice to choose which form of care you desire. We will honor and support your choice and your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

□ Relief Care □ Corrective Care □ Comprehensive Care □ Would like to discuss options with the doctor

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Please list your major health concerns in order of severity:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Complaint # 1:

When did you first notice this condition? _____

Did it begin □ Immediately or □ Gradually? (please describe briefly) _____
_____

What is the exact location of your symptoms? _____
_____

Do your symptoms spread? □ No □ Yes Where?_____

How often do you experience these symptoms?
□ Constant □ Frequent (75% of day) □ Often (50%) □ Seldom (25%) □ Rarely (less than 25%)
_____

Is this condition progressively □ Worsening □ Improving or □ Unchanged

What is the intensity of your symptoms? □ Severe □ Moderate □ Mild

Rate your symptoms on a scale of 1-10, considering 1 (minimal) and 10 (severe/excruciating)

Is your pain □ Deep or □ Superficial

Please indicate the character of your pain: □ Dull □ Sharp □ Burning □ Aching □ Knife-like □ Throbbing

Are you experiencing any of the following associated symptoms? □ Pins & Needles □ Tingling
□ Numbness □ Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

□ Sitting ___min □ Lying □ Lifting _____lbs. □ Bowel Movements □ Hot or Cold
□ Standing □ Pushing □ Gripping □ Mental Activities □ Walking
□ Pulling □ Coughing/Sneezing □ Bright Lights □ Other (Please explain)____

Please indicate what helps you to relieve the pain.

□ Lying □ Walking □ Rest □ Medications_____
□ Sitting □ Standing □ Heat or Cold □ Other (Please explain)_____

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition)

Please include any other relevant history in regards to this complaint.

Complaint # 2:

When did you first notice this condition? _____

Did it begin □ Immediately or □ Gradually? (please describe briefly) _____
_____

What is the exact location of your symptoms? _____
_____

Do your symptoms spread? □ No □ Yes Where?_____

How often do you experience these symptoms?
□ Constant □ Frequent (75% of day) □ Often (50%) □ Seldom (25%) □ Rarely (less than 25%)
_____

Is this condition progressively □ Worsening □ Improving or □ Unchanged

What is the intensity of your symptoms? □ Severe □ Moderate □ Mild

Rate your symptoms on a scale of 1-10, considering 1 (minimal) and 10 (severe/excruciating)

Is your pain □ Deep or □ Superficial

Please indicate the character of your pain: □ Dull □ Sharp □ Burning □ Aching □ Knife-like □ Throbbing

Are you experiencing any of the following associated symptoms? □ Pins & Needles □ Tingling
□ Numbness □ Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

□ Sitting ___min	□ Lying	□ Lifting _____lbs.	□ Bowel Movements	□ Hot or Cold
□ Standing	□ Pushing	□ Gripping	□ Mental Activities	□ Walking
□ Pulling	□ Coughing/Sneezing		□ Bright Lights	□ Other (Please explain)____

_____
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Please indicate what helps you to relieve the pain.
□ Lying □ Walking □ Rest □ Medications_____
□ Sitting □ Standing □ Heat or Cold □ Other (Please explain)_____
_____

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition)
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Please include any other relevant history in regards to this complaint.

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Complaint # 3:

When did you first notice this condition? _____

Did it begin □ Immediately or □ Gradually? (please describe briefly) _____
_____

What is the exact location of your symptoms? _____
_____

Do your symptoms spread? □ No □ Yes Where?_____

How often do you experience these symptoms?
□ Constant □ Frequent (75% of day) □ Often (50%) □ Seldom (25%) □ Rarely (less than 25%)
_____

Is this condition progressively □ Worsening □ Improving or □ Unchanged

What is the intensity of your symptoms? □ Severe □ Moderate □ Mild

Rate your symptoms on a scale of 1-10, considering 1 (minimal) and 10 (severe/excruciating)

Is your pain □ Deep or □ Superficial

Please indicate the character of your pain: □ Dull □ Sharp □ Burning □ Aching □ Knife-like □ Throbbing

Are you experiencing any of the following associated symptoms? □ Pins & Needles □ Tingling
□ Numbness □ Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:

□ Sitting ___min □ Lying □ Lifting _____lbs. □ Bowel Movements □ Hot or Cold
□ Standing □ Pushing □ Gripping □ Mental Activities □ Walking
□ Pulling □ Coughing/Sneezing □ Bright Lights □ Other (Please explain)____

_____
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_____

Please indicate what helps you to relieve the pain.

□ Lying □ Walking □ Rest □ Medications_____
□ Sitting □ Standing □ Heat or Cold □ Other (Please explain)_____
_____

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition)

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Please include any other relevant history in regards to this complaint.

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Past Medical History

Please include any of your previous conditions. If possible include dates, diagnosis, treatment received and any residuals you still suffer from.

Utero, Birth, and Infancy:

Was your mother healthy when you were in utero? □ Yes □ No (Please explain_____
_____

Did she smoke or consume alcohol? □ No □ Yes

Where were you born? _____

Were you delivered vaginally or through cesarean section? *Circle one*

Were there any complications during your birth process? □ No □ Yes (Please explain)_____
_____

Were you vaccinated? □ No □ Yes

Did you have normal neurological, structural, emotional, and social development? □ Yes □ No (Please explain) _____
_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas □ none_____
Illnesses/Hospitalizations: □ none _____
Surgeries: □ none_____

Childhood (ages 2 – 12)

Did you have normal neurological, structural, emotional, social, and academic development?
□ Yes □ No _____
_____

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	□	□	□	□	□	_____
Athletics	□	□	□	□	□	_____
Emotional	□	□	□	□	□	_____
Dietary Habits	□	□	□	□	□	_____
Overall Health	□	□	□	□	□	_____

Did you have any of the following:
Injuries, Accidents, Falls or Traumas □ none_____
_____
Illnesses/Hospitalizations: □ none _____
_____
Surgeries: □ none_____

Teens (ages 13-19)

Did you have normal neurological, structural, emotional, social, and academic development?

□ Yes □ No _____

_____

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	□	□	□	□	□	_____
Athletics	□	□	□	□	□	_____
Emotional	□	□	□	□	□	_____
Dietary Habits	□	□	□	□	□	_____
Overall Health	□	□	□	□	□	_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas □ none_____

_____

Illnesses/Hospitalizations: □ none _____

_____

Surgeries: □ none_____

Females only: What age did you start your menses? ____ □ Regular □ Irregular

Twenties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	□	□	□	□	□	_____
Athletics	□	□	□	□	□	_____
Emotional	□	□	□	□	□	_____
Dietary Habits	□	□	□	□	□	_____
Overall Health	□	□	□	□	□	_____

Did you have any of the following:

Motor Vehicle Accidents □ none _____

_____

Work Injuries □ none _____

Injuries, Accidents, Falls or Traumas □ none_____

_____

Illnesses/Hospitalizations: □ none _____

_____

Surgeries: □ none_____

Thirties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	☐	☐	☐	☐	☐	_____
Exercise Level	☐	☐	☐	☐	☐	_____
Emotional	☐	☐	☐	☐	☐	_____
Dietary Habits	☐	☐	☐	☐	☐	_____
Overall Health	☐	☐	☐	☐	☐	_____

Did you have any of the following:

Motor Vehicle Accidents ☐ none _____
_____
Work Injuries ☐ none _____
Injuries, Accidents, Falls or Traumas ☐ none_____
_____
Illnesses/Hospitalizations: ☐ none _____
_____
Surgeries: ☐ none_____

Forties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	☐	☐	☐	☐	☐	_____
Exercise Level	☐	☐	☐	☐	☐	_____
Emotional	☐	☐	☐	☐	☐	_____
Dietary Habits	☐	☐	☐	☐	☐	_____
Overall Health	☐	☐	☐	☐	☐	_____

Did you have any of the following:

Motor Vehicle Accidents ☐ none _____
_____
Work Injuries ☐ none _____
Injuries, Accidents, Falls or Traumas ☐ none_____
_____
Illnesses/Hospitalizations: ☐ none _____
_____
Surgeries: ☐ none_____

Females only: Menopausal symptoms ☐ none ☐ yes _____

Fifties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	□	□	□	□	□	_____
Exercise Level	□	□	□	□	□	_____
Emotional	□	□	□	□	□	_____
Dietary Habits	□	□	□	□	□	_____
Overall Health	□	□	□	□	□	_____

Did you have any of the following:

Motor Vehicle Accidents □ none _____
_____
Work Injuries □ none _____
Injuries, Accidents, Falls or Traumas □ none_____
_____
Illnesses/Hospitalizations: □ none _____
_____
Surgeries: □ none_____

Females only: Menopausal symptoms □ none □ yes _____

Sixties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	□	□	□	□	□	_____
Exercise Level	□	□	□	□	□	_____
Emotional	□	□	□	□	□	_____
Dietary Habits	□	□	□	□	□	_____
Overall Health	□	□	□	□	□	_____

Did you have any of the following:

Motor Vehicle Accidents □ none _____
_____
Work Injuries □ none _____
Injuries, Accidents, Falls or Traumas □ none_____
_____
Illnesses/Hospitalizations: □ none _____
_____

Seventies

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor
Academics	□	□	□	□	□ _____
Exercise Level	□	□	□	□	□ _____
Emotional	□	□	□	□	□ _____
Dietary Habits	□	□	□	□	□ _____
Overall Health	□	□	□	□	□ _____

Did you have any of the following:

Motor Vehicle Accidents □ none _____
_____
Work Injuries □ none _____
Injuries, Accidents, Falls or Traumas □ none_____
_____
Illnesses/Hospitalizations: □ none _____
_____

Eighties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor
Academics	□	□	□	□	□ _____
Exercise Level	□	□	□	□	□ _____
Emotional	□	□	□	□	□ _____
Dietary Habits	□	□	□	□	□ _____
Overall Health	□	□	□	□	□ _____

Did you have any of the following:

Motor Vehicle Accidents □ none _____
_____
Work Injuries □ none _____
Injuries, Accidents, Falls or Traumas □ none_____
_____
Illnesses/Hospitalizations: □ none _____
_____

Nineties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	☐	☐	☐	☐	☐	_____
Exercise Level	☐	☐	☐	☐	☐	_____
Emotional	☐	☐	☐	☐	☐	_____
Dietary Habits	☐	☐	☐	☐	☐	_____
Overall Health	☐	☐	☐	☐	☐	_____

Did you have any of the following:

Motor Vehicle Accidents ☐ none _____
_____
Work Injuries ☐ none _____
Injuries, Accidents, Falls or Traumas ☐ none_____
_____
Illnesses/Hospitalizations: ☐ none _____
_____

Family History

Mother □ Alive & Well, age___ □ Deceased age ___ from what? _____
Any health conditions _____

Father □ Alive & Well, age___ □ Deceased age ___ from what?_____
Any health conditions _____

Brother □ Alive & Well, age___ □ Deceased age ___ from what? _____
Any health conditions _____

Brother □ Alive & Well, age___ □ Deceased age ___ from what? _____
Any health conditions_____

Sister □ Alive & Well, age___ □ Deceased age ___ from what?_____
Any health conditions _____

Sister □ Alive & Well, age___ □ Deceased age ___ from what? _____
Any health conditions _____

Children: Ages _____ Any health conditions?_____
_____

Maternal Grandmother □ A&W □ Deceased age ___ from what?_____
Any health conditions _____

Maternal Grandfather □ A&W □ Deceased age ___ from what?_____
Any health conditions _____

Paternal Grandmother □ A&W □ Deceased age ___ from what?_____
Any health conditions _____

Paternal Grandfather □ A&W □ Deceased age ___ from what?_____
Any health conditions _____

Have any of your family members ever suffered from any of the following conditions?

□ Diabetes □ Neurological Disorders _____ □ Depression/Mental Illness
□ Heart Disease □ Autoimmune Diseases _____ □ Stroke
□ Cancer _____ □ Other_____

Medications Please list your current medications and the condition they are treating.
_____
_____
_____
_____

Vitamins and Minerals Please list your current supplements and who prescribed them.
_____
_____
_____
_____

Habits

Cigarettes □ none How many per week? _____ **Cigars** □ none How many per week? _____
Alcohol □ none How many drinks per week? _____ Type of alcohol_____
Coffee □ none How many cups per week? _____
Recreational Drugs □ none Types _____ Frequency _____Years of Usage _____
Exercise □ none Hours/Days per week _____ Types_____
Water □ none Glasses per day_____
Soft Drinks □ none Amount per week _____ Types _____
Sleep Average per night _____ Do you have difficulty falling asleep or staying asleep? □ Yes □ No
Hours desired per night? _____
Meals per days _____ What type of foods do you eat? _____
Do you consider your diet healthy? □ Yes □ No _____

DATE OF LAST

Physical Examination: _____ By Whom? _____ Results _____
Blood Work:_____ By Whom? _____ Results _____
Bone Density Study _____ Results _____ **Mammogram**_____Results_____
Pelvic Exam _____ Results _____**Self Breast Exam** _____Regularity _____
PSA level _____ Results _____ **Digital Prostate Examination** _____ Results _____
Chest X-rays _____ Results _____ **EKG** _____ Results _____
Echocardiogram_____Results_____
Spinal X-rays _____ By Whom? _____Where are they located? _____
MRI / CAT Scan _____ Re_____ Where are they located? _____
Other tests: _____

CHECK any of the following conditions you have HAD and CIRCLE anything you currently HAVE.

□ Mental Disorders □ Diabetes □ Pneumonia □ Infective Diseases___
□ Epilepsy □ Anemia □ Tuberculosis □ Fungal Infection____
□ Tumors □ Glaucoma □ Hepatitis___ □ Herpes____
□ Alcoholism □ Heart Disease □ Thyroid Disease □ Arthritis
□ Drug Addiction □ Rheumatic Fever □ Parasites □ Autoimmune Disease
□ Cancer □ Scarlet Fever □ Venereal Infection □ _____

NERVOUS SYSTEM
□ Depression
□ Memory loss/Confusion
□ Dizziness
□ Fainting
□ Convulsions
□ Numbness
□ Weakness
□ Poor Balance/Coordination
Twitches/Tremor
□ Cold/Tingling Extremities
□ Sleeping Difficulties
□ Headaches

C-V
□ Chest Pain
□ Irregular Heartbeat
□ High Blood Pressure
□ Shortness of Breath
□ Lung Problems/Congestion
□ Varicose Veins
□ Ankle Swelling

GU
□ Discolored Urine
□ Bladder Trouble
□ Painful Urination
□ Excessive Urination
□ Incontinence

EENT
□ Vision Problems
□ Flashing Lights
□ Black Spots
□ Blurriness
□ Hearing Loss
□ Ringing in Ears
□ Swallowing Difficulty

GI

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Frequent Diarrhea
- ☐ Frequent Constipation
- ☐ Hemorrhoids
- ☐ Abdominal Cramping
- ☐ Black/Bloody Stools
- ☐ Heartburn
- ☐ Digestive Problems
- ☐ Weight Problems
- ☐ Gas/Bloating After Meals
- ☐ Gall Bladder Problems
- ☐ Liver Problems

MUSCULOSKELETAL

- ☐ Jaw Pain
- ☐ Difficulty Chewing
- ☐ Face Pain
- ☐ Neck Pain
- ☐ Arm/Elbow Pain
- ☐ Wrist/Hand Pain
- ☐ Mid Back Pain
- ☐ Lower Back Pain
- ☐ Thigh/Knee Pain
- ☐ Ankle/Foot Pain
- ☐ Difficulty Walking
- ☐ Leg/Arm Fatigue

REPRODUCTIVE

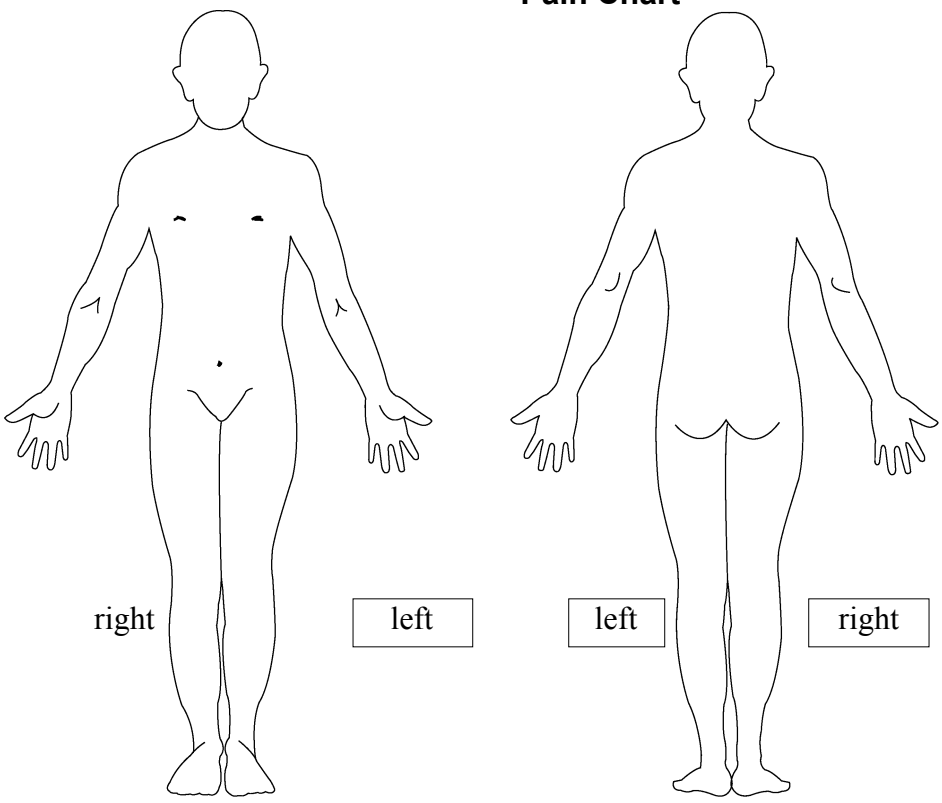
- ☐ Erectile Difficulties
- ☐ Sexual Dysfunction
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping

How often do you have a bowel movement? _____ Are your movements consistent? ☐ Yes ☐ No
Do your stools ☐ float or ☐ sink

How many times a day do you urinate? _____ Is this consistent? ☐ Yes ☐ No _____
Do you experience any urgency, dribbling, incontinence? _____

Show Area(s) of Pain or Unusual Feeling

Mark the areas on this body where you feel pain or unusual sensations. Include all affected areas.



Pain Chart

Neck-Shoulder-Arm-Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

Mid Back Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

Low Back and Leg Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
no pain **severe pain**

SYSTEMS SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date _____ Approximate Weight _____ Sex: Male ☐ Female ☐

Pulse: Recumbent _____ Standing _____ Vegetarian: Yes ☐ No ☐

Blood Pressure: Recumbent _____ Standing _____ Gallbladder Removed: ☐

INSTRUCTIONS: Fill in **only** the circles which apply to you. Leave circles **blank** if they don't apply to you! Some questions will repeat.

1 2 3
- ● ○ ○ **MILD** symptoms (occurs infrequently)
- ○ ● ○ **MODERATE** symptoms (occurs frequently)
- ○ ○ ● **SEVERE** symptoms (chronic, always present)

GROUP 1

1. Acid foods upset
2. Get chilled often
3. "Lump" in throat
4. Dry mouth-eyes-nose
5. Pulse speeds after meal
6. Keyed up - fail to calm
7. Cut heals slowly
8. Gag easily
9. Unable to relax; startles easily
10. Extremities cold, clammy
11. Strong light irritates
12. Urine amount reduced
13. Heart pounds after retiring
14. Nervous stomach
15. Appetite reduced
16. Cold sweats often
17. Fever easily raised
18. Neuralgia-like pains
19. Staring, blinks little
20. Sour stomach often

GROUP 2

21. Joint stiffness on arising
22. Muscle-leg-toe cramps at night
23. "Butterfly" stomach, cramps
24. Eyes or nose water
25. Eyes blink often
26. Eyelids swollen, puffy
27. Indigestion soon after meals
28. Always seems hungry; feels "lightheaded" often
29. Digestion rapid
30. Vomiting frequent
31. Hoarsenss frequent
32. Breathing irregular
33. Pulse slow; feels "irregular"
34. Gagging reflex slow
35. Difficulty swallowing
36. Constipation, diarrhea alternating
37. "Slow starter"
38. Get "chilled" infrequently
39. Perspire easily
40. Circulation poor, sensitive to cold
41. Subject to colds, asthma, bronchitis

GROUP 3

42. Eat when nervous
43. Excessive appetite
44. Hungry between meals
45. Irritable before meals
46. Get "shaky" before meals
47. Fatigue, eating relieves
48. "Lightheaded" if meals delayed
49. Heart palpitates if meals missed or delayed
50. Afternoon headaches
51. Overeating sweets upsets
52. Awaken after few hours sleep - hard to go back to sleep
53. Crave candy or coffee in afternoons
54. Moods of depression - "blues" or melancholy
55. Abnormal craving for sweets or snacks

GROUP 4

56. Hands and feet go to sleep easily, numbness
57. Sigh frequently, "air hunger"
58. Aware of "breathing heavily"
59. High altitude discomfort
60. Opens windows in closed rooms
61. Susceptible to colds and fevers
62. Afternoon "yawner"
63. Get "drowsy" often
64. Swollen ankles, worse at night
65. Muscle cramps, worse during excercise: get "charley horses"
66. Shortness of breath on exertion
67. Dull pain in chest or radiating into left arm, worse on exertion
68. Bruise easily, "black and blue" spots
69. Tendency to anemia
70. "Nose bleeds" frequent
71. Noises in head, or "ringing in ears"
72. Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

73. Dizziness
74. Dry skin
75. Burning feet
76. Blurred vision
77. Itching skin and feet
78. Excessive falling hair
79. Frequent skin rashes
80. Bitter, metallic taste in mouth in mornings
81. Bowel movements painful or difficult
82. Worrier, feels insecure
83. Feeling queasy; headache over eyes
84. Greasy foods upset
85. Stools light colored
86. Skin peels on foot soles
87. Pain between shoulder blades
88. Use laxatives
89. Stools alternate from soft to watery
90. History of gallbladder attacks or gallstones
91. Sneezing attacks
92. Dreaming, nightmare type bad dreams
93. Bad breath (halitosis)
94. Milk products cause distress
95. Sensitive to hot weather
96. Burning or itching anus
97. Crave sweets

GROUP 6

98. Loss of taste for meat
99. Lower bowel gas several hours after eating
100. Burning stomach sensations, eating relieves
101. Coated tongue
102. Pass large amounts of foul-smelling gas
103. Indigestion 1/2-1 hour after eating; may be up to 3-4 hours
104. Mucous colitis or irritable bowel
105. Gas shortly after eating
106. Stomach "bloating" after eating

1 2 3 **GROUP 7A**

107. Insomnia
108. Nervousness
109. Can't gain weight
110. Intolerance to heat
111. Highly emotional
112. Flush easily
113. Night sweats
114. Thin, moist skin
115. Inward trembling
116. Heart palpitates
117. Increased appetite without weight gain
118. Pulse fast at rest
119. Eyelids and face twitch
120. Irritable and restless
121. Can't work under pressure

GROUP 7B

122. Increase in weight
123. Decrease in appetite
124. Fatigue easily
125. Ringing in ears
126. Sleepy during day
127. Sensitive to cold
128. Dry or scaly skin
129. Constipation
130. Mental sluggishness
131. Hair coarse, falls out
132. Headaches upon arising, wear off during day
133. Slow pulse, below 65
134. Frequency of urination
135. Impaired hearing
136. Reduced initiative

GROUP 7C

137. Failing memory
138. Low blood pressure
139. Increased sex drive
140. Headaches, "splitting or rending" type
141. Decreased sugar tolerance

GROUP 7D

142. Abnormal thirst
143. Bloating of abdomen
144. Weight gain around hips or waist
145. Sex drive reduced or lacking
146. Tendency to ulcers, colitis
147. Increased sugar tolerance
148. Women: menstrual disorders
149. Young girls: lack of menstrual function

GROUP 7E

150. Dizziness
151. Headaches
152. Hot flashes
153. Increased blood pressure
154. Hair growth on face or body (female)
155. Sugar in urine (not diabetes)
156. Masculine tendencies (female)

GROUP 7F

157. Weakness, dizziness
158. Chronic fatigue
159. Low blood pressure
160. Nails weak, ridged
161. Tendency to hives
162. Arthritic tendencies
163. Perspiration increased
164. Bowel disorders
165. Poor circulation
166. Swollen ankles
167. Crave salt
168. Brown spots or bronzing of skin
169. Allergies - tendency to asthma

1 2 3

170. Weakness after colds, influenza
171. Exhaustion - muscular and nervous
172. Respiratory disorders

GROUP 8

173. Muscle weakness
174. Lack of stamina
175. Drowsiness after eating
176. Muscular soreness
177. Rapid heartbeat
178. Hyper-irritable
179. Feeling of a band around your head
180. Melancholia (feeling of sadness)
181. Swelling of ankles
182. Diminished urination
183. Tendency to consume sweets or carbohydrates
184. Muscle spasms
185. Blurred vision
186. Loss of muscular control
187. Numbness
188. Night sweats
189. Rapid digestion
190. Sensitivity to noise
191. Redness of palms of hands and bottom of feet
192. Visible veins on chest and abdomen
193. Hemorrhoids
194. Apprehension (feeling that something bad will happen
195. Nervousness causing loss of appetite
196. Nervousness with indigestion
197. Gastritis
198. Forgetfulness
199. Thinning hair

FEMALE ONLY

200. Very easily fatigued
201. Premenstrual tension
202. Painful menses
203. Depressed feelings before menstruation
204. Menstruation excessive and prolonged
205. Painful breasts
206. Menstruate too frequently
207. Vaginal discharge
208. Hysterectomy / ovaries removed (circle: yes / no)
209. Menopausal hot flashes
210. Menses scanty or missed
211. Acne, worse at menses
212. Depression of long standing

MALE ONLY

213. Prostate trouble
214. Urination difficult or dribbling
215. Night urination frequent
216. Depression
217. Pain on inside of legs or heels
218. Feeling of incomplete bowel evacuation
219. Lack of energy
220. Migrating aches and pains
221. Tire too easily
222. Avoids activity
223. Leg nervousness at night
224. Diminished sex drive

IMPORTANT: List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____