CLIENT INTAKE FORM

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INTEGRATIVE health COACHING

Thank you for taking the time to fill out this form and provide us with details of your health, goals and medical history. Feel free to save this form to your computer and type in your answers at your convenience. The boxes where you type your responses will expand to accommodate your text, so you will have as much space as you need.

Client Information

Name _____

Address _____

City _____

State _____ Zip Code _____

Phone (day) _____

Phone (cell) _____

Phone (night) _____

Email _____

Referred by _____

Statistics

Age _____

Birth Date _____

Gender at birth _____ Chosen gender _____

Height _____

Blood type _____

Current weight _____

Ideal weight _____

Weight one year ago _____

Birth Weight (if known) _____

Birth Order (please list ages of biological siblings) _____

_____

Family/Living Situation _____

_____

Partner's gender at birth _____

Partner's chosen gender _____

Children: _____

_____

Occupation: _____

_____

Exercise/Recreation: _____

_____

History

1. Have you lived or traveled outside of the United States? If so, when and where?:

2. Have you or your family recently experienced any major life changes? If so, please comment:

3. How much time have you had to take off from work or school in the last year?

   - ☐ 0 to 2 days
   - ☐ 3 to 14 days
   - ☐ more than 15 days

Stressful Life Events

Studies show that past and continued trauma play a significant role in health and health outcomes. Our understanding of your history will help us to best support you moving forward.

4. Have you experienced one or more of these stressful life events or traumas in your life?

Death of a family member, romantic partner or very close friend because of accident, homicide, or suicide	☐ yes	☐ no
Sexual or physical abuse by a family member, romantic partner, stranger, or someone else	☐ yes	☐ no
Emotional neglect or abuse such as ridicule, bullying, put downs, being ignored or told you were no good by a family member or romantic partner	☐ yes	☐ no
Discrimination	☐ yes	☐ no
Life-threatening accident or situation (military combat or lived in a war zone)	☐ yes	☐ no
Life-threatening illness	☐ yes	☐ no
Physical force or weapon threatened or used against you in a robbery or mugging	☐ yes	☐ no
Witness the murder, serious injury or assault of another person	☐ yes	☐ no

5. Is there anything else that you'd like to share about these stressful life events or traumas?

Health Concerns

6. What are your main health concerns? (Describe in detail, including the severity of the symptoms):

7. When did you first experience these concerns?

8. How have you dealt with these concerns in the past?

   - ☐ doctors
   - ☐ self-care

9. Have you experienced any success with these approaches?

10. What other health practitioners are you currently seeing? List name, specialty and phone # below.

11. Please list the date and description of any surgical procedures you have had (including breast reduction or augmentation).

12. How often did you take antibiotics in infancy/childhood?

13. How often have you taken antibiotics as a teen?

14. How often have you taken antibiotics as an adult?

15. List any medicine you are currently taking:

16. List all vitamins, minerals, herbs and nutritional supplements you are now taking:

17. Have any other family members had similar problems (describe)?

Nutritional Status

18. Are there any foods that you avoid because of the way they make you feel?
    If yes, please name the food and the symptom:

19. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives?
    If so, please explain:

20. Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

21. Are there foods that you crave? If so, please explain:

22. Describe your diet at the onset of your health concerns:

23. Do you have any known food allergies or sensitivities?

24. Which of the following foods do you consume regularly?

- ☐ soda
- ☐ diet soda
- ☐ refined sugar
- ☐ alcohol
- ☐ fast food
- ☐ gluten (wheat, rye, barley)
- ☐ dairy (milk, cheese, yogurt)
- ☐ coffee

25. Are you currently on a special diet?

- ☐ autoimmune paleo (AIP)
- ☐ SCD/GAPS
- ☐ dairy restricted or dairy-free
- ☐ vegetarian
- ☐ vegan
- ☐ paleo
- ☐ blood type
- ☐ raw
- ☐ refined sugar-free
- ☐ gluten-free
- ☐ ketogenic diet
- ☐ Other (please describe)

26. What percentage of your meals are home-cooked?

☐ 10	☐ 30	☐ 50	☐ 70	☐ 90
☐ 20	☐ 40	☐ 60	☐ 80	☐ 100

27. Is there anything else we should know about your current diet, history or relationship to food?

Intestinal Status

28. Bowel Movement Frequency

- ☐ 1–3 times per day
- ☐ more than 3 times per day
- ☐ not regularly every day

29. Bowel Movement Consistency

- ❑ soft & well formed
- ❑ often float
- ❑ difficult to pass
- ❑ diarrhea
- ❑ thin, long or narrow
- ❑ small and hard
- ❑ loose but not watery
- ❑ alternating between hard and loose

30. Bowel Movement Color

- ❑ medium brown
- ❑ very dark or black
- ❑ greenish
- ❑ blood is visible
- ❑ variable
- ❑ yellow, light brown
- ❑ chalky colored
- ❑ greasy, shiny

31. Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc:

32. Have you ever had food poisoning? If yes, please describe in detail, including 1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it:

Medical Status

33. Please identify any current or past conditions and add a date for when the condition appeared. In the space below each list, please briefly describe your symptoms, chosen treatment(s), and dates.

Gastrointestinal

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Irritable Bowel Syndrome	☐	☐	_____	Gut infections
☐	☐	_____	Crohn's	☐	☐	_____	Dysbiosis
☐	☐	_____	Ulcertative Colitis	☐	☐	_____	Leaky gut
☐	☐	_____	Gastritis or Peptic Ulcer Disease	☐	☐	_____	Food allergies, intolerances or reactions
☐	☐	_____	GERD (reflux or heartburn)	☐	☐	_____	Gallstones
☐	☐	_____	Celiac Disease	☐	☐	_____	Known absorption or assimilation issues
☐	☐	_____	SIBO	☐	☐	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Cardiovascular

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Heart attack	☐	☐	_____	Hypertension (high blood pressure)
☐	☐	_____	Heart Disease	☐	☐	_____	Rheumatic Fever
☐	☐	_____	Stroke	☐	☐	_____	Mitral Valve Prolapse
☐	☐	_____	Elevated cholesterol	☐	☐	_____	Other
☐	☐	_____	Arrhythmia (irregular heartbeat)				

Please briefly describe your symptoms, chosen treatment(s) and dates:

Hormones/Metabolic

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Type 1 Diabetes	☐	☐	_____	Endocrine problems
☐	☐	_____	Type 2 Diabetes	☐	☐	_____	Polycystic Ovarian Syndrome (PCOS)
☐	☐	_____	Hypoglycemia	☐	☐	_____	Infertility
☐	☐	_____	Metabolic Syndrome	☐	☐	_____	Weight gain
☐	☐	_____	Insulin Resistance or Pre-Diabetes	☐	☐	_____	Weight loss
☐	☐	_____	Hypothyroidism (low thyroid)	☐	☐	_____	Frequent weight fluctuations
☐	☐	_____	Hyperthyroidism (overactive thyroid)	☐	☐	_____	Eating disorder
☐	☐	_____	Hashimoto's (autoimmune hypothyroid)	☐	☐	_____	Menopause difficulties
☐	☐	_____	Grave's Disease (autoimmune hyperthyroid)	☐	☐	_____	Hair loss
				☐	☐	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Cancer

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Lung Cancer	☐	☐	_____	Prostate Cancer
☐	☐	_____	Breast Cancer	☐	☐	_____	Skin Cancer (Melanoma)
☐	☐	_____	Colon Cancer			_____	Skin Cancer (Squamous, Basal)
☐	☐	_____	Ovarian Cancer			_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Genital & Urinary Systems

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Kidney Stones	☐	☐	_____	Interstitial Cystitis
☐	☐	_____	Gout	☐	☐	_____	Frequent urinary tract infections

☐	☐	_____	Erectile Dysfunction or Sexual Dysfunction	☐	☐	_____	Frequent Yeast Infections
				☐	☐	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Musculoskeletal/Pain

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Osteoarthritis	☐	☐	_____	Sore muscles or joints, undiagnosed
☐	☐	_____	Fibromyalgia				
☐	☐	_____	Chronic Pain	☐	☐	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Immune/Inflammatory

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Chronic Fatigue Syndrome	☐	☐	_____	Environmental allergies
☐	☐	_____	Rheumatoid Arthritis	☐	☐	_____	Multiple chemical sensitivities
☐	☐	_____	Lupus SLE	☐	☐	_____	Latex allergy
☐	☐	_____	Raynaud's	☐	☐	_____	Hepatitis
☐	☐	_____	Psoriasis			_____	Lyme (and co-infections)
☐	☐	_____	Mixed Connetive Tissue Disease (MCTD)	☐	☐	_____	Chronic Infections (Epstein-Barr, Cytomegalo-virus, Herpes, etc.)
☐	☐	_____	Poor immune function (frequent infections)	☐	☐	_____	Other
☐	☐	_____	Food allergies				

Please briefly describe your symptoms, chosen treatment(s) and dates:

Respiratory Conditions

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Asthma	☐	☐	_____	Sleep Apnea
☐	☐	_____	Chronic Sinusitis	☐	☐	_____	Frequent or recurrent Colds/Flus
☐	☐	_____	Bronchitis				
☐	☐	_____	Emphysema	☐	☐	_____	Other
☐	☐	_____	Pneumonia				

Please briefly describe your symptoms, chosen treatment(s) and dates:

Skin Conditions

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Eczema	☐	☐	_____	Acne
☐	☐	_____	Psoriasis	☐	☐	_____	Skin Cancer (Melanoma)
☐	☐	_____	Dermatitis	☐	☐	_____	Skin Cancer (Squamous, Basal)
☐	☐	_____	Hives				
☐	☐	_____	Rash, undiagnosed	☐	☐	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Neurologic/Mood

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Depression	☐	☐	_____	Mild Cognitive Impairment
☐	☐	_____	Anxiety	☐	☐	_____	Memory problems
☐	☐	_____	Bipolar Disorder	☐	☐	_____	Parkinson's Disease
☐	☐	_____	Schizophrenia	☐	☐	_____	Multiple Sclerosis
☐	☐	_____	Headaches	☐	☐	_____	ALS
☐	☐	_____	Migraines	☐	☐	_____	Seizures
☐	☐	_____	ADD/ADHD	☐	☐	_____	Alzheimer's
☐	☐	_____	Autism	☐	☐	_____	Concussion/Traumatic Brain Injury

☐ ☐ _____ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Miscellaneous

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Anemia	☐	☐	_____	Mumps
☐	☐	_____	Chicken Pox	☐	☐	_____	Whooping Cough
☐	☐	_____	German Measles	☐	☐	_____	Tuberculosis
☐	☐	_____	Measles	☐	☐	_____	Known genetic variants (SNPs, polymorphisms, etc)
☐	☐	_____	Mononucleosis	☐	☐	_____	Other

34. Please check frequency of the following:

Short term memory impairment	☐ yes	☐ no	☐ sometimes
Shortened focus of attention and ability to concentrate	☐ yes	☐ no	☐ sometimes
Coordination and balance problems	☐ yes	☐ no	☐ sometimes
Problems with lack of inhibition	☐ yes	☐ no	☐ sometimes
Poor organization abilities	☐ yes	☐ no	☐ sometimes
Problems with time management (late or forget appts)	☐ yes	☐ no	☐ sometimes
Mood instability	☐ yes	☐ no	☐ sometimes
Difficulty understanding speech and word finding	☐ yes	☐ no	☐ sometimes
Brain fog, brain fatigue	☐ yes	☐ no	☐ sometimes
Lower effectiveness at work, home or school	☐ yes	☐ no	☐ sometimes
Judgment problems like leaving the stove on, etc	☐ yes	☐ no	☐ sometimes

Health Hazards

35. Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

36. Do odors affect you?

37. Are you or have you been exposed to second-hand smoke?

38. Are you currently or have you been exposed to mold? (If so, what is/was the source of the exposure and for how long have you been/were you exposed to mold, if known?)

Oral Health History

39. How long since you last visited the dentist? What was the reason for that visit?

40. In the past 12 months has a dentist or hygienist talked to you about your oral health, blood sugar or other health concerns? (Explain.)

41. What is your current oral and dental regimen? (Please note whether this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)

42. Do you have any mercury amalgams? (If no, were they removed? If so, how?)

43. Have you had any root canals? (If yes, how many and when?)

44. Do you have any concerns about your oral or dental health? (gums bleed after flossing, receding gums)

45. Is there anything else about your current oral or dental health or health history that you'd like us to know?

Lifestyle History

46. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time.

47. Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

48. How do you handle stress?

Sleep History

49. Are you satisfied with your sleep?

50. Do you stay awake all day without dozing?

51. Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

52. Do you fall asleep in less than 30 minutes?

53. Do you sleep between 6 and 8 hours per night?

For Women Only

54. How old were you when you first got your period?

55. How are/were your menses? Do/did you have PMS? Painful periods? If so, explain.

56. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

57. Have you experienced any yeast infections or urinary tract infections? Are they regular?

58. Have you/do you still take birth control pills: If so, please list length of time and type.

59. Have you had any problems with conception or pregnancy?

60. Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

Sexual History

61. Do you have any concerns or issues with your sexual functioning that you'd like to share with us (pain with intercourse, dryness, libido issues, erectile dysfunction)?

62. In the past year, have your sexual partners been men, women, or both? And how many partners have you had in the past year?

Mental Health Status

63. How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

64. On a scale of 1–10, one being the worst and 10 being the best, describe your usual level of energy.

65. At what point in your life did you feel best? Why?

Other

66. What role do you play in your wellness plan?

67. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

68. Who in you family or on your health care team will be most supportive of you making dietary change?

69. Please describe any other information you think would be useful in helping to address your health concern(s):

70. What are your health goals and aspirations?

71. Though it may seem odd, please consider why you might want to achieve that for yourself:

FxNA sleep assessment

SLEEP HISTORY

While "sleep troubles" are often lumped together as one singular symptom, the reasons leading to your inability to catch those nightly Zzzzs can be varied. Help us to target our recommendations to your unique needs by taking a moment to answer these key sleep questions and assessments.

1. Are you satisfied with your sleep?

2. Do you feel rested in the morning?

3. Do you stay awake all day without dozing?

4. Do you fall asleep in less than 30 minutes?

5. Do you sleep between 6 and 8 hours per night?

6. Do you have a regular bedtime? (If so, when?)

7. Do you have a regular awakening time? (If so, when?)

8. Do you wake in the middle of the night? (If so, is there a regular waking time and how long are you awake?)

9. Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

10. Do you currently have any practices that enhance the quality of your sleep?

11. What have you tried (habits, supplements, etc.) to remedy sleep troubles in the past?

12. What (if any) electronics are in your room at nighttime?

13. On a scale of 1–10, how dark is your bedroom?

14. Do you consume any stimulants during the day? If so, when?

15. Please identify how you would most generally categorize your sleep troubles: MIND (racing, working, etc.), BODY (pain, discomfort, etc.), or SPIRIT (depression, anxiety, etc.).

SLEEP SYMPTOMS SCALE

Rate how often you experience each of the following symptoms using the following frequency scale: *0 = never 1 = monthly 2 = weekly 3 = daily*

	0	1	2	3
Daytime sleepiness	●	○	○	○
No dream recall	●	○	○	○
Sleepwalking	●	○	○	○
Nightmares	●	○	○	○
Snoring	●	○	○	○
Sleep apnea	●	○	○	○

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SYMPTOM TRACKER

Rate how often you experience each of the following symptoms using the following frequency scale:

0 = never 1 = monthly 2 = weekly 3 = daily

GENERAL

0	1	2	3		0	1	2	3	
●	○	○	○	Fever	●	○	○	○	Excessive sweating
●	○	○	○	Chills/Cold all over	●	○	○	○	Heat intolerance
●	○	○	○	Cold intolerance	●	○	○	○	Swollen glands
●	○	○	○	Aches/Pains	●	○	○	○	Cold hands & feet
●	○	○	○	General weakness	●	○	○	○	Low blood pressure
●	○	○	○	Difficulty sweating	●	○	○	○	Distorted vision

EARS

0	1	2	3		0	1	2	3	
●	○	○	○	Aches	●	○	○	○	Itching
●	○	○	○	Discharge	●	○	○	○	Pressure
●	○	○	○	Pains	●	○	○	○	Frequent infections
●	○	○	○	Ringing	●	○	○	○	Tubes in ears
●	○	○	○	Deafness/Hearing loss	●	○	○	○	Sensitive to loud noises
●	○	○	○	Feeling of fullness	●	○	○	○	Hearing hallucinations

THROAT

0	1	2	3		0	1	2	3	
●	○	○	○	Mucus	●	○	○	○	Enlarged glands
●	○	○	○	Difficulty swallowing	●	○	○	○	Constant clearing of throat
●	○	○	○	Frequent hoarseness	●	○	○	○	Throat closes up
●	○	○	○	Tonsillitis					

FREQUENCY SCALE
0 = never 1 = monthly 2 = weekly 3 = daily

HEAD

0	1	2	3	
●	○	○	○	Headaches after meals
●	○	○	○	Headaches if meals skipped
●	○	○	○	Headaches severe
●	○	○	○	Headaches migraine
●	○	○	○	Headaches frontal
●	○	○	○	Occipital (back of head) aches

0	1	2	3	
●	○	○	○	Piercing headaches
●	○	○	○	Afternoon headaches
●	○	○	○	Daytime headaches
●	○	○	○	Headaches relieved by eating sweets
●	○	○	○	Face twitch or ticks

EYES

0	1	2	3	
●	○	○	○	Feeling of sand in eyes
●	○	○	○	Double vision
●	○	○	○	Blurred vision
●	○	○	○	Poor night vision
●	○	○	○	See bright flashes
●	○	○	○	Halo around lights
●	○	○	○	Eye pains

0	1	2	3	
●	○	○	○	Floaters in eyes
●	○	○	○	Puffiness under eyes
●	○	○	○	Strong light irritates
●	○	○	○	Cataracts
●	○	○	○	Visual hallucinations
●	○	○	○	Conjunctivitis
●	○	○	○	Eye crusting

NECK

0	1	2	3	
●	○	○	○	Stuffy
●	○	○	○	Stiffness
●	○	○	○	Swelling

0	1	2	3	
●	○	○	○	Lumps
●	○	○	○	Neck glands swell

FREQUENCY SCALE

0 = never 1 = monthly 2 = weekly 3 = daily

SKIN/HAIR/NAILS

0	1	2	3	
◉	○	○	○	Cuts heal slowly
◉	○	○	○	Bruise easily
◉	○	○	○	Rashes
◉	○	○	○	Pigmentation
◉	○	○	○	Changing moles
◉	○	○	○	Calluses
◉	○	○	○	Eczema
◉	○	○	○	Psoriasis
◉	○	○	○	Dryness/cracking skin
◉	○	○	○	Oiliness
◉	○	○	○	Itching
◉	○	○	○	Acne
◉	○	○	○	Boils
◉	○	○	○	Hives
◉	○	○	○	Fungus on nails
◉	○	○	○	Hair loss
◉	○	○	○	Peeling skin

0	1	2	3	
◉	○	○	○	Shingles
◉	○	○	○	Nails split
◉	○	○	○	Fingernails chip, break or peel
◉	○	○	○	White spots/Lines on nails
◉	○	○	○	Crawling sensation
◉	○	○	○	Burning on bottom of feet
◉	○	○	○	Athletes foot
◉	○	○	○	Cellulite
◉	○	○	○	Circles under eyes
◉	○	○	○	Bugs love to bite you

Is your skin sensitive to:

◉	○	○	○	Sun?
◉	○	○	○	Fabrics?
◉	○	○	○	Detergents?
◉	○	○	○	Lotions & creams?

FREQUENCY SCALE

0 = never 1 = monthly 2 = weekly 3 = daily

NOSE/SINUSES

0	1	2	3	
●	○	○	○	Stuffy
●	○	○	○	Bleeding
●	○	○	○	Running/Discharge
●	○	○	○	Watery nose
●	○	○	○	Congested
●	○	○	○	Infection
●	○	○	○	Polyps
●	○	○	○	Acute smell
●	○	○	○	Drainage

0	1	2	3	
●	○	○	○	Sneezing spells
●	○	○	○	Post nasal drip
●	○	○	○	No sense of smell
●	○	○	○	Change of seasons tend to make your symptoms worse

If yes, is it worse in the:

●	○	○	○	Spring?
●	○	○	○	Summer?
●	○	○	○	Fall?
●	○	○	○	Winter?

MOUTH

0	1	2	3	
●	○	○	○	Coated tongue
●	○	○	○	Sore tongue
●	○	○	○	Dental problems
●	○	○	○	Bleeding gums
●	○	○	○	Canker sores
●	○	○	○	TMJ
●	○	○	○	Cracked lips/corners

0	1	2	3	
●	○	○	○	Chapped lips
●	○	○	○	Fever blisters
●	○	○	○	Wear dentures
●	○	○	○	Grind teeth when sleeping
●	○	○	○	Bad breath
●	○	○	○	Dry mouth

FREQUENCY SCALE
0 = never 1 = monthly 2 = weekly 3 = daily

CIRCULATION/RESPIRATION

0	1	2	3	
◉	○	○	○	Swollen ankles
◉	○	○	○	Sensitive to hot
◉	○	○	○	Sensitive to cold
◉	○	○	○	Extremities cold or clammy
◉	○	○	○	Hands/Feet go to sleep/ numbness/tingling
◉	○	○	○	High Blood Pressure
◉	○	○	○	Chest pain
◉	○	○	○	Pain between shoulders
◉	○	○	○	Dizziness upon standing
◉	○	○	○	Fainting spells
◉	○	○	○	High cholesterol
◉	○	○	○	High triglycerides
◉	○	○	○	Wheezing
◉	○	○	○	Irregular heartbeat
◉	○	○	○	Palpitations
◉	○	○	○	Low exercise tolerance
◉	○	○	○	Frequent coughs
◉	○	○	○	Breathing heavily

0	1	2	3	
◉	○	○	○	Frequently sighing
◉	○	○	○	Shortness of breath
◉	○	○	○	Night sweats
◉	○	○	○	Varicose veins/spider veins
◉	○	○	○	Mitral valve prolapse
◉	○	○	○	Murmurs
◉	○	○	○	Skipped heartbeat
◉	○	○	○	Heart enlargement
◉	○	○	○	Angina pain
◉	○	○	○	Bronchitis/Pneumonia
◉	○	○	○	Emphysema
◉	○	○	○	Croup
◉	○	○	○	Frequent colds
◉	○	○	○	Heavy/tight chest
◉	○	○	○	Phlebitis

FREQUENCY SCALE
0 = never 1 = monthly 2 = weekly 3 = daily

GASTROINTESTINAL

0	1	2	3		0	1	2	3	
◉	○	○	○	Peptic/Duodenal Ulcer	◉	○	○	○	Diarrhea
◉	○	○	○	Poor appetite	◉	○	○	○	Constipation
◉	○	○	○	Excessive appetite	◉	○	○	○	Changes in bowels
◉	○	○	○	Gallstones	◉	○	○	○	Rectal bleeding
◉	○	○	○	Gallbladder pain	◉	○	○	○	Tar-like stools
◉	○	○	○	Liver pain	◉	○	○	○	Rectal itching
◉	○	○	○	Nervous stomach	◉	○	○	○	Bloating
◉	○	○	○	Full feeling after small meal	◉	○	○	○	Belch frequently
◉	○	○	○	Indigestion	◉	○	○	○	Anal itching
◉	○	○	○	Heartburn	◉	○	○	○	Anal fissures
◉	○	○	○	Acid Reflux	◉	○	○	○	Bloody stools
◉	○	○	○	Hiatal Hernia	◉	○	○	○	Pale yellow/tan/gray stools
◉	○	○	○	Nausea	◉	○	○	○	Green stools
◉	○	○	○	Vomiting	◉	○	○	○	Mucus in stool
◉	○	○	○	Vomiting blood	◉	○	○	○	Undigested food in stools
◉	○	○	○	Abdominal Pains/Cramps	◉	○	○	○	Bad breath
◉	○	○	○	Loss of taste for meat	◉	○	○	○	Stomach upset taking vitamins
◉	○	○	○	Feeling of incomplete bowel evacuation	◉	○	○	○	Anemia unresponsive to iron
◉	○	○	○	Gas					

FREQUENCY SCALE

0 = never 1 = monthly 2 = weekly 3 = daily

KIDNEY/URINARY TRACT

0	1	2	3	
◉	○	○	○	Burning
◉	○	○	○	Frequent urination
◉	○	○	○	Blood in urine
◉	○	○	○	Night time urination
◉	○	○	○	Problem passing urine
◉	○	○	○	Kidney pain
◉	○	○	○	Kidney stones

0	1	2	3	
◉	○	○	○	Painful urination
◉	○	○	○	Bladder infections
◉	○	○	○	Kidney infections
◉	○	○	○	Bedwetting
◉	○	○	○	Pain in mid back region
◉	○	○	○	Incontinence or loss of bladder control

JOINTS/MUSCLES/TENDONS

0	1	2	3	
◉	○	○	○	Pain wakes you
◉	○	○	○	Muscle twitches
◉	○	○	○	Weakness in legs and arms
◉	○	○	○	Balance problems
◉	○	○	○	Muscle cramping
◉	○	○	○	Foot cramps
◉	○	○	○	Pain in tendons
◉	○	○	○	Joint issues

0	1	2	3	
◉	○	○	○	Spasms
◉	○	○	○	Head injury
◉	○	○	○	Muscle stiffness in morning
◉	○	○	○	Damp weather bothers you
◉	○	○	○	Pain in mid back region
◉	○	○	○	Restless leg syndrome
◉	○	○	○	Considered clumsy

NERVOUS SYSTEM

0	1	2	3	
◉	○	○	○	Convulsions
◉	○	○	○	Dizziness
◉	○	○	○	Fainting spells
◉	○	○	○	Blackouts/amnesia

0	1	2	3	
◉	○	○	○	Forgetfulness

FREQUENCY SCALE
0 = never 1 = monthly 2 = weekly 3 = daily

MENTAL HEALTH

0	1	2	3	
◉	○	○	○	Poor memory
◉	○	○	○	Forgetfulness
◉	○	○	○	Indecisive
◉	○	○	○	Confusion
◉	○	○	○	Mental sluggishness
◉	○	○	○	Poor concentration
◉	○	○	○	Frequently keyed up and jittery
◉	○	○	○	Startled by sudden noises
◉	○	○	○	Anxiety/Feeling of panic
◉	○	○	○	Go to pieces easily
◉	○	○	○	Listless/groggy
◉	○	○	○	Withdrawn feeling/Feeling 'lost'
◉	○	○	○	Unable to concentrate/short attention span
◉	○	○	○	Unable to reason
◉	○	○	○	Tend to worry needlessly
◉	○	○	○	Considered a nervous person by others
◉	○	○	○	Unusual tension
◉	○	○	○	Frustration
◉	○	○	○	Emotional numbness

0	1	2	3	
◉	○	○	○	Often break out in cold sweats
◉	○	○	○	Profuse sweating
◉	○	○	○	Depressed
◉	○	○	○	Often awakened by frightening dreams
◉	○	○	○	Misunderstood by others
◉	○	○	○	Irritable
◉	○	○	○	Feeling of hostility/volatile or aggressive
◉	○	○	○	Fatigue
◉	○	○	○	Hyperactive
◉	○	○	○	Vision changes
◉	○	○	○	Unable to coordinate muscles
◉	○	○	○	Have difficulty falling asleep
◉	○	○	○	Have difficulty staying asleep
◉	○	○	○	Daytime sleepiness
◉	○	○	○	Workaholic
◉	○	○	○	Have had hallucinations
◉	○	○	○	Feel regular grief
◉	○	○	○	Feel regular joy
◉	○	○	○	Often feel relaxed

FREQUENCY SCALE

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SLEEP SYMPTOMS

0	1	2	3	
◉	○	○	○	Difficulty falling asleep
◉	○	○	○	Early waking
◉	○	○	○	Waking between 2:00 and 4:00 am
◉	○	○	○	Unable to fall back asleep after waking in the night
◉	○	○	○	Sleep 6 to 8 hours per night
◉	○	○	○	Wake up unrefreshed

0	1	2	3	
◉	○	○	○	Daytime sleepiness
◉	○	○	○	Fatigue
○	○	○	○	No dream recall
◉	○	○	○	Sleepwalker
○	○	○	○	Nightmares
○	○	○	○	Snoring
◉	○	○	○	Sleep apnea

MEN'S SYMPTOMS (MEN ONLY)

0	1	2	3	
◉	○	○	○	Prostate enlargement
◉	○	○	○	Prostate infection
◉	○	○	○	Change in libido
◉	○	○	○	Impotence
◉	○	○	○	Diminished/poor libido
◉	○	○	○	Infertility
◉	○	○	○	Lumps in testicles
◉	○	○	○	Sore on penis
◉	○	○	○	Genital pain
◉	○	○	○	Hernia

0	1	2	3	
◉	○	○	○	Low sperm count
◉	○	○	○	Difficulty obtaining erection
◉	○	○	○	Difficulty maintaining an erection
◉	○	○	○	Nocturia (urination at night)
◉	○	○	○	Urgency/Hesitancy/Change in
◉	○	○	○	Urinary Stream
◉	○	○	○	Loss of bladder control
◉	○	○	○	Pain on inside of legs or heels

FREQUENCY SCALE
0 = never 1 = monthly 2 = weekly 3 = daily

WOMEN'S SYMPTOMS (WOMEN ONLY)

0	1	2	3	
◉	○	○	○	Fibrocystic breasts
◉	○	○	○	Lumps in breast
◉	○	○	○	Fibroid Tumors in breasts
◉	○	○	○	Spotting
◉	○	○	○	Heavy periods
◉	○	○	○	Fibroid Tumors in uterus
◉	○	○	○	Painful periods
◉	○	○	○	Change in period
◉	○	○	○	Breast soreness before period
◉	○	○	○	Endometriosis
◉	○	○	○	Non-period bleeding
◉	○	○	○	Breast soreness during period
◉	○	○	○	Vaginal dryness
◉	○	○	○	Vaginal discharge
◉	○	○	○	Partial/total hysterectomy
◉	○	○	○	Depression during periods

0	1	2	3	
◉	○	○	○	Hot flashes
◉	○	○	○	Mood swings
◉	○	○	○	Concentration/Memory problems
◉	○	○	○	Ovarian cysts
◉	○	○	○	Pregnant
◉	○	○	○	Infertility
◉	○	○	○	Decreased libido
◉	○	○	○	Heavy bleeding
◉	○	○	○	Joint pains
◉	○	○	○	Headaches
◉	○	○	○	Weight gain
◉	○	○	○	Loss of bladder control
◉	○	○	○	Palpitations
◉	○	○	○	Thinning skin
◉	○	○	○	Pain during intercourse
◉	○	○	○	Food cravings