Dr. Kia VanDusen McCullen

Chiropractic, Nutrition, Natural Healing

PERSONAL HISTORY

Date ____________________

Name ______________________________ Address ______________________________

City ______________________________ State ____________________ Zip __________

Phone ________________ Birthday ____________ Age ____________ Sex ____________

Job ______________________ Type of work ______________________________

Marital Status ____________________________ Children ________________________

Emergency Contact ________________________________ Phone ________________

Referred to this office by ____

CURRENT HEALTH CONDITION

What is your major complaint? ____

Onset? ____

Events preceding onset ____

What makes it worse? ____

What do you do to decrease the pain? ____

Does the pain stay in one place or radiate? ____

Is the pain worse in morning, afternoon or night? ____

Is this getting worse? ____

Is it interfering with work? ________ Sleep? ________ Daily routine? ________ Other? ________

How long has it been since you really felt good? ____

List previous diagnoses and treatments ______________________________

____

What do you believe is wrong? ______________________________

Personal health goals ______________________________

Do you suffer from other conditions? ______________________________

____

To give a total over all picture of your health, your family's health history is important. Please describe any health problems of your mother, father, sister(s), brother(s), grandparents, aunts, uncles, children, spouse.

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MEDICAL HISTORY SYSTEMS REVIEW

If you **HAVE** the following mark **A.** If you **HAD** the following mark **B.**

Abcesses______ Acne______ Aids______ Alcoholic______ Allergies______ Alopecia_____
Anemia______ Attempted Suicide______ Arteriosclerosis_______ Back Problems______
Benign Breast Tumor______ Bleeding Gums______ Bronchitis______ Candida Albicans______
Cataracts______ Chest Pains______ Chicken Pox______ Chorea______ Cirrhosis______
Crohn's Disease______ Depression______ Diphtheria______ Diverticulosis______
Drug Addiction______ Ear Infections______ Eczema______ Emphysema______ Endometriosis______
Excessive Fatigue______ Eye Disease______ Fainting or Dizzy Spells______ Gall Stones______
Gastritis______ Giardiasis______ Gingivitis______ Goiter______ Gonorrhea______ Hay Fever______
Hearing Problems______ Hemorrhoids______ Hernia______ Herniated Disc______ Herpes______
High Blood Pressure______ Hives______ Influenza______ Insomnia______ Jaundice______
Kidney Stones______ Liver Disease______ Low Blood Pressure______ Lupus______
Major Surgery______ Malaria______ Measles_____ Mononucleosis______ Multiple Sclerosis______
Mumps______ Myopia______ Nervous Breakdown______ Nervousness______ Neuralgia______
Night Blindness______ Numbness______ Pancreatitis______ Parasites______ Persistent Cough______
Pneumonia______ Polio______ Psoriasis______ Rheumatic Fever______ Scarlet Fever______
Sciatica______ Skin Ulcers______ Skipped Heart Beats______ Small Pox______ Stroke______
Syphilis______ Thyroid Disease______ Typhoid Fever______ Tonsillitis______
Ulcerative Colitis______ Venereal Disease______ Vision Problems______ Whopping Cough______

Use the following to rate the intensity of the different conditions:

1= Never **2= Occasionally** **3=Always**

GENERAL SYMPTOMS

- ___704.0 Headache
- ___780.6 Fever
- ___780.9 Chills
- ___780.8 Night Sweats
- ___780.2 Fainting
- ___780.4 Dizziness
- ___780.3 Convulsions
- ___780.52 Loss of Sleep
- ___780.7 Fatigue
- ___799.2 Nervousness
- ___783 Loss of Weight
- ___782 Numbness or Pain in arms/legs/hands
- ___995.3 Allergy (What)
- ___786.09 Wheezing
- ___729.2 Neuralgia

GASTRO-INTESTINAL

- ___783 Poor Appetite
- ___536.8 Poor Digestion
- ___994.2 Excessive Hunger
- ___787.3 Belching or Gas
- ___787 Nausea
- ___787 Vomiting
- ___578 Vomiting Blood
- ___536.8 Pain Over Stomach
- ___564 Constipation
- ___558.9 Diarrhea
- ___789 Colon Trouble
- ___455.6 Hemorrhoids (Piles)
- ___785.1 Liver Trouble
- ___782.4 Jaundice
- ___575.9 Gall Bladder Trouble

EYE EAR NOSE THROAT

- ___368.9 Poor Vision
- ___378.9 Crossed Eyes
- ___379.91 Pain in Eyes
- ___389.9 Deafness
- ___388.70 Earache
- ___388.30 Ear Noises
- ___388.60 Ear Discharges
- ___478.1 Nasal Obstruction
- ___784.7 Nose Bleeds
- ___462 Sore Throat
- ___784.49 Hoarseness
- ___477.9 Hay Fever
- ___493.3 Asthma
- ___460 Frequent Colds
- ___240.9 Enlarged Thyroid
- ___463 Tonsillitis
- ___686.9 Sinus Trouble

RESPIRATORY

- ___786.2 Chronic Cough
- ___786.3 Spitting Blood
- ___933.1 Spitting Phlegm
- ___786.50 Chest Pain
- ___786.09 Difficulty Breathing

GENITO-URINARY

- ___788.3 Frequent Urination
- ___788.1 Painful Urination
- ___599.7 Blood in Urine
- ___592 Kidney Infection
- ___788.3 Bed Wetting
- ___788.1 Inability to Complete Urine
- ___501.9 Prostate Trouble

MUSCLES AND JOINTS

- ___ Weakness
- ___ Twitching
- ___847 Stiff Neck
- ___722.10 Backache
- ___719 Swollen Joints
- ___781 Tremors
- ___729.5 Foot Troubles
- ___724.79 Painful Tail Bone
- ___724.5 Pain Between Shoulders
- ___553.9 Hernia
- ___737.3 Spinal Curvature

CARDIO-VASCULAR

- ___783 Rapid Heart
- ___427.89 Slow Heart
- ___401.9 High Blood Pressure
- ___458.9 Low Blood Pressure
- ___786.51 Pain Over Heart
- ___438 Prev. Heart Trouble
- ___719.07 Swelling of Ankles
- Varicose Veins
- ___436 Strokes

SKIN OR ALLERGIES

- ___368.9 Skin Eruptions
- ___698.9 Itching
- ___287.8 Bruising Easily
- ___701.1 Dryness
- ___ Boils
- ___782 Sensitive Skin
- ___708.9 Hives or Allergy
- ___892.9 Eczema
- ___ Medicines

1= Never
2= Occasionally
3=Always

Circle any of the following medications you are taking:

- Antacids
- Antibiotic/Antifungal
- Antidepressants
- Antidiabetic/Insulin
- Aspirin/Tylenol
- Chemotherapy
- Cortisone/Anti-inflammatories
- High Blood Pressure
- Heart Medications
- Hormones
- Laxatives
- Lithium
- Oral Contraceptives
- Radiation
- Recreational Drugs Specify___________
- Relaxants/Sleeping Pills
- Thyroid
- Ulcer Medications
- Other_______________

Circle if you eat, drink or use:

- Alcohol
- Candy
- Carbonated Beverages
- Cigarettes
- Coffee
- Distilled Water
- At fast food restaurants regularly
- Fried Foods
- Luncheon Meats
- Margarine
- Vitamins and/or Minerals (Please list) _______________
- Refined Sugars
- Saccharine (Sweet N Low)
- Chew Tobacco

Circle if you:

- Diet often
- Do not exercise regularly
- Salt food without tasting
- Are under excessive stress
- Are exposed to chemicals at work
- Are exposed to cigarette smoke

INSTRUCTIONS:* *Circle the number which best describes the intensity of your symptoms. If you do not know the answer to a question, leave it blank.

0 = Symptom is not present 1 = Mild 2 = Moderate 3 = Severe

I A:

	Symptom				
1.	Burping	0	1	2	3
2.	Fullness for extended time after meals	0	1	2	3
3.	Bloating	0	1	2	3
4.	Poor appetite	0	1	2	3
5.	Stomach upsets easily	0	1	2	3
6.	History of constipation	0	1	2	3
7.	Known food allergies	0	1	2	3

I B:

	Symptom				
1.	Abdominal cramps	0	1	2	3
2.	Indigestion 1-3 hours after eating	0	1	2	3
3.	Fatigue after eating	0	1	2	3
4.	Lower bowel gas	0	1	2	3
5.	Alternating constipation and diarrhea	0	1	2	3
6.	Diarrhea	0	1	2	3
7.	Roughage and fiber causes constipation	0	1	2	3
8.	Mucous in stools	0	1	2	3
9.	Stool poorly formed	0	1	2	3
10.	Shiny stool	0	1	2	3
11.	Three or more large bowel movements daily	0	1	2	3
12.	Foul smelling stool	0	1	2	3
13.	Dry, flaky skin and /or dry brittle hair	0	1	2	3
14.	Pain in left side under rib cage	0	1	2	3
15.	Acne	0	1	2	3
16.	Food allergies	0	1	2	3
17.	Difficulty gaining weight	0	1	2	3

I C:

	Symptom				
1.	Stomach Pains	0	1	2	3
2.	Stomach pains just before and/or after meals	0	1	2	3
3.	Dependency on antacids	0	1	2	3
4.	Chronic Abdominal pain	0	1	2	3
5.	Butterfly sensation in stomach	0	1	2	3
6.	Difficulty belching	0	1	2	3
7.	Stomach pain when emotionally upset	0	1	2	3
8.	Sudden, acute indigestion	NO			YES
9.	Relief of symptoms by carbonated beverages	NO			YES
10.	Relief of stomach pain by drinking cream/milk	NO			YES
11.	History of ulcer or gastritis	NO			YES
12.	Current ulcer	NO			YES
13.	Black stool when not taking iron supplements	NO			YES

I D:

	Symptom				
1.	Seasonal diarrhea	0	1	2	3
2.	Frequent and recurrent infections (colds)	0	1	2	3
3.	Bladder and kidney infections	0	1	2	3
4.	Vaginal yeast infection	0	1	2	3
5.	Abdominal cramps	0	1	2	3
6.	Toe and fingernail fungus	0	1	2	3
7.	Alternating diarrhea/constipation	0	1	2	3
8.	Constipation	0	1	2	3
9.	History of antibiotic use	NO			YES
10.	Meat eater	NO			YES
11.	Rapidly failing vision	NO			YES

II A:

#	Symptom				
1.	Intolerance to greasy foods	0	1	2	3
2.	Headaches after eating	0	1	2	3
3.	Light colored stool	0	1	2	3
4.	Foul smelling stool	0	1	2	3
5.	Less than one bowel movement daily	0	1	2	3
6.	Constipation	0	1	2	3
7.	Hard stool	0	1	2	3
8.	Sour taste in mouth	0	1	2	3
9.	Grey colored skin	0	1	2	3
10.	Yellow in whites of eyes	0	1	2	3
11.	Bad breath	0	1	2	3
12.	Body odor	0	1	2	3
13.	Fatigue and sleepiness after eating	0	1	2	3
14.	Pain in right side under rib cage	0	1	2	3
15.	Painful to pass stool	0	1	2	3
16.	Retain water	0	1	2	3
17.	Big toe painful	0	1	2	3
18.	Pain radiates along outside of let	0	1	2	3
19.	Dry skin/hair	0	1	2	3
20.	Red blood in stool	NO			YES
21.	Have had jaundice or hepatitis	NO			YES
22.	High blood cholesterol and low HDL cholesterol	NO	UNKNOWN		YES(10)
23.	Is your cholesterol level above 200	NO	UNKNOWN		YES
24.	Is your triglyceride level above 115	NO	UNKNOWN		YES

II B:

#	Symptom				
1.	Swollen eyes (bulging)	0	1	2	3
2.	Strong smelling urine	0	1	2	3
3.	Thick skin and fingernails	0	1	2	3
4.	Dry skin	0	1	2	3
5.	Sensitive to the cold	0	1	2	3
6.	Cold hands and feet	0	1	2	3
7.	Excessive menstrual bleeding	0	1	2	3
8.	Chronic fatigue	0	1	2	3
9.	Trouble waking up in the morning	0	1	2	3
10.	Depressed, apathetic	0	1	2	3
11.	Low sex drive	0	1	2	3
12.	Puffy, wrinkly skin	0	1	2	3
13.	Sugar causes irritability and mood swings	0	1	2	3
14.	Premenstrual tension	0	1	2	3
15.	Constipation	0	1	2	3
16.	Thinning or loss of outside portion of eyebrow	NO			YES
17.	Gain weight easily	NO			YES
18.	Anemia unaffected by iron	NO			YES
19.	Axillary (armpit) temperature below 97.6°F	NO			YES
20.	Slow reflexes	NO			YES
21.	Infertility	NO			YES

III A:

#	Symptom				
1.	Sensitive to exhaust fumes, smoke, smog, petrochemicals	0	1	2	3
2.	Periodic constipation	0	1	2	3
3.	Cannot tolerate much exercise	0	1	2	3
4.	Depression or rapid mood swings	0	1	2	3
5.	Dark circles under the eyes	0	1	2	3
6.	Dizziness upon standing	0	1	2	3
7.	Lack of mental alertness	0	1	2	3
8.	Catch colds easily when weather changes	0	1	2	3
9.	Headaches	0	1	2	3
10.	Difficulty breathing	0	1	2	3
11.	Water retention	0	1	2	3
12.	Eyes sensitive to bright light	0	1	2	3
13.	Feel weak and shaky	0	1	2	3

III B:

#	Symptom				
1.	Inflamed or bleeding gums	0	1	2	3
2.	Running nose	0	1	2	3
3.	Get boils or styes	0	1	2	3
4.	Nose bleeds	0	1	2	3
5.	Loss of smell	0	1	2	3
6.	Throat infections	0	1	2	3
7.	Cold sores, fever blisters	0	1	2	3
8.	Loss of taste	0	1	2	3
9.	Poor wound healing	0	1	2	3
10.	Hair falls out	0	1	2	3
11.	Swollen lymph glands	0	1	2	3
12.	Ear infection	0	1	2	3
13.	Hair grows slowly	0	1	2	3
14.	Slow to recover from cold or flu	0	1	2	3
15.	Catch colds or flu easily	0	1	2	3
16.	Bumpy skin on back of arms	0	1	2	3

III C:

#	Symptom				
1.	Itching of nose or eyes	0	1	2	3(5)
2.	Itching of roof of mouth or throat	0	1	2	3(5)
3.	Migraine headaches	NO			YES(10)
4.	Entire body aches, painful to touch	0	1	2	3
5.	Swollen joints	0	1	2	3
6.	Food sensitivity or allergy	0	1	2	3
7.	Certain foods make you sick, depressed, jittery	0	1	2	3
8.	Chronic pain	0	1	2	3
9.	Painful stomach and/or intestine	0	1	2	3
10.	Alternating constipation and diarrhea	0	1	2	3
11.	Mucous in throat	0	1	2	3
12.	Post nasal drip	0	1	2	3
13.	Discharge from eyes	0	1	2	3
14.	Watery eyes	0	1	2	3
15.	Puffiness or dark circles under eyes	0	1	2	3
16.	Ear discharge or ears stuffed up	0	1	2	3
17.	Nasal congestion	0	1	2	3
18.	Running nose	0	1	2	3
19.	Breathe through mouth	0	1	2	3
20.	Swollen tongue	0	1	2	3
21.	Difficulty swallowing	0	1	2	3
22.	Bedwetting	NO			YES(5)
23.	Hyperactivity	0	1	2	3
24.	Chronic lung congestion	0	1	2	3
25.	Use aspirin, Tylenol regularly	NO			YES
26.	Wheezing	0	1	2	3
27.	Skin rashes	0	1	2	3
28.	Sneezing	0	1	2	3

IV A:

#	Symptom				
1.	Difficulty breathing at night	0	1	2	3
2.	Chest pain while walking	0	1	2	3
3.	Heaviness in legs	0	1	2	3
4.	Calf muscles cramp while walking	0	1	2	3
5.	Heart pounds easily	0	1	2	3
6.	Feel jittery	0	1	2	3
7.	Heart misses beats or has extra beats	0	1	2	3
8.	Swelling of feet and ankles	0	1	2	3
9.	Rapid beating heart	0	1	2	3
10.	Heartburn after eating	0	1	2	3
11.	Pain in left arm	0	1	2	3
12.	Exhaust with minor exertion	0	1	2	3
13.	Do you aerobic exercise?	YES			NO
14.	Have you ever exercised regularly?	YES			NO
15.	Drink 5 or more cups of coffee daily?	NO			YES
16.	Severe cough	NO			YES
17.	Has a doctor ever told you that you have heart trouble?	NO			YES(6)

IV B:

#	Symptom				
1.	Cold hands and feet	0	1	2	3
2.	Slurred Speech	0	1	2	3
3.	Calf muscles cramp while walking	0	1	2	3
4.	Headaches	0	1	2	3
5.	Numbness in extremities	0	1	2	3
6.	Poor concentration	0	1	2	3
7.	Ringing in ears	0	1	2	3
8.	Ear canal hair	NO			YES
9.	Tingling and/or burning in hands or feet	NO			YES
10.	Spider veins on nose and/or face	NO			YES

IV C:

#	Symptom				
1.	Pain when getting up in morning in back of head and neck	0	1	2	3
2.	Dizziness	0	1	2	3
3.	Vertigo	0	1	2	3
4.	Blushing with no apparent cause	0	1	2	3
5.	Is your blood pressure high?	NO			YES(10)

V A:

#	Symptom				
1.	Dizziness when standing suddenly	0	1	2	3
2.	Loss of vision when standing suddenly	0	1	2	3
3.	Crave sweets	0	1	2	3
4.	Headaches relieved by eating sweets or alcohol	0	1	2	3
5.	Feel shaky or jittery	0	1	2	3
6.	Irritable if a meal is missed	0	1	2	3
7.	Wake up in middle of night craving sweets	0	1	2	3
8.	Feel tired or weak if a meal is missed	0	1	2	3
9.	Heart palpitations after eating sweets	0	1	2	3
10.	Need to drink coffee to get started	0	1	2	3
11.	Impatient, moody, nervous	0	1	2	3
12.	Feel tired 1 to 3 hours after eating	0	1	2	3
13.	Poor memory	0	1	2	3
14.	Feel faint	0	1	2	3
15.	Poor concentration	0	1	2	3
16.	Forgetful	0	1	2	3
17.	Calmer after eating	NO			YES

V B:

#	Symptom				
1.	Night sweats	0	1	2	3
2.	Increased thirst	0	1	2	3
3.	Lowered resistance to infection	0	1	2	3
4.	Fatigue	0	1	2	3
5.	Boils and leg sores	0	1	2	3
6.	Lesions, cuts take a long time to heal	0	1	2	3
7.	Overweight	0	1	2	3
8.	Feel pick up from exercise	0	1	2	3
9.	Failing eyesight	0	1	2	3
10.	Crave sweets, but eating sweets does not relieve symptoms	0	1	2	3
11.	Family history of diabetes	0	1	2	3
12.	Sugar in urine	NO			YES

VI A:

#	Symptom				
1.	Chest pain	0	1	2	3
2.	Chronic cough	0	1	2	3
3.	Difficulty breathing	0	1	2	3
4.	Coughing up blood	0	1	2	3
5.	Coughing up phlegm	0	1	2	3
6.	Pain around ribs	0	1	2	3
7.	Shortness of breath	0	1	2	3
8.	Rattling mucous when you breathe	0	1	2	3
9.	Sensitive to smog	0	1	2	3
10.	Infections settle in lungs	0	1	2	3
11.	Live or work around people who smoke	0	1	2	3
12.	Bronchitis	NO			YES(10)
13.	Exposed to chemicals and radiation	NO			YES(6)
14.	Smoker	NO			YES(6)

VII A:

#	Symptom				
1.	Frequent urination	0	1	2	3
2.	Frequent bladder infections	0	1	2	3
3.	Rarely need to urinate	0	1	2	3
4.	Urination when you cough or sneeze	0	1	2	3
5.	Coughing up phlegm	0	1	2	3
6.	Difficulty passing urine	0	1	2	3
7.	Shortness of breath	0	1	2	3
8.	Can't hold urine	0	1	2	3
9.	Sensitive to smog	0	1	2	3
10.	Cloudy urine	0	1	2	3
11.	Strong smelling urine	0	1	2	3
12.	Back or leg pains associated with dripping after urination	0	1	2	3
13.	History of kidney or bladder infection	NO			YES
14.	Have used antibiotics to control urinary tract infections	NO			YES

IF YES, WHEN DID YOU LAST USE THEM? ____________

TREATMENT DURATION ____________

#	Symptom				
15.	Back pain in the kidney area	0	1	2	3
16.	General water retention	0	1	2	3

(Males Only)

VIII A:

1.	Difficulty urinating	0	1	2	3
2.	A sense of bladder fullness	0	1	2	3
3.	Increased straining with smaller and smaller amounts of urine passed	0	1	2	3
4.	Rose colored (bloody) urine	0	1	2	3
5.	Pain or burning while urinating	0	1	2	3
6.	Wake up to urinate at night	0	1	2	3
7.	Dripping after urination	0	1	2	3
8.	Pain or fatigue in the legs or back	0	1	2	3
9.	Lack of sex drive	0	1	2	3
10.	Ejaculation causes pain	0	1	2	3

VIII B:

1.	Difficulty attaining and/or maintaining an erection	0	1	2	3
2.	Low sexual drive	0	1	2	3
3.	Premature ejaculation	0	1	2	3
4.	Pain/coldness in genital area	0	1	2	3
5.	Infertile	NO			YES(5)
6.	Varicose veins on scrotum	NO			YES
7.	Low sperm count	NO			YES(5)

VIII C:

1.	Discharge from penis	0	1	2	3
2.	Past or present rash on penis	0	1	2	3
3.	Swollen genitals	0	1	2	3
4.	Swelling in groin	0	1	2	3
5.	Venereal disease (gonorrhea, syphilis, herpes or other)	NO			YES(9)

Have V.D. now? ____________

Had in past? ____________

(Females Only)

IX A: Circle if you experience any of these symptoms within approximately 2 weeks (ovulation) prior to menstruation (Section A Only)

1.	Monthly weight gain	0	1	2	3
2.	Depression	0	1	2	3
3.	Moodiness/irritability	0	1	2	3
4.	Bloating and swelling	0	1	2	3
5.	Nausea and/or vomiting	0	1	2	3
6.	Suicidal feeling	NO			YES(10)
7.	Anxiety	0	1	2	3
8.	Leg cramps and tenderness	0	1	2	3
9.	Asthma attacks	NO			YES(10)
10.	Headaches	0	1	2	3
11.	Easily distracted	0	1	2	3
12.	Anger	0	1	2	3
13.	Tender breasts	0	1	2	3
14.	Low backache	0	1	2	3
15.	Other ____________				

IX B:

1.	Vaginal itching	0	1	2	3
2.	Vaginal discharge	0	1	2	3
3.	Low or no desire for sex	0	1	2	3
4.	Dislike for intercourse	0	1	2	3
5.	Missed periods	NO			YES(9)
6.	Over 15 years of age and have not begun menstruation	NO			YES
7.	Unable to get pregnant	NO			YES
8.	Miscarriages (How many ____________)	NO			YES
9.	Abortion (How many ____________)	NO			YES

IX C: Check if you experience any of these symptoms during menstruation (Section C only)

1.	Low abdominal pain	0	1	2	3
2.	Dull ache radiating to low back or legs	0	1	2	3
3.	Increased urinary frequency	0	1	2	3
4.	Pelvic soreness	0	1	2	3
5.	Diarrhea	0	1	2	3
6.	Headaches	0	1	2	3
7.	Abdominal bloating	0	1	2	3
8.	Menstrual pain	0	1	2	3
9.	Nausea and/or vomiting	0	1	2	3
10.	Have to lie down on first 1 or 2 days of period	0	1	2	3
11.	Craving for sweets	0	1	2	3
12.	Insomnia	0	1	2	3
13.	Light scanty blow flow	0	1	2	3
14.	Pain and cramps without blood flow	0	1	2	3
15.	Heavy menstrual bleeding	0	1	2	3
16.	Anxiety about menstrual cycle	0	1	2	3
17.	Pain during period is progressively getting worse with time	0	1	2	3

IX D:

1.	Vaginal bumps and sores	0	1	2	3
2.	Pubic area sore	0	1	2	3
3.	Ovarian cysts	0	1	2	3
4.	Uterine cysts	NO			YES(10)
5.	Pain in ovaries	NO			YES(10)
6.	Breast lumps	0	1	2	3
7.	Breasts sore to touch	NO			YES(10)
8.	Breasts painful	0	1	2	3
9.	Water retention	0	1	2	3
10.	Swollen feeling	0	1	2	3
11.	Premenstrual breast pain or discomfort	0	1	2	3
12.	Mother used D.E.S. (hormones) while pregnant	NO			YES
13.	Recent pap smear positive	NO			YES(15)
14.	Family history of breast cancer	NO			YES

15. Form of birth control: ___None ___Pill ___IUD ___Sponge ___Diaphragm ___Foam Other____________

IX E:

1.	Hot flashes	0	1	2	3
2.	Night sweats	0	1	2	3
3.	Hysterectomy	NO			YES
4.	Depression/Mood swings	0	1	2	3
5.	Insomnia	0	1	2	3
6.	Craving for sweets	0	1	2	3
7.	Heavy bleeding two weeks/month	0	1	2	3
8.	Sweating throughout the day	0	1	2	3
9.	Dryness of skin, hair, and vagina	0	1	2	3
10.	Painful intercourse	0	1	2	3
11.	Vaginal pain	0	1	2	3
12.	Vaginal itching	0	1	2	3
13.	Osteoporosis (Bone loss)	NO			YES

X A:

#	Item				
1.	Pain in fingers	0	1	2	3
2.	Bones sore/painful	0	1	2	3
3.	Eat meat	0	1	2	3
4.	Cavities	0	1	2	3
5.	Arthritis	0	1	2	3
6.	Drink carbonated beverages/soda... ______ oz. per week				YES
7.	Gum disease	NO			YES
8.	Bone loss	NO			YES
9.	Calcium deposits	NO			YES
10.	Use antacids ______ # per week				YES
11.	Dentures	NO			YES
12.	Bone deformity	NO			YES
13.	Told you have osteoporosis/osteomalagia	NO			YES(5)
14.	Recent bone fracture	NO			YES
15.	Are you post menopausal	NO			YES

X B:

#	Item				
1.	Muscle spasms	0	1	2	3
2.	Tightness in shoulder muscles	0	1	2	3
3.	Muscle cramps	0	1	2	3
4.	Pain in arms, hands	0	1	2	3
5.	Leg cramps at night	0	1	2	3
6.	Stiff all over	0	1	2	3
7.	Stiff in morning	0	1	2	3
8.	Unable to sit straight	0	1	2	3
9.	Pain in neck and/or shoulders	0	1	2	3
10.	Back pain	0	1	2	3

X C:

#	Item				
1.	Over-flexible joints (double jointed)	0	1	2	3
2.	Back pain	0	1	2	3
3.	Swollen knees/elbows	0	1	2	3
4.	Athletic injury	0	1	2	3
5.	Bursitis	0	1	2	3
6.	Tendonitis	0	1	2	3
7.	Joint pain	0	1	2	3
8.	Slipped disc	NO			YES(5)
9.	Herniated disc	NO			YES(10)
10.	Loss in height	NO			YES
11.	Injure easily	NO			YES

XI

#	Item				
1.	Head feels heavy	0	1	2	3
2.	Light headedness/fainting	0	1	2	3
3.	Loss of balance	0	1	2	3
4.	Dizziness	0	1	2	3
5.	Ringing/buzzing in ears	0	1	2	3
6.	Trembling hands	0	1	2	3
7.	Loss of feeling in hands and/or feet (toes)	0	1	2	3
8.	Exhaustion on slightest effort	0	1	2	3
9.	Limbs feel too heavy to hold up	0	1	2	3
10.	Loss of grip strength	0	1	2	3
11.	Tingling pain sensation	0	1	2	3
12.	Convulsions	NO	1	2	YES(10)
13.	Incoordination	0	1	2	3
14.	Nervousness	0	1	2	3
15.	Accident prone	NO			YES
16.	Loss of muscle tone	NO			YES
17.	Need for 10-12 hours of sleep	NO			YES
18.	Have had shingles	NO			YES

XII

#	Item				
1.	Nightmares	0	1	2	3
2.	Can't fall asleep	0	1	2	3
3.	Intense dreams	0	1	2	3
4.	Leg cramps/restless leg at night	0	1	2	3
5.	Restless, uneasy sleeper	0	1	2	3
6.	Awake frequently throughout the night	NO			YES
7.	Wake up in the middle of night, can't fall back to sleep	NO			YES
8.	Sleep walk	NO			YES

IMPORTANT

TO THE PATIENT: Please list below the five main heath complaints you have in order of their importance:

1. ______________________________
____

2. ______________________________
____

3. ______________________________
____

4. ______________________________
____

5. ______________________________
____

Do you have any other symptoms that have not been covered in the questionnaire?______________________________

____

____

____

____

____

	100 – 75		50		25 – 0	Score
Sleep patterns	9+ 8 7	6	5 4	3	2	
Neurological	30+ 25 20	15	10	5	3 1	
C. Connective Tissue	12+ 9	7	5	3	2 1	
B. Muscle	15+ 12 9		7 5	3	2 1	
A. Bone integrity	15+ 13	11	9 7	5	3 1	
E. Menopause	19+ 17 15 13 11		9 7 5 3		2 1	
D. Fibrocystic Problems	30+ 25 20	15	12	9	5 1	
C. Dysmenorrhea	30+ 27 24 21	18	15 12 9	6	3 1	
B. Amenorrhea	15+ 12	9	6	3	2 1	
A. PMS	25+ 20 15	11	8	5	3 1	
C. Genital Infection	9+ 7	5	4 3		2 1	
B. Reproduction	15+ 12 9		7 5	3	2 1	
A. Prostate	15+ 12 9		7 5	3	2 1	
Urological	21+ 18 15 12	9	6	3	2 1	
Lungs	15+ 13 11	9	6	3	2 1	
B. Hyperglycemia	24+ 21 18 15	12	9	6	3 1	
A. Hypoglycemia	21- 18 15	12	9	6	3 1	
C. Hypertension	9+ 8 7	6	5 4	3	2 1	
B. Circulation	15+ 13	11	9	7	4 1	
A. Heart	15+ 13	11	9	7	4 1	
C. Hyperimmune	45+ 35 25	15	10	5	3 1	
B. Hypoimmune	30+ 25 20 15	12	9	6	3 1	
A. Hypoadrenal	20+ 18 16 14	12	9	6	3 1	
B. Thyroid	25+ 20 15 12	9	7	5	3 1	
A. Liver/gallbadder	18+ 15 12 9	6	5 4 3		2 1	
D. Colon	15+ 13 11	9	7	5	3 1	
C. Hyperacidity	15+ 13 11	9	7	5	3 1	
B. Small Intestine	15+ 13 11	9	7	5	3 1	
A. Hypoacidity	15+ 13 11	9	7	5	3 1	

100 75 50 25 0 Score

HIGH PRIORITY | MODERATE PRIORITY | LOW PRIORITY