

Doc McCullen

Chiropractic, Nutrition, Natural Healing

Welcome to Our Office

Today's Date _____

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Phone (H) _____ (W) _____ Fax _____

Date of Birth _____ Height _____ Weight _____ Children _____

Email address _____ S.S.# _____ Marital Status (S) (M) (D) (W)

Who may we thank for referring you? _____

Occupation _____

Employment: (Full) (Part Time) (Retired) (Unemployed)

Employer's Name _____

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 _____

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.

MEDICAL HISTORY SYSTEMS REVIEW

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

Abscesses _____ 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 _____ Whooping Cough _____

II A:				
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 leg.....	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(m)	
23. Is your cholesterol level above 200.....	NO	UNKNOWN	YES	
24. Is your triglyceride level above 115.....	NO	UNKNOWN	YES	

II B:				
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:				
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:				
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:				
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(m)
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:					IV B:						
1.	Difficulty breathing at night.....	0	1	2	3	1.	Cold hands and feet.....	0	1	2	3
2.	Chest pain while walking.....	0	1	2	3	2.	Slurred Speech.....	0	1	2	3
3.	Heaviness in legs.....	0	1	2	3	3.	Calf muscles cramp while walking.....	0	1	2	3
4.	Calf muscles cramp while walking.....	0	1	2	3	4.	Headaches.....	0	1	2	3
5.	Heart pounds easily.....	0	1	2	3	5.	Numbness in extremities.....	0	1	2	3
6.	Feel jittery.....	0	1	2	3	6.	Poor concentration.....	0	1	2	3
7.	Heart misses beats or has extra beats.....	0	1	2	3	7.	ringing in ears.....	0	1	2	3
8.	Swelling of feet and ankles.....	0	1	2	3	8.	Ear canal hair.....	NO			YES
9.	Rapid beating heart.....	0	1	2	3	9.	Tingling and/or burning in hands or feet.....	NO			YES
10.	Heartburn after eating.....	0	1	2	3	10.	Spider veins on nose and/or face..	NO			YES
11.	Pain in left arm.....	0	1	2	3	IV C:					
12.	Exhaust with minor exertion.....	0	1	2	3	1.	Pain when getting up in morning in back of head and neck.....	0	1	2	3
13.	Do you aerobic exercise?.....	YES			NO	2.	Dizziness.....	0	1	2	3
14.	Have you ever exercised regularly?.....	YES			NO	3.	Vertigo.....	0	1	2	3
15.	Drink 5 or more cups of coffee daily?.....	NO			YES	4.	Blushing with no apparent cause	0	1	2	3
16.	Severe cough.....	NO			YES	5.	Is your blood pressure high?.....	NO			YES ¹⁰
17.	Has a doctor ever told you that you have heart trouble?.....	NO			YES ⁽⁶⁾						

V A:					V B:						
1.	Dizziness when standing suddenly.....	0	1	2	3	16.	Forgetful.....	0	1	2	3
2.	Loss of vision when standing suddenly.....	0	1	2	3	17.	Calmer after eating.....	NO			YES
3.	Crave sweets.....	0	1	2	3						
4.	Headaches relieved by eating sweets or alcohol.....	0	1	2	3	1.	Night sweats.....	0	1	2	3
5.	Feel shaky or jittery.....	0	1	2	3	2.	Increased thirst.....	0	1	2	3
6.	Irritable if a meal is missed.....	0	1	2	3	3.	Lowered resistance to infection... ..	0	1	2	3
7.	Wake up in middle of night craving sweets..	0	1	2	3	4.	Fatigue.....	0	1	2	3
8.	Feel tired or weak if a meal is missed.....	0	1	2	3	5.	Boils and leg sores.....	0	1	2	3
9.	Heart palpitations after eating sweets.....	0	1	2	3	6.	Lesions, cuts take a long time to heal.....	0	1	2	3
10.	Need to drink coffee to get started.....	0	1	2	3	7.	Overweight.....	0	1	2	3
11.	Impatient, moody, nervous.....	0	1	2	3	8.	Feel pick up from exercise.....	0	1	2	3
12.	Feel tired 1 to 3 hours after eating.....	0	1	2	3	9.	Failing eyesight.....	0	1	2	3
13.	Poor memory.....	0	1	2	3	10.	Crave sweets, but eating sweets does not relieve symptoms.....	0	1	2	3
14.	Feel faint.....	0	1	2	3	11.	Family history of diabetes.....	0	1	2	3
15.	Poor concentration.....	0	1	2	3	12.	Sugar in urine.....	NO			YES

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

VII A:					VII B:						
1.	Frequent urination.....	0	1	2	3	11.	Strong smelling urine.....	0	1	2	3
2.	Frequent bladder infections.....	0	1	2	3	12.	Back or leg pains associated with dripping after urination.....	0	1	2	3
3.	Rarely need to urinate.....	0	1	2	3	13.	History of kidney or bladder infection.....	NO			YES
4.	Urination when you cough or sneeze.....	0	1	2	3	14.	Have used antibiotics to control urinary tract infections.....	NO			YES
5.	Coughing up phlegm.....	0	1	2	3	IF YES, WHEN DID YOU LAST USE THEM? TREATMENT DURATION					
6.	Difficulty passing urine.....	0	1	2	3	15.	Back pain in the kidney area.....	0	1	2	3
7.	Shortness of breath.....	0	1	2	3	16.	General water retention.....	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						

(Males Only)

VIII A:					2. Low sexual drive.....	0	1	2	3
1. Difficulty urinating.....	0	1	2	3	3. Premature ejaculation.....	0	1	2	3
2. A sense of bladder fullness.....	0	1	2	3	4. Pain/coldness in genital area.....	0	1	2	3
3. Increased straining with smaller and smaller amounts of urine passed.....	0	1	2	3	5. Infertile.....	NO			YES(5)
4. Rose colored (bloody) urine.....	0	1	2	3	6. Varicose veins on scrotum.....	NO			YES
5. Pain or burning while urinating.....	0	1	2	3	7. Low sperm count.....	NO			YES(5)
6. Wake up to urinate at night.....	0	1	2	3	VIII C:				
7. Dripping after urination.....	0	1	2	3	1. Discharge from penis.....	0	1	2	3
8. Pain or fatigue in the legs or back.....	0	1	2	3	2. Past or present rash on penis.....	0	1	2	3
9. Lack of sex drive.....	0	1	2	3	3. Swollen genitals.....	0	1	2	3
10. Ejaculation causes pain.....	0	1	2	3	4. Swelling in groin.....	0	1	2	3
VIII B:					5. Venereal disease (gonorrhea, syphilis, herpes or other).....	NO			YES(9)
1. Difficulty attaining and/or maintaining an erection.....	0	1	2	3	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)					11. Craving for sweets.....	0	1	2	3
1. Monthly weight gain.....	0	1	2	3	12. Insomnia.....	0	1	2	3
2. Depression.....	0	1	2	3	13. Light scanty flow.....	0	1	2	3
3. Moodiness/irritability.....	0	1	2	3	14. Pain and cramps without blood flow.....	0	1	2	3
4. Bloating and swelling.....	0	1	2	3	15. Heavy menstrual bleeding.....	0	1	2	3
5. Nausea and/or vomiting.....	0	1	2	3	16. Anxiety about menstrual cycle.....	0	1	2	3
6. Suicidal feeling.....	NO			YES(10)	17. Pain during period is progressively getting worse with time.....	0	1	2	3
7. Anxiety.....	0	1	2	3	IX D:				
8. Leg cramps and tenderness.....	0	1	2	3	1. Vaginal bumps and sores.....	0	1	2	3
9. Asthma attacks.....	NO			YES(10)	2. Pubic area sore.....	0	1	2	3
10. Headaches.....	0	1	2	3	3. Ovarian cysts.....	0	1	2	3
11. Easily distracted.....	0	1	2	3	4. Uterine cysts.....	NO			YES(10)
12. Anger.....	0	1	2	3	5. Pain in ovaries.....	NO			YES(10)
13. Tender breasts.....	0	1	2	3	6. Breast lumps.....	0	1	2	3
14. Low backache.....	0	1	2	3	7. Breasts sore to touch.....	NO			YES(10)
15. Other _____					8. Breasts painful.....	0	1	2	3
IX B:					9. Water retention.....	0	1	2	3
1. Vaginal itching.....	0	1	2	3	10. Swollen feeling.....	0	1	2	3
2. Vaginal discharge.....	0	1	2	3	11. Premenstrual breast pain or discomfort.....	0	1	2	3
3. Low or no desire for sex.....	0	1	2	3	12. Mother used D.E.S. (hormones) while pregnant.....	NO			YES
4. Dislike for intercourse.....	0	1	2	3	13. Recent pap smear positive.....	NO			YES(10)
5. Missed periods.....	NO			YES(9)	14. Family history of breast cancer.....	NO			YES
6. Over 15 years of age and have not begun menstruation.....	NO			YES	15. Form of birth control: ___None ___Pill ___IUD ___Sponge				
7. Unable to get pregnant.....	NO			YES	___Diaphragm ___Foam Other _____				
8. Miscarriages.....	NO			YES	IX E:				
9. Abortion.....	NO			YES	1. Hot flashes.....	0	1	2	3
How many _____					2. Night sweats.....	0	1	2	3
IX C: Check if you experience any of these symptoms during menstruation (Section C only)					3. Hysterectomy.....	NO			YES
1. Low abdominal pain.....	0	1	2	3	4. Depression/Mood swings.....	0	1	2	3
2. Dull ache radiating to low back or legs.....	0	1	2	3	5. Insomnia.....	0	1	2	3
3. Increased urinary frequency.....	0	1	2	3	6. Craving for sweets.....	0	1	2	3
4. Pelvic soreness.....	0	1	2	3	7. Heavy bleeding two weeks/month.....	0	1	2	3
5. Diarrhea.....	0	1	2	3	8. Sweating throughout the day.....	0	1	2	3
6. Headaches.....	0	1	2	3	9. Dryness of skin, hair, and vagina.....	0	1	2	3
7. Abdominal bloating.....	0	1	2	3	10. Painful intercourse.....	0	1	2	3
8. Menstrual pain.....	0	1	2	3	11. Vaginal pain.....	0	1	2	3
9. Nausea and/or vomiting.....	0	1	2	3	12. Vaginal itching.....	0	1	2	3
10. Have to lie down on first 1 or 2 days of period.....	0	1	2	3	13. Osteoporosis (Bone loss).....	NO			YES

2	1. Joint stiffness after arising.....	<input type="checkbox"/>	11. Hoarseness frequent.....	<input type="checkbox"/>
	2. Muscle-leg-toe cramps at night.....	<input type="checkbox"/>	12. Breathing irregular.....	<input type="checkbox"/>
	3. "Butterfly" stomach, cramps.....	<input type="checkbox"/>	13. Pulse slow; feels "irregular".....	<input type="checkbox"/>
	4. Eyes or nose watery.....	<input type="checkbox"/>	14. Gagging reflex slow.....	<input type="checkbox"/>
	5. Eyes blink often.....	<input type="checkbox"/>	15. Difficulty swallowing.....	<input type="checkbox"/>
	6. Eyelids swollen, puffy.....	<input type="checkbox"/>	16. Constipation, diarrhea alternating.....	<input type="checkbox"/>
	7. Indigestion soon after meals.....	<input type="checkbox"/>	17. "Slow starter".....	<input type="checkbox"/>
	8. Always seems hungry; feels "lightheaded" often.....	<input type="checkbox"/>	18. Get "chilled" infrequently.....	<input type="checkbox"/>
	9. Digestion rapid.....	<input type="checkbox"/>	19. Perspire easily.....	<input type="checkbox"/>
	10. Vomiting frequent.....	<input type="checkbox"/>	20. Circulation poor, sensitive to cold.....	<input type="checkbox"/>
			21. Subject to colds, asthma, bronchitis....	<input type="checkbox"/>

3	1. Eat when nervous.....	<input type="checkbox"/>	9. Afternoon headaches.....	<input type="checkbox"/>
	2. Excessive appetite.....	<input type="checkbox"/>	10. Overeating sweets upsets.....	<input type="checkbox"/>
	3. Hungry between meals.....	<input type="checkbox"/>	11. Awaken after few hours sleep - hard to get back to sleep.....	<input type="checkbox"/>
	4. Irritable before meals.....	<input type="checkbox"/>	12. Crave candy or coffee in afternoons....	<input type="checkbox"/>
	5. Get "shaky" if hungry.....	<input type="checkbox"/>	13. Moods of depression- "blues" or melancholy.....	<input type="checkbox"/>
	6. Fatigue, eating relieves.....	<input type="checkbox"/>	14. Abnormal craving for sweets or snacks.	<input type="checkbox"/>
	7. "Lightheaded" if meals delayed.....	<input type="checkbox"/>		
	8. Heart palpitates if meals missed or delayed.	<input type="checkbox"/>		

4	1. Hands and feet go to sleep easily, numbness..	<input type="checkbox"/>	11. Shortness of breath on exertion.....	<input type="checkbox"/>
	2. Sigh frequently, "air hunger".....	<input type="checkbox"/>	12. Dull pain in chest or radiating into left arm, worse on exertion.....	<input type="checkbox"/>
	3. Aware of "breathing heavily".....	<input type="checkbox"/>	13. Bruise easily, "black/blue" spots.....	<input type="checkbox"/>
	4. High altitude discomfort.....	<input type="checkbox"/>	14. Tendency to anemia.....	<input type="checkbox"/>
	5. Opens windows in closed room.....	<input type="checkbox"/>	15. "Nose bleeds" frequent.....	<input type="checkbox"/>
	6. Susceptible to colds and fevers.....	<input type="checkbox"/>	16. Noises in head or "ringing in ears".....	<input type="checkbox"/>
	7. Afternoon "yawner".....	<input type="checkbox"/>	17. Tension under the breastbone, or feeling of "lightness", worse on exertion.....	<input type="checkbox"/>
	8. Get "drowsy" often.....	<input type="checkbox"/>		
	9. Swollen ankles worse at night.....	<input type="checkbox"/>		
	10. Muscle cramps, worse during exercise, get "charley horses".....	<input type="checkbox"/>		

5	1. Dizziness.....	<input type="checkbox"/>	14. Skin peels on foot soles.....	<input type="checkbox"/>
	2. Dry skin.....	<input type="checkbox"/>	15. Pain between shoulder blades.....	<input type="checkbox"/>
	3. Burning feet.....	<input type="checkbox"/>	16. Use laxatives.....	<input type="checkbox"/>
	4. Blurred vision.....	<input type="checkbox"/>	17. Stools alternate from soft to watery.....	<input type="checkbox"/>
	5. Itching skin and feet.....	<input type="checkbox"/>	18. History of gallbladder attacks or gallstones.....	<input type="checkbox"/>
	6. Excessive falling hair.....	<input type="checkbox"/>	19. Sneezing attacks.....	<input type="checkbox"/>
	7. Frequent skin rashes.....	<input type="checkbox"/>	20. Dreaming, nightmare type bad dreams...	<input type="checkbox"/>
	8. Bitter, metallic taste in mouth in mornings...	<input type="checkbox"/>	21. Bad breath (halitosis).....	<input type="checkbox"/>
	9. Bowel movements painful or difficult.....	<input type="checkbox"/>	22. Milk products causes distress.....	<input type="checkbox"/>
	10. Worrier, feels insecure.....	<input type="checkbox"/>	23. Sensitive to hot weather.....	<input type="checkbox"/>
	11. Feeling queasy; headache over eyes.....	<input type="checkbox"/>	24. Burning or itching anus.....	<input type="checkbox"/>
	12. Greasy foods upset.....	<input type="checkbox"/>	25. Crave sweets.....	<input type="checkbox"/>
	13. Stools light-colored.....	<input type="checkbox"/>		

6	1. Loss of taste for meat.....	<input type="checkbox"/>	6. Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours.....	<input type="checkbox"/>
	2. Lower bowel gas several hours after eating...	<input type="checkbox"/>	7. Mucus, colitis or "irritable bowel".....	<input type="checkbox"/>
	3. Burning stomach sensations, eating relieves...	<input type="checkbox"/>	8. Gas shortly after eating.....	<input type="checkbox"/>
	4. Coated tongue.....	<input type="checkbox"/>	9. Stomach "bloating" after eating.....	<input type="checkbox"/>
	5. Pass large amounts of foul-smelling gas.....	<input type="checkbox"/>		

- 7 A
1. Insomnia.....
 2. Nervousness.....
 3. Can't gain weight.....
 4. Intolerance to heat.....
 5. Highly emotional.....
 6. Flush easily.....
 7. Night sweats.....
 8. Thin, moist skin.....
 9. Inward trembling.....
 10. Heart palpitates.....
 11. Increased appetite without weight gain.....
 12. Pulse fast at rest.....
 13. Eyelids and face twitch.....
 14. Irritable and restless.....
 15. Can't work under pressure.....

- 7 B
1. Increase in weight.....
 2. Decrease in appetite.....
 3. Fatigue easily.....
 4. Ringing in ears.....
 5. Sleepy during day.....
 6. Sensitive to cold.....
 7. Dry or scaly skin.....
 8. Constipation.....
 9. Mental sluggishness.....
 10. Hair coarse, falls out.....
 11. Headaches upon arising wear off during day.....
 12. Slow pulse, below 65.....
 13. Frequency of urination.....
 14. Impaired hearing.....
 15. Reduced initiative.....

- 7 C
1. Failing memory.....
 2. Low blood pressure.....
 3. Increased sex drive.....
 4. Headaches, "splitting or rending" type.....

5. Decreased sugar tolerance.....

- 7 D
1. Abnormal thirst.....
 2. Bloating of abdomen.....
 3. Weight gain around hips or waist.....
 4. Sex drive reduced or lacking.....
 5. Tendency to ulcers, colitis.....
 6. Increased sugar tolerance.....
 7. Women: menstrual disorders.....
 8. Young girls: lack of menstrual function.....

- 7 E
1. Dizziness.....
 2. Headaches.....
 3. Hot flashes.....
 4. Increased blood pressure.....
 5. Hair growth on face or body (female).....
 6. Sugar in urine (not diabetes).....
 7. Masculine tendencies (female).....

- 7 F
1. Weakness, dizziness.....
 2. Chronic fatigue.....
 3. Low blood pressure.....
 4. Nails weak, ridged.....
 5. Tendency to hives.....
 6. Arthritic tendencies.....
 7. Perspiration increase.....
 8. Bowel disorders.....
 9. Poor circulation.....
 10. Swollen ankles.....
 11. Crave salt.....
 12. Brown spots or bronzing of skin.....
 13. Allergies - tendency to asthma.....
 14. Weakness after colds, influenza.....
 15. Exhaustion - muscular and nervous.....
 16. Respiratory disorders.....

FEMALE ONLY

1. Very easily fatigued.....
2. Premenstrual tension.....
3. Painful menses.....
4. Depressed feelings before menstruation.....
5. Menstruation excessive and prolonged.....
6. Painful breasts.....
7. Menstruate too frequently.....

8. Vaginal discharge.....
9. Hysterectomy/ovaries removed.....
10. Menopausal hot flashes.....
11. Menses scanty or missed.....
12. Acne, worse at menses.....
13. Depression of long standing.....

MALE ONLY

1. Prostate trouble.....
2. Urination difficult or dribbling.....
3. Night urination frequent.....
4. Depression.....
5. Pain on inside of legs or heels.....
6. Feeling of incomplete bowel evacuation.....

7. Lack of energy.....
8. Migrating aches and pains.....
9. Tire too easily.....
10. Avoids activity.....
11. Leg nervousness at night.....
12. Diminished sex drive.....

IMPORTANT

TO THE PATIENT: Please list below the five main health 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? _____

