Lozier Natural Health Center, PC

Integrative Treatments for Whole Body Health

Last Name: _____ First: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____) _____Cell: (_____)_____
Email: _____
Date of Birth: _____ Sex: □ Male □ Female
Marital Status: □ Married □Single □ Divorced □ Widowed □ Other
Social Security #: _____Referred to this office by: _____

Have you been treated by a physician for any condition in the past year?
□ Yes □ No If yes by whom? _____
Describe condition: _____

Have you received Chiropractic Care before? ☐ Yes ☐ No
Are you currently receiving Chiropractic Care? ☐ Yes ☐ No

List Current Medications:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8._____
4. _____ 9. _____
5. _____ 10. _____

Any known medication allergies? ☐ Yes ☐ No
List: _____

List nutritional/ herbal supplements you are currently taking:

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

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1. Why did you decide to come to this clinic?

_____
_____

2. What do you know about our approach to natural health?

_____
_____

3. What expectations do you have from this visit?

_____
_____

4. What long-term expectations do you have from working with our clinic?

_____
_____

5. What expectations do you have of Dr. Lozier as your health care provider?

_____
_____

6. What is your present level of commitment to address your health concerns?

Rate from 0 to 10 (10 being 100% committed)

0% 1 2 3 4 5 6 7 8 9 100%

7. What behaviors/habits do you currently engage in that support your health?

_____
_____

8. What behaviors/habits do you currently engage in that are self-destructive?

_____
_____

9. List any potential obstacles that might undermine your ability to adhere to the therapeutic protocols we will be sharing with you?

1. _____
2. _____
3. _____

10. List someone that will support you with the beneficial changes you will be making?

_____

11. What do you love to do? _____

Family History Checklist Name:_____

	You	Mother	Father	Children	Siblings	Father's Parents	Mother's Parents
Allergies							
Alcohol Abuse							
Alzheimer's or Dementia							
Anemia							
Asthma							
Arthritis							
Bleeding Problems							
Birth Defects							
Any Cancer							
Breast Cancer							
Ovarian Cancer							
Lung Cancer							
Colon Cancer							
Other Cancer_____							
Other Cancer_____							
High Cholesterol							
Chronic Infections							
Chicken Pox							
Clotting Problems							
Depression							
Diabetes Type I							
Drug Abuse							
Diabetes Type II							
Downs Syndrome							
Emphysema							
Epilepsy/ Seizures							
Epstein Barr Virus							
Glaucoma							
Hearing Loss							
Heart Trouble							
Hemochromatosis							
High Blood Pressure							
Infertility							
Kidney/ Renal Issues							
Memory Loss							
Measles							
Mental Illness							
Mental Retardation							
Mononucleosis							
Mumps							
Neurofibromatosis							
Obesity							
Osteoporosis							
PKU/ "metabolic disease" at birth							
Sickle Cell Anemia							
Smoking							
Stillborn/ Infant death							
Stroke							
Violence/ Domestic abuse							

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Integrative Treatments for Whole Body Health

Please list your Primary Health Concerns:

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

Please list your Health Goals:

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

Surgical History:

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____
5. _____ Date:_____

Dietary:

How many times per week do you eat out? _____

Do you have food allergies or food sensitivities? _____

How many times per week do you eat raw nuts and seeds? _____

How many times per week do you eat fish? _____

List the 3 worst foods you eat during an average week? _____

List the 3 healthiest foods you eat during an average week? _____

How much water to you drink in a typical day? _____

How many fresh fruit do you eat in a typical day? _____

How many fresh vegetables do you eat in typical day? _____

Name_____ Date_____ consistency taking supplements_____%

WOMEN'S FUNCTIONAL HEALTH ANALYSIS

FOR YOUR 1ST VISIT-CHECKMARK ANY SYMPTOM YOU HAVE EXPERIENCED IN THE LAST MONTH.

FOR RE-EXAMS- CHECKMARK SYMPTOMS YOU ARE CURENTLY EXPERIENCING.

HEADACHES
___ Base of Skull (back)
___ Side of Head (Temples)
___ Frontal (above eyes)
___ Top of Head
___ Entire Head
___ Migraines
___ TMJ
___ Cluster
Other_____

EARS
___ Noise (Ring/Hiss/Pound)
___ Plugged
___ Popping
___ Ear Ache
___ Ear Infections
___ Draining
___ Itchy
___ Hearing Loss
___ Dizziness/ Vertigo
___ Excessive Ear Wax
Other_____

EYES
___ Burn
___ Tear
___ Ache
___ Red
___ Dry
___ Eye Film
___ Crust in morning
___ Itchy Eyes
___ Bouts of Blurriness
___ Floaters
___ Spots
___ Tired
___ Puffy
___ Stye
___ Twitching around eyes
___ Dark Circles
___ Light Bothers Eyes
___ Nearsighted
___ Farsighted
___ Other_____

SINUS
___ Dry
___ Drain
___ Stuffy/Plugged/ pressure
___ Post nasal drip….Circle Color
white/yellow/green/gray
brown/blood/clear
___ Excessive sneezing
___ Loss of smell
___ Loss of Taste
___ Thirsty
___ Not Thirsty
___ Unquenchable thirst
___ Other_____

MOUTH/THROAT/IMMUNE
___ Sore Throat
___ Hoarseness
___ Cough (dry or productive)
___ Allergies
___ Upper Respiratory Infection
___ Fever
___ Chills
___ Bad Breath
___ Canker Sores
___ Blisters
___ Frequent colds/flu
___ Neck Stiffness
___ Shoulder Tension
___ Cracks at lip corner/ Chielosis
___ Dry Mouth
___ Cold sweaty hands & feet
___ Bleeding gums
___ Receeding gums
___ Teeth Health Problems
___ Swelling of glands

Chest
___ Tension
___ Tight
___ Pressure
___ Heaviness
___ Anxiety
___ Congestion
___ Chest Pain
___ Sternal Pain
___ Sharp Heart Pain
___ Palpitations-Heart skip/ Flutter
___ Mitral Valve Prolaspe
___ Tachycardia/ Heart Racing
___ Bradycardia/ Heart Slowing down
___ Murmur
___ Arm Pain
___ Constant shortness of breath
Other_____

SHORTNESS OF BREATH
___ Constant
___ Upon Exertion
___ Asthma
___ Wheezing
___ Air Hunger/ Frequent Sighs
___ Yawning
___ Emphysema
___ Other_____

STOMACH
___ Heartburn
___ Indigestion
___ Stomach Aches
___ Stomach Cramps
___ Nausea/ Queasy
___ Bloat after eat
___ Gas/ Flatulence
___ Belching
___ Ulcer
___ Hiatal Hernia
___ Other_____

BOWELS
___ Bowels Movements _____Per day
___ Regular
___ Incomplete Bowel Evacuation
___ Skip days_____per (week/month)
___ Sluggish bowels every _____days
___ Cramps in abdomen
___ Taking laxatives
___ Using Suppositories
___ Enemas
___ Colonics
___ Take Herbal laxatives/ Supplements
___ Bulky
___ Pain with bowel movements
___ Irritable Bowel Syndrome
___ Chrons
___ Colitis
___ Other_____

FECAL CONSISTENCY
___ Color feces light or dark_____
___ Soft/ Unformed
___ Ribbon-like
___ Mucous
___ Normal/ Banana Shaped
___ Hard
___ Pebbles
___ Dry
___ Painful
___ Diarrhea
___ Constipation
___ Broken
___ Other_____

HEMORRHOIDS
___ History
___ Current
___ Swollen
___ Burn
___ Blood
___ Distended

VAGINA
___ Burn
___ Itch
___ Dry
___ Pain
___ Pain with Intercourse
___ Blood
___ Discharge
___ Clear
___ White
___ Yellow
___ Green
___ Brown
___ Odor
___ Other_____

MENSES
___ Last Period_____
___ Length of Period_____
___ Regular
___ Irregular
___ Early (Less than 28 days)
___ Late (More than 28 days)
___ Skip period or scanty
___ Birth Control
___ Flow (heavy/ moderate/ light)
___ Cramps (mild/ moderate/ severe)
___ Low Abdominal Puffiness
___ Fluid Retention Face
___ Fluid Retention Hands
___ Fluid Retention Feet
___ Fluid Retention Body
___ Low Back Pain
___ Hot Flashes
___ Fatique during cycle
___ Diarrhea
___ Breast Tender around Cycle
___ Acne (pre/ middle/ post)
___ Clotting
___ Spotting
___ PMS
___ Mood Swings
___ Irritable
___ Depression
___ Tired during Period
___ Pain during Ovulation
___ Cysts/PCOS
___ Discharge with Ovulation
___ Regular Ovulation
___ Irregular Ovulation
___ Fibroids
___ Facial Hair
___ Hair growing up towards belly button
___ Dark nipple hair
___ Painful menstration
___ Menstrate too frequently
___ Other_____

BREASTS
___ Breast feeding
___ Fibrosis
___ Lump
___ Discharge
___ Prosthesis
___ Augmentation Surgery
___ Reduction Surgery
___ Pathology
___ Breast Tender Constant
___ Breast Shrinking

MENOPAUSE
___ Natural
___ Hysterectomy (Partial)
___ Hysterectomy (Complete)
___ Hormones
___ Patch
___ Hot Flashes

CRAMPS/ACHES/RESTLESS
___ Cramps (legs/ feet/ arms/ hands)
___ Aches (legs/ feet/ arms/ hands)
___ Restless (legs/ feet/ arms/ hands)

SKIN/ HAIR/ NAILS
___ Skin rash
___ Acne
___ Dry Skin
___ Itchy Skin
___ Fungus
___ Patches (skin looks different)
___ Cellulite
___ Nails (weak/ spots/ lines)
___ Hair loss
___ Limp Hair
___ Cherry Hemangiomas
___ Warts
___ Cracked Heels
___ Slow Healing
___ Bruise Easily
___ Other_____

URINATION
___ _____Times per day (frequency)
___ Urinate at night _____per night
___ Frequency
___ Urgency
___ Burning
___ Pain
___ Odor
___ Spasm
___ Leakage
___ Urinary Tract Infection
___ Kidney Troubles
___ Cloudy Urine
___ Difficulty starting Flow
___ Other _____

SLEEP
___ Quality (poor/ fair/ good/ great)
___ _____Hours in bed
___ _____Hours asleep
___ Difficulty falling asleep
___ Difficulty staying asleep
___ Interrupted _____per night
___ Crave sleep during day
___ Awaken Sudden (Jolt)
___ Don't Remember Dreams
___ Nightmares
___ Night Sweats
___ Restlessness
___ Sleep Apnea
___ Wake up feeling Rested
___ Other _____

EMOTIONS
___ Stressed
___ Sad
___ Grief
___ Depression
___ Moodiness
___ Irritable
___ Worrisome
___ Angry
___ Nervous
___ Frustrated
___ Anxiety
___ Panic
___ Cry
___ Fear
___ Shame
___ Apathy

APPETITE/ DIET
___ Appetite (Low/ Normal/ High)
___ Crave Salt/ Salty foods
___ Crave Sweets
___ Crave Starch (pasta/ bread/ potatoes)
___ Crave Chocolate
___ Crave Spicy Foods
___ Coffee _____cups per day
___ Alcohol _____Drinks per week
___ Soda _____Per week
___ Artificial Sweetners
___ Animal Protein per day _____oz

ENERGY
___ Low
___ Variable
___ Normal
___ High
___ Slow to Start in morning
___ Energy Crash _____am/pm
___ Low energy after meals
___ Dizzy when stand quickly
___ Irritable with skip meals
___ Eating relieves fatigue
___ Bouts of blurred vision
___ Light headed when skip meals

EXERCISE
___ Cardiovascular _____times/week
___ Weight Training _____times/week

MEMORY
___ Short Term Loss
___ Long Term Loss
___ Forget Names
___ Forget Numbers
___ Forget Words
___ Forget Actions
___ Difficulty Concentrating
___ Other _____

LIBIDO/SEXUALITY
___ Sex Drive (Flat/ Low/ Normal/ High)
___ Orgasm Quality (poor/ good/ great)
Other _____

PAIN/ STIFFNESS/ SWELLING NUMBNESS/ TINGLING
___ Facial
___ Neck
___ Trapezius
___ Upper Back
___ Shoulders
___ Arms
___ Elbows
___ Wrist
___ Hand
___ Mid Back
___ Low Back
___ Sacral Iliac
___ Hips
___ Buttocks
___ Legs
___ Sciatica
___ Knees
___ Ankles
___ Feet

LIST PRIMARY CONCERNS
1)_____
_____
2)_____
_____
3)_____
_____

FOR DOCTOR'S USE
Luna Fingernails-
Rt 1 2 3 4 5 Lt 1 2 3 4 5
Splinter Hemorrhages
Frenular Cyst
Cracks in Tongue
Allergy Patches Tongue
Geographic Tongue
Red Spots Tongue
Swollen Tongue
Color Tongue _____
Dark Veins Tongue
Coated Tongue (Mild/ Mod/ Severe)
Ear Creases (Rt/ Lt) mild/ mod/severe
Cherry Hemangioma
Height:_____
Weight:_____
Pulse:_____
Blood Pressure:_____
Saliva PH_____Urine PH_____
Allergies:_____
Current Meds:_____

Name_____ Date_____

Symptom Survey

Circle the number that applies to you. Use (1) for MILD (occurs 1-2 times per month)

Use (2) for MODERATE (occurs several times per month) Use (3) SEVERE (occurs almost constantly)

				GROUP 1- SYM					GROUP 2- PARA					GROUP 3- SUGAR HANDLING
0	1	2	3	Acids Food Upset	0	1	2	3	Joint Stiffness after rising	0	1	2	3	Eat when nervous
0	1	2	3	Get Chilled Often	0	1	2	3	Muscle, leg, toe cramps at night	0	1	2	3	Excessive appetite
0	1	2	3	"Lump in Throat"	0	1	2	3	"Butterfly" Stomach	0	1	2	3	Hungry between meals
0	1	2	3	Dry Mouth, eyes, nose	0	1	2	3	Eyes or Nose watery	0	1	2	3	Irritable before meals
0	1	2	3	Pulse speeds after meal	0	1	2	3	Eyes Blink often	0	1	2	3	Get "shaky" if hungry
0	1	2	3	Keyed up- Fail to calm	0	1	2	3	Eyelids swollen, puffy	0	1	2	3	Fatigue, eating relieves
0	1	2	3	Cuts Heal Slowly	0	1	2	3	Indigestion Soon after meals	0	1	2	3	"Lightheaded" if meals delayed
0	1	2	3	Gag Easily	0	1	2	3	Always seem hungry "lightheaded"	0	1	2	3	Heart palpitation if meals missed
0	1	2	3	Unable to Relax- Startle easily	0	1	2	3	Digestion rapid	0	1	2	3	Afternoon headaches
0	1	2	3	Extremities cold, clammy	0	1	2	3	Vomiting frequent	0	1	2	3	Overeating Sweets upsets
0	1	2	3	Strong light irritates	0	1	2	3	Hoarseness frequent	0	1	2	3	Awaken after few hour sleep
0	1	2	3	Urine amount reduced	0	1	2	3	Breathing Irregular					hard to get back to sleep
0	1	2	3	Heart Pounds after retiring	0	1	2	3	Pulse Slow, feels "irregular"	0	1	2	3	Crave candy or coffee afternoons
0	1	2	3	"Nervous" Stomach	0	1	2	3	Gagging reflex slow	0	1	2	3	Moods of depression-
0	1	2	3	Appetite reduced	0	1	2	3	Difficulty swallowing					"blues" or melancholy
0	1	2	3	Cold Sweats often	0	1	2	3	Constipation/ diarrhea alternating	0	1	2	3	Abnormal craving for sweets
0	1	2	3	Fever Easily raised	0	1	2	3	"Slow Starter"					
0	1	2	3	Neuralgia like pains	0	1	2	3	Get "chilled" infrequently					
0	1	2	3	Staring, Blinks little	0	1	2	3	Perspire easily					**GROUP 5A-BIL**
0	1	2	3	Sour stomach frequently	0	1	2	3	Circulation poor, sensitive to cold	0	1	2	3	Greasy or high-fat foods cause distress
					0	1	2	3	Subject to colds, asthma, bronchitis	0	1	2	3	Lower bowel gas and/or bloating several hours
										0	1	2	3	after eating
				GROUP 3A-BLOOD SUGAR HYPO					**GROUP 3B- INSULIN RESISTANCE**	0	1	2	3	Bitter metallic taste in mouth especially in the morning
0	1	2	3	Crave sweets during the day	0	1	2	3	Fatigue after meals	0	1	2	3	Burp, fishy taste after consuming fish oils
0	1	2	3	Irritable if meals are missed	0	1	2	3	Crave sweets during the day	0	1	2	3	Difficulty losing weight
0	1	2	3	Depend on coffee to keep going/ get started	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3	Unexplained itchy skin
0	1	2	3	Get light-headed if meals are missed	0	1	2	3	Must have sweets after meals	0	1	2	3	Yellowish cast to eyes
0	1	2	3	Eating relieves fatigue	0	1	2	3	Waist girth is equal or larger than hip girth	0	1	2	3	Stool color alternates from clay colored to normal
0	1	2	3	Feel shaky, jittery, or have tremors	0	1	2	3	Frequent urination	0	1	2	3	Reddened skin, especially palms
0	1	2	3	Agitated, easily upset, nervous	0	1	2	3	Increased thirst and appetite	0	1	2	3	Dry or flaky skin and/or hair
0	1	2	3	Poor memory/ forgetful	0	1	2	3	Difficulty losing weight	0	1	2	3	History of gallbladder attacks or stones
0	1	2	3	Blurred vision						0	1	2	3	Had gallbladder removed
														GROUP 5B-HEP DETOX
				GROUP 4- CARDIO					**GROUP 5- GB/LVR**	0	1	2	3	Acne and unhealthy skin
0	1	2	3	Hands & feet go to sleep easily	0	1	2	3	Dizziness	0	1	2	3	Excessive hair loss
0	1	2	3	Sigh frequently	0	1	2	3	Dry Skin	0	1	2	3	Overall sense of bloating
0	1	2	3	Aware of "breathing heavily"	0	1	2	3	Burning Feet	0	1	2	3	Bodily swelling for no reason
0	1	2	3	High altitude discomfort	0	1	2	3	Blurred Vision	0	1	2	3	Hormone imbalances
0	1	2	3	Opens windows in closed rooms	0	1	2	3	Itchy skin & feet	0	1	2	3	Weight gain
0	1	2	3	Susceptible to colds & fevers	0	1	2	3	Excessive falling hair	0	1	2	3	Poor bowel function
0	1	2	3	Afternoon "yawner"	0	1	2	3	Frequent skin rashes	0	1	2	3	Excessively foul-smelling sweat
0	1	2	3	Get drowsy often	0	1	2	3	Bitter metallic taste in mouth					
0	1	2	3	Swollen ankles worse at night					in morning					**GROUP 6A-STM HYPO**
0	1	2	3	Muscle cramps, worse during	0	1	2	3	Bowel movements painful	0	1	2	3	Excessive belching, burping, or bloating
				exercise; get "charley horses"	0	1	2	3	Worrier, feels insecure	0	1	2	3	Gas immediately following a meal
0	1	2	3	Shortness of breath on exertion	0	1	2	3	Feeling queasy; headache over eyes	0	1	2	3	Offensive breath
0	1	2	3	Dull pain in chest or radiating into	0	1	2	3	Greasy foods upset	0	1	2	3	Difficult bowel movements
				left arm, worse on exertion	0	1	2	3	Stools Light colored	0	1	2	3	Sense of fullness during and after meals
0	1	2	3	Bruise easily, "black & blue" spots	0	1	2	3	Skin peels on foot soles	0	1	2	3	Difficulty digesting fruits and vegetables;
0	1	2	3	Tendency to anemia	0	1	2	3	Pain between shoulder blades					undigested foods found in stools
0	1	2	3	"Nose bleeds" frequent	0	1	2	3	Use Laxatives					
0	1	2	3	Noises in head or "ringing in ears"	0	1	2	3	Stools alternate from soft to watery					**GROUP 6A- HYPER**
0	1	2	3	Tension under breastbone or	0	1	2	3	History of gallbladder attacks	0	1	2	3	Stomach pain, burning or aching 1-4 hours after eating
				feeling of "tightness"					or gallstones	0	1	2	3	Frequently use antacids
				worse on exertion	0	1	2	3	Sneezing attacks	0	1	2	3	Feeling hungry an hour or two after eating
					0	1	2	3	Dreaming, nightmare type dreams	0	1	2	3	Heartburn when lying down or bending forward
					0	1	2	3	Bad Breath (halitosis)	0	1	2	3	Temporary relief using antacids, food, milk,
					0	1	2	3	Milk products cause distress					or carbonated beverages
					0	1	2	3	Sensitive to hot weather	0	1	2	3	Digestive problems subside with rest & relaxation
					0	1	2	3	Burning or itching anus	0	1	2	3	Heartburn due to spicy foods, chocolate, citrus,
					0	1	2	3	Crave Sweets					peppers, alcohol, and caffeine

Name_____ Date_____

Symptom Survey

Circle the number that applies to you. Use (1) for MILD (occurs 1-2 times per month)

Use (2) for MODERATE (occurs several times per month) Use (3) SEVERE (occurs almost constantly)

				GROUP 6- GB					GROUP 6B- SMI/PAN					GROUP 6C- COLON
0	1	2	3	Loss of Taste for meats	0	1	2	3	Roughage and fiber cause constipation	0	1	2	3	Feeling that bowel do not empty completely
0	1	2	3	Lower bowel gas several hours after eating	0	1	2	3	Indigestion/ fullness lasts 2-4 hours after eating	0	1	2	3	Lower abdominal pain relief by passing gas
0	1	2	3	Burning stomach sensations, eating relieves	0	1	2	3	Pain, tenderness, soreness, on left side under	0	1	2	3	Alternating constipation and diarrhea
0	1	2	3	Coated tongue					rib cage	0	1	2	3	Diarrhea
0	1	2	3	Pass large amounts of foul-smelling gas	0	1	2	3	Excessive passage of gas	0	1	2	3	Constipation
0	1	2	3	Indigestion 1/2- 1 hour after eating,	0	1	2	3	Nausea and/or vomiting	0	1	2	3	Hair, dry, or small stool
				maybe up to 3-4 hours	0	1	2	3	Stool undigested, foul smelling, mucous like,	0	1	2	3	Coated tongue of "fuzzy" debris on tongue
0	1	2	3	Mucous colitis or "irritable bowel"					greasy, or poorly formed	0	1	2	3	Pass large amount of foul smelling gas
0	1	2	3	Gas shortly after eating	0	1	2	3	Frequent urination	0	1	2	3	More than 3 bowel movements daily
0	1	2	3	Stomach bloating after eating	0	1	2	3	Increased thirst and appetite	0	1	2	3	Use laxatives frequently
				GROUP 6C-INTESTIONAL INTEGRITY					**GROUP 7A- PIT UP**					**GROUP 7A- THY HYPER**
0	1	2	3	Increasing frequency of food reactions	0	1	2	3	Insomnia	0	1	2	3	Heart palpitations
0	1	2	3	Unpredictable food reactions	0	1	2	3	Nervousness	0	1	2	3	Inward trembling
0	1	2	3	Aches, pains, & swelling throughout the body	0	1	2	3	Can't gain weight	0	1	2	3	Increased pulse even at rest
0	1	2	3	Unpredictable abdominal swelling	0	1	2	3	Intolerance to heat	0	1	2	3	Nervous and emotional
0	1	2	3	Frequent bloating and distention after eating	0	1	2	3	Highly emotional	0	1	2	3	Insomnia
0	1	2	3	Abdominal intolerance to sugars and starches	0	1	2	3	Flush easily	0	1	2	3	Night sweats
					0	1	2	3	Night Sweats	0	1	2	3	Difficulty gaining weight
					0	1	2	3	Thin, moist skin					
				GROUP 7B- THY HYPO	0	1	2	3	Inward trembling					**GROUP 7C- PIT HYPER**
0	1	2	3	Increase in weight	0	1	2	3	Heart palpitates	0	1	2	3	Failing memory
0	1	2	3	Decrease in appetite	0	1	2	3	Increased appetite without weight gain	0	1	2	3	Low blood pressure
0	1	2	3	Fatigue easily	0	1	2	3	Pulse fast at rest	0	1	2	3	Increased sex drive
0	1	2	3	Ringing in ears	0	1	2	3	Eyelids and face twitch	0	1	2	3	Headaches "splitting or rending"
0	1	2	3	Sleepy during day	0	1	2	3	Irritable and restless	0	1	2	3	Decreased sugar intolerance
0	1	2	3	Sensitive to cold	0	1	2	3	Can't work under pressure	0	1	2	3	Increased sex drive
0	1	2	3	Dry or scaly skin						0	1	2	3	Tolerance to sugars reduced
0	1	2	3	Constipation					**GROUP 7B- THY HYPO**	0	1	2	3	"Splitting" type headaches
0	1	2	3	Mental Sluggishness	0	1	2	3	Tired/ sluggish					
0	1	2	3	Hair Coarse, falls out	0	1	2	3	Feel cold- hands, feet, all over					**GROUP 7D- PIT HYPO**
0	1	2	3	Headaches upon arising wear off	0	1	2	3	Require excessive amounts of sleep to function	0	1	2	3	Abnormal thirst
				during day	0	1	2	3	Increase in weight even with low calorie diet	0	1	2	3	Bloating of abdomen
0	1	2	3	Slow pulse, below 65	0	1	2	3	Gain weight easily	0	1	2	3	Weight gain around hips or waist
0	1	2	3	Frequency of urination	0	1	2	3	Difficult, infrequent bowel movements	0	1	2	3	Sex drive reduced or lacking
0	1	2	3	Impaired hearing	0	1	2	3	Depression/ lack of motivation	0	1	2	3	Tendency to ulcers, colitis
0	1	2	3	Reduced initiative	0	1	2	3	Morning headaches that wear off as day progresses	0	1	2	3	Increased sugar tolerance
					0	1	2	3	Outer third of eyebrows thin	0	1	2	3	Women: menstrual disorders
					0	1	2	3	Thinning of hair on head or body, excessive hair loss	0	1	2	3	Young Girls: lack of menstrual function
				GROUP 7E	0	1	2	3	Dryness of skin and/or scalp	0	1	2	3	Diminished sex drive
0	1	2	3	Dizziness	0	1	2	3	Mental sluggishness	0	1	2	3	Menstrual disorders of lack of menstruation
0	1	2	3	Headaches						0	1	2	3	Increased ability to eat sugars without symptoms
0	1	2	3	Hot flashes										**GROUP 8**
0	1	2	3	Increased Blood pressure					**GROUP 7F-ADR HYPO**	0	1	2	3	Apprehension
0	1	2	3	Hair growth on face or body(female)	0	1	2	3	Weakness, dizziness	0	1	2	3	Irritability
0	1	2	3	Sugar in urine (not diabetes)	0	1	2	3	Chronic Fatigue	0	1	2	3	Morbid fears
0	1	2	3	Masculine tendencies (female)	0	1	2	3	Low blood pressure	0	1	2	3	Never seems to get well
					0	1	2	3	Nails weak, ridged	0	1	2	3	Forgetfulness
				GROUP 7E- ADR HYPER	0	1	2	3	Tendency to hives	0	1	2	3	Indigestion
0	1	2	3	Cannot fall asleep	0	1	2	3	Arthritic tendencies	0	1	2	3	Poor appetite
0	1	2	3	Perspire easily	0	1	2	3	Perspiration increase	0	1	2	3	Craving for sweets
0	1	2	3	Under high amounts of stress	0	1	2	3	Bowel disorders	0	1	2	3	Muscular soreness
0	1	2	3	Weight gain when under stress	0	1	2	3	Poor circulation	0	1	2	3	Depression; feelings of dread
0	1	2	3	Wake up tired even after 6 or more hours sleep	0	1	2	3	Swollen ankles	0	1	2	3	Noise sensitivity
0	1	2	3	Excessive perspiration/ perspiration w/ no activity	0	1	2	3	Crave salt	0	1	2	3	Acoustic hallucinations
					0	1	2	3	Brown spots or bronzing of skin	0	1	2	3	Tendency to cry without reason
				GROUP 9- ELECTRO	0	1	2	3	Allergies- tendency to asthma	0	1	2	3	Hair is coarse and/or thinning
0	1	2	3	Edema and swelling in ankles and wrist	0	1	2	3	Weakness after colds, influenza	0	1	2	3	Weakness
0	1	2	3	Muscle cramping	0	1	2	3	Exhaustion- muscular & nervous	0	1	2	3	Fatigue
0	1	2	3	Poor muscle endurance	0	1	2	3	Respiratory Disorders	0	1	2	3	Skin sensitive to touch
0	1	2	3	Frequent urination						0	1	2	3	Tendency toward hives
0	1	2	3	Frequent thirst						0	1	2	3	Nervousness
0	1	2	3	Crave Salt						0	1	2	3	Headache
0	1	2	3	Abnormal sweating with minimal activity						0	1	2	3	Insomnia
0	1	2	3	Alteration in bowel regularity						0	1	2	3	Anxiety
0	1	2	3	Inability to hold breath for long periods						0	1	2	3	Anorexia
0	1	2	3	Shallow, rapid breathing						0	1	2	3	Inability to concentrate; confusion
										0	1	2	3	Frequently stuffy nose;
														sinus infections
										0	1	2	3	Allergy to foods
										0	1	2	3	Loose joints