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. _____

Lozier Natural Health Center, PC

Integrative Treatments for Whole Body Health

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 for 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)

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 protocol we will be sharing with you?

   1. _____
   2. _____
   3. _____

Lozier Natural Health Center, PC

Integrative Treatments for Whole Body Health

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

11. What do you love to do? _____

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 do 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 a typical day? _____

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 Can**er**	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐
Chronic Infections	☐	☐	☐	☐	☐	☐	☐
Chicken Pox	☐	☐	☐	☐	☐	☐	☐
Clotting Problems	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Diabetes Type I	☐	☐	☐	☐	☐	☐	☐
Diabetes Type II	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐
Downs Syndrome	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐
Epilepsy / Seizures	☐	☐	☐	☐	☐	☐	☐

	You	Mother	Father	Children	Siblings	Father's Parents	Mother's Parents
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	☐	☐	☐	☐	☐	☐	☐

Name_____ Date_____

Symptom Survey

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

Name_____ Date_____

Symptom Survey

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

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… Write 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
- ☐ Fatigue 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
- ☐ Worts
- ☐ 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:_____