



# 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 healthiest foods you eat during an average week?

List the 3 worst 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 Cancer

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							

**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		
		Acids Food Upset			Joint Stiffness after rising			Eat when nervous
		Get Chilled Often			Muscle, leg, toe cramps at night			Excessive appetite
		"Lump in Throat"			"Butterfly" Stomach			Hungry between meals
		Dry Mouth, eyes, nose			Eyes or Nose watery			Irritable before meals
		Pulse speeds after meal			Eyes Blink often			Get "shaky" if hungry
		Keyed up- Fail to calm			Eyelids swollen, puffy			Fatigue, eating relieves
		Cuts Heal Slowly			Indigestion Soon after meals			"Lightheaded" if meals delayed
		Gag Easily			Always seem hungry "lightheaded"			Heart palpitation if meals missed
		Unable to Relax- Startle easily			Digestion rapid			Afternoon headaches
		Extremities cold, clammy			Vomiting frequent			Overeating Sweets upsets
		Strong light irritates			Hoarseness frequent			Awaken after few hour sleep
		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			<b>GROUP 5A-BIL</b>
		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
		<b>GROUP 3A-BLOOD SUGAR HYPO</b>			<b>GROUP 3B- INSULIN RESISTANCE</b>			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
								<b>GROUP 5B-HEP DETOX</b>
		<b>GROUP 4- CARDIO</b>			<b>GROUP 5- GB/LVR</b>			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			<b>GROUP 6A-STM HYPO</b>
		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			<b>GROUP 6A- HYPER</b>
		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-INTESTINAL 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			GROUP 7B- THY HYPO			GROUP 7C- PIT HYPER		
		Increase in weight			Inward trembling			Failing memory
		Decrease in appetite			Heart palpitates			Low blood pressure
		Fatigue easily			Increased appetite without weight gain			Increased sex drive
		Ringing in ears			Pulse fast at rest			Headaches "splitting or rending"
		Sleepy during day			Eyelids and face twitch			Decreased sugar intolerance
		Sensitive to cold			Irritable and restless			Increased sex drive
		Dry or scaly skin			Can't work under pressure			Tolerance to sugars reduced
		Constipation						"Splitting" type headaches
		Mental Sluggishness			Tired/ sluggish			
		Hair Coarse, falls out			Feel cold- hands, feet, all over			
		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 7E- ADR HYPER			GROUP 7F-ADR HYPO			GROUP 8		
		Increased Blood pressure			Weakness, dizziness			Apprehension
		Hair growth on face or body(female)			Chronic Fatigue			Irritability
		Sugar in urine (not diabetes)			Low blood pressure			Morbid fears
		Masculine tendencies (female)			Nails weak, ridged			Never seems to get well
					Tendency to hives			Forgetfulness
		Cannot fall asleep			Arthritic tendencies			Indigestion
		Perspire easily			Perspiration increase			Poor appetite
		Under high amounts of stress			Bowel disorders			Craving for sweets
		Weight gain when under stress			Poor circulation			Muscular soreness
		Wake up tired even after 6 or more hours sleep			Swollen ankles			Depression; feelings of dread
		Excessive perspiration/ perspiration w/ no activity			Crave salt			Noise sensitivity
					Brown spots or bronzing of skin			Acoustic hallucinations
GROUP 9- ELECTRO					Allergies- tendency to asthma			Tendency to cry without reason
		Edema and swelling in ankles and wrist			Weakness after colds, influenza			Hair is coarse and/or thinning
		Muscle cramping			Exhaustion- muscular & nervous			Weakness
		Poor muscle endurance			Respiratory Disorders			Fatigue
		Frequent urination						Skin sensitive to touch
		Frequent thirst						Tendency toward hives
		Crave Salt						Nervousness
		Abnormal sweating with minimal activity						Headache
		Alteration in bowel regularity						Insomnia
		Inability to hold breath for long periods						Anxiety
		Shallow, rapid breathing						Anorexia
								Inability to concentrate; confusion
								Frequently stuffy nose;
								sinus infections
								Allergy to foods
								Loose joints

Name \_\_\_\_\_

Date \_\_\_\_\_

consistency taking supplements \_\_\_\_\_ %

**MEN'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 CURRENTLY 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  
☐ Styte  
☐ 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/ Cheliosis  
☐ Dry Mouth  
☐ Cold sweaty hands & feet  
☐ Bleeding gums  
☐ Receding 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 Prolapse  
☐ 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 \_\_\_\_\_

**PECKS**

☐ Breast Shrinking  
☐ Fibrosis  
☐ Lump  
☐ Discharge  
☐ Prosthesis  
☐ Augmentation Surgery  
☐ Reduction Surgery  
☐ Pathology  
☐ Breast Tender Constant

**CRAMPS/ACHES/RESTLESS**

☐ Cramps  
☐ Aches  
☐ Restless

**STAMINA**

☐ Decreased morning Erections  
☐ Decreased Fullness Erections  
☐ Inability to Concentrate  
☐ Episodes of Depression  
☐ Decreased physical Stamina  
☐ Sweating attacks  
☐ More emotional than past  
☐ Unexplained weight gain  
☐ Avoids Activity  
☐ Lack of Energy  
☐ Tire too easily  
☐ Leg Nervousness at night  
☐ Pain on the inside of legs

**PROSTATE**

☐ History  
☐ Current  
☐ Burn  
☐ Achyness  
☐ Pain  
☐ Restriction  
☐ Dribbling  
☐ Emission  
☐ Swelling  
☐ Testicular Pain

**LIBIDO/SEXUALITY**

☐ Sex Drive- Check One  
     Flat  
     Low  
     Normal  
     High  
☐ Orgasm Quality- Check One  
     Poor  
     Good  
     Great  
☐ Other \_\_\_\_\_

**APPETITE/ DIET**

☐ Appetite  
☐ Crave Salt/ Salty foods \_\_\_\_\_  
☐ Crave Sweets  
☐ Crave Starch \_\_\_\_\_  
☐ Crave Chocolate  
☐ Crave Spicy Foods  
☐ Coffee \_\_\_\_\_ cups per day  
☐ Alcohol \_\_\_\_\_ Drinks per week  
☐ Soda \_\_\_\_\_ Per week  
☐ Artificial Sweetners  
☐ Animal Protein per day \_\_\_\_\_ oz

**HEMORRHOIDS**

☐ History  
☐ Current  
☐ Swollen  
☐ Burn  
☐ Blood  
☐ Distended

**SKIN/ HAIR/ NAILS**

☐ Skin rash  
☐ Acne  
☐ Dry Skin  
☐ Itchy Skin  
☐ Fungus  
☐ Patches (skin looks different)  
☐ Cellulite  
☐ Nails  
☐ 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 \_\_\_\_\_  
☐ 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

**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 \_\_\_\_\_

**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 (R/ Lt) mild/ mod/severe  
 Cherry Hemangioma  
 Height: \_\_\_\_\_  
 Weight: \_\_\_\_\_  
 Pulse: \_\_\_\_\_  
 Blood Pressure: \_\_\_\_\_  
 Saliva PH \_\_\_\_\_ Urine PH \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Current Meds: \_\_\_\_\_