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 <u>this visit</u>?

____

____

4. What <u>long-term</u> 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________%

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 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 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 (legs/ feet/ arms/ hands)
___ Aches (legs/ feet/ arms/ hands)
___ Restless (legs/ feet/ arms/ hands)

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- Circle one
Flat
Low
Normal
High
Orgasm Quality- Circle One
Poor
Good
Great
___ Other ________________________

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

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

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

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 (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
0	1	2	3	Acids Food Upset
0	1	2	3	Get Chilled Often
0	1	2	3	"Lump in Throat"
0	1	2	3	Dry Mouth, eyes, nose
0	1	2	3	Pulse speeds after meal
0	1	2	3	Keyed up- Fail to calm
0	1	2	3	Cuts Heal Slowly
0	1	2	3	Gag Easily
0	1	2	3	Unable to Relax- Startle easily
0	1	2	3	Extremities cold, clammy
0	1	2	3	Strong light irritates
0	1	2	3	Urine amount reduced
0	1	2	3	Heart Pounds after retiring
0	1	2	3	"Nervous" Stomach
0	1	2	3	Appetite reduced
0	1	2	3	Cold Sweats often
0	1	2	3	Fever Easily raised
0	1	2	3	Neuralgia like pains
0	1	2	3	Staring, Blinks little
0	1	2	3	Sour stomach frequently
				GROUP 3A-BLOOD SUGAR HYPO
0	1	2	3	Crave sweets during the day
0	1	2	3	Irritable if meals are missed
0	1	2	3	Depend on coffee to keep going/ get started
0	1	2	3	Get light-headed if meals are missed
0	1	2	3	Eating relieves fatigue
0	1	2	3	Feel shaky, jittery, or have tremors
0	1	2	3	Agitated, easily upset, nervous
0	1	2	3	Poor memory/ forgetful
0	1	2	3	Blurred vision
				GROUP 4- CARDIO
0	1	2	3	Hands & feet go to sleep easily
0	1	2	3	Sigh frequently
0	1	2	3	Aware of "breathing heavily"
0	1	2	3	High altitude discomfort
0	1	2	3	Opens windows in closed rooms
0	1	2	3	Susceptible to colds & fevers
0	1	2	3	Afternoon "yawner"
0	1	2	3	Get drowsy often
0	1	2	3	Swollen ankles worse at night
0	1	2	3	Muscle cramps, worse during
				exercise; get "charley horses"
0	1	2	3	Shortness of breath on exertion
0	1	2	3	Dull pain in chest or radiating into
				left arm, worse on exertion
0	1	2	3	Bruise easily, "black & blue" spots
0	1	2	3	Tendency to anemia
0	1	2	3	"Nose bleeds" frequent
0	1	2	3	Noises in head or "ringing in ears"
0	1	2	3	Tension under breastbone or
				feeling of "tightness"
				worse on exertion

				GROUP 2- PARA
0	1	2	3	Joint Stiffness after rising
0	1	2	3	Muscle, leg, toe cramps at night
0	1	2	3	"Butterfly" Stomach
0	1	2	3	Eyes or Nose watery
0	1	2	3	Eyes Blink often
0	1	2	3	Eyelids swollen, puffy
0	1	2	3	Indigestion Soon after meals
0	1	2	3	Always seem hungry "lightheaded"
0	1	2	3	Digestion rapid
0	1	2	3	Vomiting frequent
0	1	2	3	Hoarseness frequent
0	1	2	3	Breathing Irregular
0	1	2	3	Pulse Slow, feels "irregular"
0	1	2	3	Gagging reflex slow
0	1	2	3	Difficulty swallowing
0	1	2	3	Constipation/ diarrhea alternating
0	1	2	3	"Slow Starter"
0	1	2	3	Get "chilled" infrequently
0	1	2	3	Perspire easily
0	1	2	3	Circulation poor, sensitive to cold
0	1	2	3	Subject to colds, asthma, bronchitis
				GROUP 3B- INSULIN RESISTANCE
0	1	2	3	Fatigue after meals
0	1	2	3	Crave sweets during the day
0	1	2	3	Eating sweets does not relieve cravings for sugar
0	1	2	3	Must have sweets after meals
0	1	2	3	Waist girth is equal or larger than hip girth
0	1	2	3	Frequent urination
0	1	2	3	Increased thirst and appetite
0	1	2	3	Difficulty losing weight
				GROUP 5- GB/LVR
0	1	2	3	Dizziness
0	1	2	3	Dry Skin
0	1	2	3	Burning Feet
0	1	2	3	Blurred Vision
0	1	2	3	Itchy skin & feet
0	1	2	3	Excessive falling hair
0	1	2	3	Frequent skin rashes
0	1	2	3	Bitter metallic taste in mouth
				in morning
0	1	2	3	Bowel movements painful
0	1	2	3	Worrier, feels insecure
0	1	2	3	Feeling queasy; headache over eyes
0	1	2	3	Greasy foods upset
0	1	2	3	Stools Light colored
0	1	2	3	Skin peels on foot soles
0	1	2	3	Pain between shoulder blades
0	1	2	3	Use Laxatives
0	1	2	3	Stools alternate from soft to watery
0	1	2	3	History of gallbladder attacks
				or gallstones
0	1	2	3	Sneezing attacks
0	1	2	3	Dreaming, nightmare type dreams
0	1	2	3	Bad Breath (halitosis)
0	1	2	3	Milk products cause distress
0	1	2	3	Sensitive to hot weather
0	1	2	3	Burning or itching anus
0	1	2	3	Crave Sweets

				GROUP 3- SUGAR HANDLING
0	1	2	3	Eat when nervous
0	1	2	3	Excessive appetite
0	1	2	3	Hungry between meals
0	1	2	3	Irritable before meals
0	1	2	3	Get "shaky" if hungry
0	1	2	3	Fatigue, eating relieves
0	1	2	3	"Lightheaded" if meals delayed
0	1	2	3	Heart palpitation if meals missed
0	1	2	3	Afternoon headaches
0	1	2	3	Overeating Sweets upsets
0	1	2	3	Awaken after few hour sleep
				hard to get back to sleep
0	1	2	3	Crave candy or coffee afternoons
0	1	2	3	Moods of depression-
				"blues" or melancholy
0	1	2	3	Abnormal craving for sweets
				GROUP 5A-BIL
0	1	2	3	Greasy or high-fat foods cause distress
0	1	2	3	Lower bowel gas and/or bloating several hours
0	1	2	3	after eating
0	1	2	3	Bitter metallic taste in mouth especially in the morning
0	1	2	3	Burp, fishy taste after consuming fish oils
0	1	2	3	Difficulty losing weight
0	1	2	3	Unexplained itchy skin
0	1	2	3	Yellowish cast to eyes
0	1	2	3	Stool color alternates from clay colored to normal
0	1	2	3	Reddened skin, especially palms
0	1	2	3	Dry or flaky skin and/or hair
0	1	2	3	History of gallbladder attacks or stones
0	1	2	3	Had gallbladder removed
				GROUP 5B-HEP DETOX
0	1	2	3	Acne and unhealthy skin
0	1	2	3	Excessive hair loss
0	1	2	3	Overall sense of bloating
0	1	2	3	Bodily swelling for no reason
0	1	2	3	Hormone imbalances
0	1	2	3	Weight gain
0	1	2	3	Poor bowel function
0	1	2	3	Excessively foul-smelling sweat
				GROUP 6A-STM HYPO
0	1	2	3	Excessive belching, burping, or bloating
0	1	2	3	Gas immediately following a meal
0	1	2	3	Offensive breath
0	1	2	3	Difficult bowel movements
0	1	2	3	Sense of fullness during and after meals
0	1	2	3	Difficulty digesting fruits and vegetables;
				undigested foods found in stools
				GROUP 6A- HYPER
0	1	2	3	Stomach pain, burning or aching 1-4 hours after eating
0	1	2	3	Frequently use antacids
0	1	2	3	Feeling hungry an hour or two after eating
0	1	2	3	Heartburn when lying down or bending forward
0	1	2	3	Temporary relief using antacids, food, milk,
				or carbonated beverages
0	1	2	3	Digestive problems subside with rest & relaxation
0	1	2	3	Heartburn due to spicy foods, chocolate, citrus,
				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 starche	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
				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
				Cannot fall asleep	0	1	2	3	Arthritic tendencies	0	1	2	3	Poor appetite
				Perspire easily	0	1	2	3	Perspiration increase	0	1	2	3	Craving for sweets
				Under high amounts of stress	0	1	2	3	Bowel disorders	0	1	2	3	Muscular soreness
				Weight gain when under stress	0	1	2	3	Poor circulation	0	1	2	3	Depression; feelings of dread
				Wake up tired even after 6 or more hours sleep	0	1	2	3	Swollen ankles	0	1	2	3	Noise sensitivity
				Excessive perspiration/ perspiration w/ no activit	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
				Edema and swelling in ankles and wrist	0	1	2	3	Weakness after colds, influenza	0	1	2	3	Weakness
				Muscle cramping	0	1	2	3	Exhaustion- muscular & nervous	0	1	2	3	Fatigue
				Poor muscle endurance	0	1	2	3	Respiratory Disorders	0	1	2	3	Skin sensitive to touch
				Frequent urination						0	1	2	3	Tendency toward hives
				Frequent thirst						0	1	2	3	Nervousness
				Crave Salt						0	1	2	3	Headache
				Abnormal sweating with minimal activity						0	1	2	3	Insomnia
				Alteration in bowel regularity						0	1	2	3	Anxiety
				Inability to hold breath for long periods						0	1	2	3	Anorexia
				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