



# 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. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

Any known medication allergies?  Yes  No

List: \_\_\_\_\_

List nutritional/ herbal supplements you are currently taking:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_



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

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

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3. What expectations do you have from this visit?

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

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

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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?

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

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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?

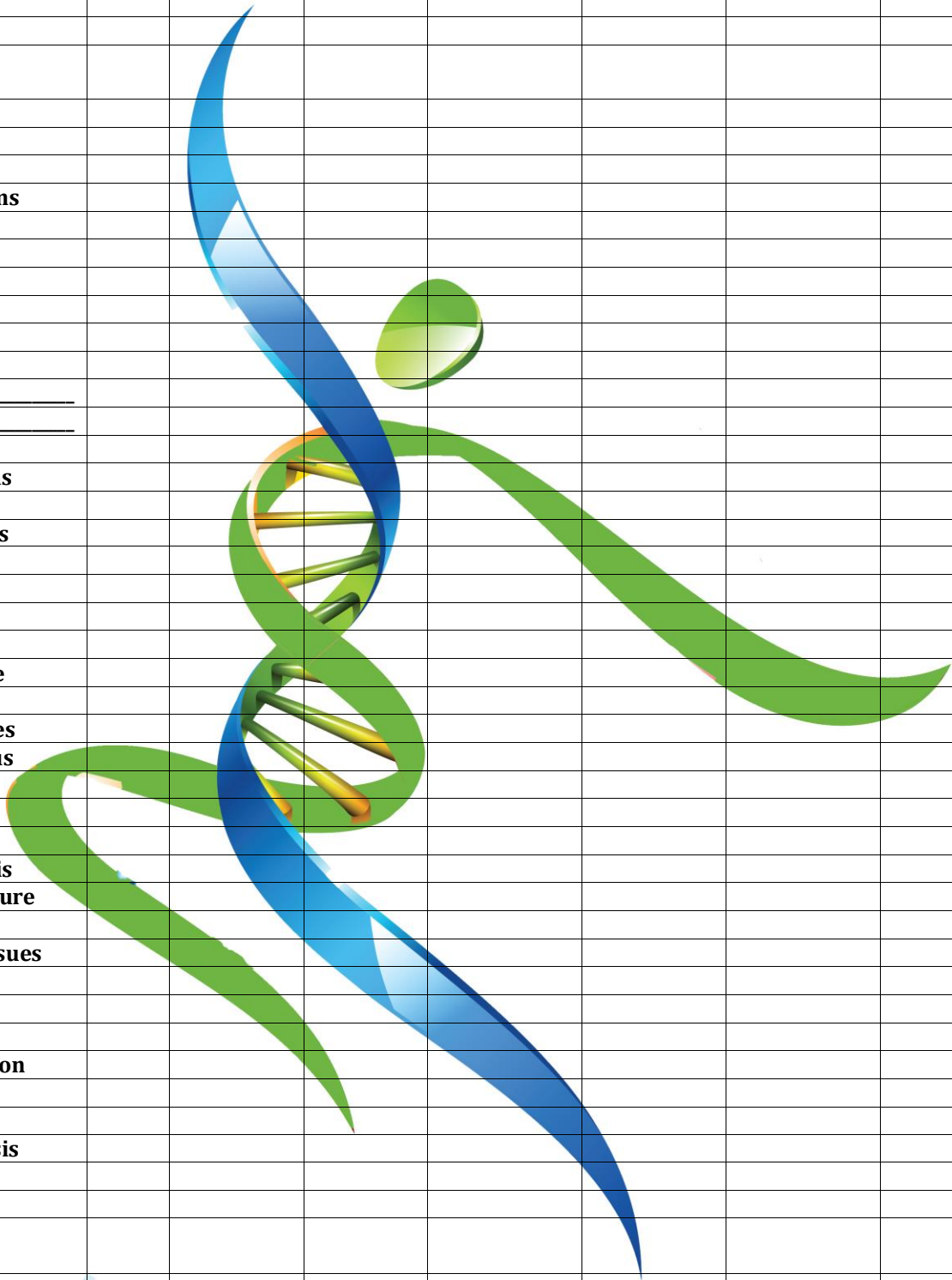
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11. What do you love to do? \_\_\_\_\_

# 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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Please list your Primary Health Concerns:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please list your Health Goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
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 fruits 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 CURRENTLY EXPERIENCING.

<p><b>HEADACHES</b></p> <p>___ Base of Skull (back)</p> <p>___ Side of Head (Temples)</p> <p>___ Frontal (above eyes)</p> <p>___ Top of Head</p> <p>___ Entire Head</p> <p>___ Migraines</p> <p>___ TMJ</p> <p>___ Cluster</p> <p>___ Other _____</p> <p><b>EARS</b></p> <p>___ Noise (Ring/Hiss/Pound)</p> <p>___ Plugged</p> <p>___ Popping</p> <p>___ Ear Ache</p> <p>___ Ear Infections</p> <p>___ Draining</p> <p>___ Itchy</p> <p>___ Hearing Loss</p> <p>___ Dizziness/ Vertigo</p> <p>___ Excessive Ear Wax</p> <p>___ Other _____</p> <p><b>EYES</b></p> <p>___ Burn</p> <p>___ Tear</p> <p>___ Ache</p> <p>___ Red</p> <p>___ Dry</p> <p>___ Eye Film</p> <p>___ Crust in morning</p> <p>___ Itchy Eyes</p> <p>___ Bouts of Blurriness</p> <p>___ Floaters</p> <p>___ Spots</p> <p>___ Tired</p> <p>___ Puffy</p> <p>___ Sty</p> <p>___ Twitching around eyes</p> <p>___ Dark Circles</p> <p>___ Light Bothers Eyes</p> <p>___ Nearsighted</p> <p>___ Farsighted</p> <p>___ Other _____</p> <p><b>SINUS</b></p> <p>___ Dry</p> <p>___ Drain</p> <p>___ Stuffy/Plugged/ pressure</p> <p>___ Post nasal drip...Circle Color</p> <p style="padding-left: 20px;">white/yellow/green/gray</p> <p style="padding-left: 20px;">brown/blood/clear</p> <p>___ Excessive sneezing</p> <p>___ Loss of smell</p> <p>___ Loss of Taste</p> <p>___ Thirsty</p> <p>___ Not Thirsty</p> <p>___ Unquenchable thirst</p> <p>___ Other _____</p> <p><b>MOUTH/THROAT/IMMUNE</b></p> <p>___ Sore Throat</p> <p>___ Hoarseness</p> <p>___ Cough (dry or productive)</p> <p>___ Allergies</p> <p>___ Upper Respiratory Infection</p> <p>___ Fever</p> <p>___ Chills</p> <p>___ Bad Breath</p> <p>___ Canker Sores</p> <p>___ Blisters</p> <p>___ Frequent colds/flu</p> <p>___ Neck Stiffness</p> <p>___ Shoulder Tension</p> <p>___ Cracks at lip corner/ Chielosis</p> <p>___ Dry Mouth</p> <p>___ Cold sweaty hands &amp; feet</p> <p>___ Bleeding gums</p> <p>___ Receding gums</p> <p>___ Teeth Health Problems</p> <p>___ Swelling of glands</p>	<p><b>Chest</b></p> <p>___ Tension</p> <p>___ Tight</p> <p>___ Pressure</p> <p>___ Heaviness</p> <p>___ Anxiety</p> <p>___ Congestion</p> <p>___ Chest Pain</p> <p>___ Sternal Pain</p> <p>___ Sharp Heart Pain</p> <p>___ Palpitations-Heart skip/ Flutter</p> <p>___ Mitral Valve Prolapse</p> <p>___ Tachycardia/ Heart Racing</p> <p>___ Bradycardia/ Heart Slowing down</p> <p>___ Murmur</p> <p>___ Arm Pain</p> <p>___ Constant shortness of breath</p> <p>___ Other _____</p> <p><b>SHORTNESS OF BREATH</b></p> <p>___ Constant</p> <p>___ Upon Exertion</p> <p>___ Asthma</p> <p>___ Wheezing</p> <p>___ Air Hunger/ Frequent Sighs</p> <p>___ Yawning</p> <p>___ Emphysema</p> <p>___ Other _____</p> <p><b>STOMACH</b></p> <p>___ Heartburn</p> <p>___ Indigestion</p> <p>___ Stomach Aches</p> <p>___ Stomach Cramps</p> <p>___ Nausea/ Queasy</p> <p>___ Bloat after eat</p> <p>___ Gas/ Flatulence</p> <p>___ Belching</p> <p>___ Ulcer</p> <p>___ Hiatal Hernia</p> <p>___ Other _____</p> <p><b>BOWELS</b></p> <p>___ Bowels Movements _____ Per day</p> <p>___ Regular</p> <p>___ Incomplete Bowel Evacuation</p> <p>___ Skip days _____ per (week/month)</p> <p>___ Sluggish bowels every _____ days</p> <p>___ Cramps in abdomen</p> <p>___ Taking laxatives</p> <p>___ Using Suppositories</p> <p>___ Enemas</p> <p>___ Colonics</p> <p>___ Take Herbal laxatives/ Supplements</p> <p>___ Bulky</p> <p>___ Pain with bowel movements</p> <p>___ Irritable Bowel Syndrome</p> <p>___ Chrons</p> <p>___ Colitis</p> <p>___ Other _____</p> <p><b>FECAL CONSISTENCY</b></p> <p>___ Color feces light or dark _____</p> <p>___ Soft/ Unformed</p> <p>___ Ribbon-like</p> <p>___ Mucous</p> <p>___ Normal/ Banana Shaped</p> <p>___ Hard</p> <p>___ Pebbles</p> <p>___ Dry</p> <p>___ Painful</p> <p>___ Diarrhea</p> <p>___ Constipation</p> <p>___ Broken</p> <p>___ Other _____</p> <p><b>HEMORRHOIDS</b></p> <p>___ History</p> <p>___ Current</p> <p>___ Swollen</p> <p>___ Burn</p> <p>___ Blood</p> <p>___ Distended</p>	<p><b>VAGINA</b></p> <p>___ Burn</p> <p>___ Itch</p> <p>___ Dry</p> <p>___ Pain</p> <p>___ Pain with Intercourse</p> <p>___ Blood</p> <p>___ Discharge</p> <p>___ Clear</p> <p>___ White</p> <p>___ Yellow</p> <p>___ Green</p> <p>___ Brown</p> <p>___ Odor</p> <p>___ Other _____</p> <p><b>MENSES</b></p> <p>___ Last Period _____</p> <p>___ Length of Period _____</p> <p>___ Regular</p> <p>___ Irregular</p> <p>___ Early (Less than 28 days)</p> <p>___ Late (More than 28 days)</p> <p>___ Skip period or scanty</p> <p>___ Birth Control</p> <p>___ Flow (heavy/ moderate/ light)</p> <p>___ Cramps (mild/ moderate/ severe)</p> <p>___ Low Abdominal Puffiness</p> <p>___ Fluid Retention Face</p> <p>___ Fluid Retention Hands</p> <p>___ Fluid Retention Feet</p> <p>___ Fluid Retention Body</p> <p>___ Low Back Pain</p> <p>___ Hot Flashes</p> <p>___ Fatigue during cycle</p> <p>___ Diarrhea</p> <p>___ Breast Tender around Cycle</p> <p>___ Acne (pre/ middle/ post)</p> <p>___ Clotting</p> <p>___ Spotting</p> <p>___ PMS</p> <p>___ Mood Swings</p> <p>___ Irritable</p> <p>___ Depression</p> <p>___ Tired during Period</p> <p>___ Pain during Ovulation</p> <p>___ Cysts/PCOS</p> <p>___ Discharge with Ovulation</p> <p>___ Regular Ovulation</p> <p>___ Irregular Ovulation</p> <p>___ Fibroids</p> <p>___ Facial Hair</p> <p>___ Hair growing up towards belly button</p> <p>___ Dark nipple hair</p> <p>___ Painful menstration</p> <p>___ Menstrate too frequently</p> <p>___ Other _____</p> <p><b>BREASTS</b></p> <p>___ Breast feeding</p> <p>___ Fibrosis</p> <p>___ Lump</p> <p>___ Discharge</p> <p>___ Prosthesis</p> <p>___ Augmentation Surgery</p> <p>___ Reduction Surgery</p> <p>___ Pathology</p> <p>___ Breast Tender Constant</p> <p>___ Breast Shrinking</p> <p><b>MENOPAUSE</b></p> <p>___ Natural</p> <p>___ Hysterectomy (Partial)</p> <p>___ Hysterectomy (Complete)</p> <p>___ Hormones</p> <p>___ Patch</p> <p>___ Hot Flashes</p> <p><b>CRAMPS/ACHES/RESTLESS</b></p> <p>___ Cramps (legs/ feet/ arms/ hands)</p> <p>___ Aches (legs/ feet/ arms/ hands)</p> <p>___ Restless (legs/ feet/ arms/ hands)</p>	<p><b>SKIN/ HAIR/ NAILS</b></p> <p>___ Skin rash</p> <p>___ Acne</p> <p>___ Dry Skin</p> <p>___ Itchy Skin</p> <p>___ Fungus</p> <p>___ Patches (skin looks different)</p> <p>___ Cellulite</p> <p>___ Nails (weak/ spots/ lines)</p> <p>___ Hair loss</p> <p>___ Limp Hair</p> <p>___ Cherry Hemangiomas</p> <p>___ Worts</p> <p>___ Cracked Heels</p> <p>___ Slow Healing</p> <p>___ Bruise Easily</p> <p>___ Other _____</p> <p><b>URINATION</b></p> <p>___ _____ Times per day (frequency)</p> <p>___ Urinate at night _____ per night</p> <p>___ Frequency</p> <p>___ Urgency</p> <p>___ Burning</p> <p>___ Pain</p> <p>___ Odor</p> <p>___ Spasm</p> <p>___ Leakage</p> <p>___ Urinary Tract Infection</p> <p>___ Kidney Troubles</p> <p>___ Cloudy Urine</p> <p>___ Difficulty starting Flow</p> <p>___ Other _____</p> <p><b>SLEEP</b></p> <p>___ Quality (poor/ fair/ good/ great)</p> <p>___ _____ Hours in bed</p> <p>___ _____ Hours asleep</p> <p>___ Difficulty falling asleep</p> <p>___ Difficulty staying asleep</p> <p>___ Interrupted _____ per night</p> <p>___ Crave sleep during day</p> <p>___ Awaken Sudden (Jolt)</p> <p>___ Don't Remember Dreams</p> <p>___ Nightmares</p> <p>___ Night Sweats</p> <p>___ Restlessness</p> <p>___ Sleep Apnea</p> <p>___ Wake up feeling Rested</p> <p>___ Other _____</p> <p><b>EMOTIONS</b></p> <p>___ Stressed</p> <p>___ Sad</p> <p>___ Grief</p> <p>___ Depression</p> <p>___ Moodiness</p> <p>___ Irritable</p> <p>___ Worrisome</p> <p>___ Angry</p> <p>___ Nervous</p> <p>___ Frustrated</p> <p>___ Anxiety</p> <p>___ Panic</p> <p>___ Cry</p> <p>___ Fear</p> <p>___ Shame</p> <p>___ Apathy</p> <p><b>APPETITE/ DIET</b></p> <p>___ Appetite (Low/ Normal/ High)</p> <p>___ Crave Salt/ Salty foods</p> <p>___ Crave Sweets</p> <p>___ Crave Starch (pasta/ bread/ potatoes)</p> <p>___ Crave Chocolate</p> <p>___ Crave Spicy Foods</p> <p>___ Coffee _____ cups per day</p> <p>___ Alcohol _____ Drinks per week</p> <p>___ Soda _____ Per week</p> <p>___ Artificial Sweetners</p> <p>___ Animal Protein per day _____ oz</p>	<p><b>ENERGY</b></p> <p>___ Low</p> <p>___ Variable</p> <p>___ Normal</p> <p>___ High</p> <p>___ Slow to Start in morning</p> <p>___ Energy Crash _____ am/pm</p> <p>___ Low energy after meals</p> <p>___ Dizzy when stand quickly</p> <p>___ Irritable with skip meals</p> <p>___ Eating relieves fatigue</p> <p>___ Bouts of blurred vision</p> <p>___ Light headed when skip meals</p> <p><b>EXERCISE</b></p> <p>___ Cardiovascular _____ times/week</p> <p>___ Weight Training _____ times/week</p> <p><b>MEMORY</b></p> <p>___ Short Term Loss</p> <p>___ Long Term Loss</p> <p>___ Forget Names</p> <p>___ Forget Numbers</p> <p>___ Forget Words</p> <p>___ Forget Actions</p> <p>___ Difficulty Concentrating</p> <p>___ Other _____</p> <p><b>LIBIDO/SEXUALITY</b></p> <p>___ Sex Drive (Flat/ Low/ Normal/ High)</p> <p>___ Orgasm Quality (poor/ good/ great)</p> <p>___ Other _____</p> <p><b>PAIN/ STIFFNESS/ SWELLING</b></p> <p><b>NUMBNESS/ TINGLING</b></p> <p>___ Facial</p> <p>___ Neck</p> <p>___ Trapezius</p> <p>___ Upper Back</p> <p>___ Shoulders</p> <p>___ Arms</p> <p>___ Elbows</p> <p>___ Wrist</p> <p>___ Hand</p> <p>___ Mid Back</p> <p>___ Low Back</p> <p>___ Sacral Iliac</p> <p>___ Hips</p> <p>___ Buttocks</p> <p>___ Legs</p> <p>___ Sciatica</p> <p>___ Knees</p> <p>___ Ankles</p> <p>___ Feet</p> <p><b>LIST PRIMARY CONCERNS</b></p> <p>1) _____</p> <p>2) _____</p> <p>3) _____</p> <p><b>FOR DOCTOR'S USE</b></p> <p>Luna Fingernails-</p> <p style="padding-left: 20px;">Rt 1 2 3 4 5 Lt 1 2 3 4 5</p> <p>Splinter Hemorrhages</p> <p>Frenular Cyst</p> <p>Cracks in Tongue</p> <p>Allergy Patches Tongue</p> <p>Geographic Tongue</p> <p>Red Spots Tongue</p> <p>Swollen Tongue</p> <p>Color Tongue</p> <p>Dark Veins Tongue</p> <p>Coated Tongue (Mild/ Mod/ Severe)</p> <p>Ear Creases (R/ Lt) mild/ mod/severe</p> <p>Cherry Hemangioma</p> <p>Height: _____</p> <p>Weight: _____</p> <p>Pulse: _____</p> <p>Blood Pressure: _____</p> <p>Saliva PH _____ Urine PH _____</p> <p>Allergies: _____</p> <p>Current Meds: _____</p>
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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					<b>GROUP 5A-BIL</b>
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					Lower bowel gas and/or bloating several hours
										0	1	2	3	after eating
				<b>GROUP 3A-BLOOD SUGAR HYPO</b>					<b>GROUP 3B- INSULIN RESISTANCE</b>	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
														<b>GROUP 5B-HEP DETOX</b>
				<b>GROUP 4- CARDIO</b>					<b>GROUP 5- GB/LVR</b>	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					<b>GROUP 6A-STM HYPO</b>
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					<b>GROUP 6A- HYPER</b>
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 rib cage	0	1	2	3	Alternating constipation and diarrhea
0	1	2	3	Coated tongue	0	1	2	3	Excessive passage of gas	0	1	2	3	Diarrhea
0	1	2	3	Pass large amounts of foul-smelling gas	0	1	2	3	Nausea and/or vomiting	0	1	2	3	Constipation
0	1	2	3	Indigestion 1/2- 1 hour after eating, maybe up to 3-4 hours	0	1	2	3	Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3	Hair, dry, or small stool
0	1	2	3	Mucous colitis or "irritable bowel"	0	1	2	3	Frequent urination	0	1	2	3	Coated tongue of "fuzzy" debris on tongue
0	1	2	3	Gas shortly after eating	0	1	2	3	Increased thirst and appetite	0	1	2	3	Pass large amount of foul smelling gas
0	1	2	3	Stomach bloating after eating	0	1	2	3		0	1	2	3	More than 3 bowel movements daily
														Use laxatives frequently
GROUP 6C-INTESTINAL 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			GROUP 7B- THY HYPO			GROUP 7C- PIT HYPER								
0	1	2	3	Increase in weight	0	1	2	3	Inward trembling	0	1	2	3	Failing memory
0	1	2	3	Decrease in appetite	0	1	2	3	Heart palpitates	0	1	2	3	Low blood pressure
0	1	2	3	Fatigue easily	0	1	2	3	Increased appetite without weight gain	0	1	2	3	Increased sex drive
0	1	2	3	ringing in ears	0	1	2	3	Pulse fast at rest	0	1	2	3	Headaches "splitting or rending"
0	1	2	3	Sleepy during day	0	1	2	3	Eyelids and face twitch	0	1	2	3	Decreased sugar intolerance
0	1	2	3	Sensitive to cold	0	1	2	3	Irritable and restless	0	1	2	3	Increased sex drive
0	1	2	3	Dry or scaly skin	0	1	2	3	Can't work under pressure	0	1	2	3	Tolerance to sugars reduced
0	1	2	3	Constipation						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					
0	1	2	3	Headaches upon arising wear off during day	0	1	2	3	Require excessive amounts of sleep to function	0	1	2	3	Abnormal thirst
0	1	2	3	Slow pulse, below 65	0	1	2	3	Increase in weight even with low calorie diet	0	1	2	3	Bloating of abdomen
0	1	2	3	Frequency of urination	0	1	2	3	Gain weight easily	0	1	2	3	Weight gain around hips or waist
0	1	2	3	Impaired hearing	0	1	2	3	Difficult, infrequent bowel movements	0	1	2	3	Sex drive reduced or lacking
0	1	2	3	Reduced initiative	0	1	2	3	Depression/ lack of motivation	0	1	2	3	Tendency to ulcers, colitis
					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			GROUP 7E			GROUP 7D- PIT HYPO								
0	1	2	3	Dizziness	0	1	2	3	Dryness of skin and/or scalp	0	1	2	3	Diminished sex drive
0	1	2	3	Headaches	0	1	2	3	Mental sluggishness	0	1	2	3	Menstrual disorders of lack of menstruation
0	1	2	3	Hot flashes						0	1	2	3	Increased ability to eat sugars without symptoms
GROUP 7E- ADR HYPER			GROUP 7F-ADR HYPO			GROUP 8								
0	1	2	3	Increased Blood pressure	0	1	2	3	Weakness, dizziness	0	1	2	3	Apprehension
0	1	2	3	Hair growth on face or body(female)	0	1	2	3	Chronic Fatigue	0	1	2	3	Irritability
0	1	2	3	Sugar in urine (not diabetes)	0	1	2	3	Low blood pressure	0	1	2	3	Morbid fears
				Masculine tendencies (female)	0	1	2	3	Nails weak, ridged	0	1	2	3	Never seems to get well
					0	1	2	3	Tendency to hives	0	1	2	3	Forgetfulness
					0	1	2	3	Arthritic tendencies	0	1	2	3	Indigestion
					0	1	2	3	Perspiration increase	0	1	2	3	Poor appetite
					0	1	2	3	Bowel disorders	0	1	2	3	Craving for sweets
					0	1	2	3	Poor circulation	0	1	2	3	Muscular soreness
					0	1	2	3	Swollen ankles	0	1	2	3	Depression; feelings of dread
					0	1	2	3	Crave salt	0	1	2	3	Noise sensitivity
					0	1	2	3	Brown spots or bronzing of skin	0	1	2	3	Acoustic hallucinations
					0	1	2	3	Allergies- tendency to asthma	0	1	2	3	Tendency to cry without reason
					0	1	2	3	Weakness after colds, influenza	0	1	2	3	Hair is coarse and/or thinning
					0	1	2	3	Exhaustion- muscular & nervous	0	1	2	3	Weakness
					0	1	2	3	Respiratory Disorders	0	1	2	3	Fatigue
										0	1	2	3	Skin sensitive to touch
										0	1	2	3	Tendency toward hives
										0	1	2	3	Nervousness
										0	1	2	3	Headache
										0	1	2	3	Insomnia
										0	1	2	3	Anxiety
										0	1	2	3	Anorexia
										0	1	2	3	Inability to concentrate; confusion
										0	1	2	3	Frequently stuffy nose;
										0	1	2	3	sinus infections
										0	1	2	3	Allergy to foods
										0	1	2	3	Loose joints