

Please answer Yes or No to the following. Do you frequently have?

Allergies _____ Sinus _____ Joint or Muscle aches _____ Skin Problems _____ Headaches _____

Colds _____ Fevers _____ Constipation _____ Diarrhea _____ Dizzy Spells _____ Earaches _____

Edema _____ Ringing in the ears _____ Chills _____ Eye problems _____ Sore throat _____

Any other complaints, symptoms or conditions:

FAMILY HISTORY

Father's Ailments _____

Mother's Ailments _____

Paternal Grandmother's Ailments _____

Paternal Grandfather's Ailments _____

Maternal Grandmother's Ailments _____

Maternal Grandfather's Ailments _____

Children's Ailments _____

Did your mother have difficulties when pregnant with you? _____ with the delivery? _____

Did your mother have any difficulties before your birth? (miscarriages, still births, etc) _____

Were you breast fed or bottle fed? _____ Were you shy as a child? _____

What fears did you have as a child? _____ Dark room _____ Heights _____ Animals _____ Strangers _____

Do you still have any of those fears? _____ Which ones? _____

Do you dislike being in a crowd of people? _____ Are you afraid of small spaces _____

Do heights make you dizzy? _____ Are you afraid of heights? _____ Do you ever want to jump while standing on a high place? _____ Are you afraid of animals or insects? _____

As a child were you closer to your mother or father _____ Explain _____

Are you married? _____ At what age were you married? _____ How many marriages _____

Do you have children? _____ How many? _____ At what ages did you have children? _____

PERSONAL LIKES AND DISLIKES

If everything were healthy for you to eat, what would you most like to eat? _____

Do you crave (1) or dislike (0) any of the following foods:

Sweets () chocolate () ice cream () milk () potatoes () meat fat () mustard () fish () meats ()

Spicy food () horseradish () butter () salt () oranges () ice () fruit juice () soda () coffee ()

lemons () tea () water () oysters () fruit () eggs () sour pickles ()

Do you usually feel warm or cool? _____ Do you feel better in warm or cool weather? _____

What time do you feel best, have the most energy and think clearest? _____

What is your worst time of day, when you are tired or irritable? _____

Do you keep your home neat and tidy? _____ Does disorganization bother you? _____
 Can you throw your clothes on the chair before going to bed? _____
 Are you bothered by scary movies or unpleasant news on T.V. _____
 Are you unusually sensitive? _____ To what? Noise _____ Smells _____ Other _____
 Do you prefer the companionship of animals more than being with people? _____
 Do you prefer to keep your feelings to yourself and not express them? _____
 Do you remember injustices a long time? _____ Do you keep your thoughts to yourself? _____
 Do you experience angry outbursts? _____ After you have lost control do you feel relieved? _____
 Sorry? _____ Guilty? _____ Upset? _____ Depressed? _____ Still angry? _____ Angry at yourself? _____
 Does consolation from another person make you uncomfortable? _____ Better? _____ Irritated? _____
 Do you like making decisions? _____ Do you have difficulty making decisions? _____

PHYSICAL TRAITS

Do you feel better doing things? _____ or sitting still? _____ Do you do things quickly? _____
 Do you exercise? _____ What do you do for exercise? _____ Do you feel better if you exercise _____
 Are your symptoms worse/better before a rainstorm approaches? _____
 Is your mouth often dry? _____ Are you thirsty during the day? _____ During the night? _____
 Do you like your drinks cold? _____ ice cold? _____ hot? _____ room temperature _____
 Do you have difficulty swallowing? _____ liquids? _____ solids? _____ when? _____
 Do you drink liquids slowly? _____ in gulps? _____ rapidly? _____ in small sips? _____
 Are you frequently constipated? _____ Does your constipation make you uncomfortable _____
 Do you often have diarrhea? _____ When? _____ Do you have "loose" bowels when nervous? _____
 Do you become gassy or have abdominal distention _____ How long after eating? _____
 Can you be relieved by belching? _____ by passing gas? _____ Is the gas foul smelling? _____
 How often do you get up to urinate at night? _____ Do you void a large amount? _____
 Are you bothered by clothes touching or pressing against your abdomen? _____ neck? _____
 Do you have difficulty falling asleep? _____ Returning to sleep? _____
 Do you get hot / warm at night? _____ Cold? _____ Do you like a warm room? _____ Cool? _____
 Do you sleep with your feet out from under the covers? _____ Are your arms on top of the covers? _____
 Do you sweat during the night? _____ What part of your body sweats at night? _____
 Do you feel worse during the evening hours? _____ At night? _____
 Describe dreams you had as a child? _____

 Describe dreams you have had recently? _____

When you wake up in the morning, how do you feel? _____
 Are your feet sore when you get up in the morning? _____ Do you feel worse in the morning? _____
 Have you had frequent infections of the throat, glands, or ears? _____
 Have you had any type of itchy rash of the skin in the past? _____ When? _____ What? _____
 Have you had a blow to the head or concussion? _____ When? _____
 Do you enjoy _____ dislike _____ or are you indifferent _____ to your sex life?
 Have you ever had thoughts of suicide? _____ When? _____ What happened? _____

The thing that concerns me most is: _____

I want most to have relief from: _____

WOMEN'S SECTION

At what age did your period begin? _____ Was it regular? _____ Is it now? _____
Have you ever had any major problems with your periods? _____ When _____ What was the
problem? _____
How long is your period? _____ Is there clotting? _____ What color is the blood? _____
Are you better before your period _____ During your period _____ After your period? _____
How many pregnancies have you had? _____ abortions? _____ miscarriages? _____
When you were pregnant did you develop brown spots on your face? _____ Other troubles? _____
What type of birth control, if any, are you currently using? _____ How long? _____
Have you ever been on the pill? _____ For how long? _____ Problems? _____

MEN'S SECTION

Have you had any problems with your prostate? _____ Describe _____
Do you have any blood in your urine? _____ When did this begin? _____
Do you have any problems with impotence? _____ When does this occur? _____

END