

Personal Health Evaluation

Note: Information provided on this forms will be held in strict confidence.

I. Personal Information

Name _____

Age _____ Sex _____ Height _____ Weight _____ Eye Color _____

Phone Number or Skype Number you wish to be contacted at _____

II. Diet, Nutrition and General Health Practices

a. On average, how many servings do you have per day of the following.

Food (serving size)	Servings	Food (serving size)	Servings
Fresh Fruits (1/2 cup servings)		White Bread (1 slice)	
Fresh Vegetables (1/2 cup servings)		Refined Sugar (1 teaspoon)	
Green Leafy Vegetables (1/2 cup servings)		Cookies, cakes, pastries	
Fresh or Frozen Fish (3-4 ounces)		Alcohol (1 oz.)	
Poultry (Chicken or Turkey) (3-4 oz.)		Coffee (1 cup)	
Red Meat (3-4 oz.)		Soda Pop (8 oz.)	
Seafood (Shrimp, Crab, etc.) (3-4 oz.)		Artificial Sweeteners	
Milk (1 cup)		Soymilk or other milk substitute (1 cup)	
Butter (1 oz.)		Margarine (1 oz.)	

b. How much water do you drink each day? _____ cups.
What kind of water do you drink?

a. How much sleep do you get each night on the average? _____ hours.
How do you sleep?

b. How often do you exercise? _____ hours per _____ .
What do you do for exercise?

c. What is your energy level like?

d. How often do your bowels eliminate?

e. Are you pregnant or nursing a baby?

e. Do you feel like you are under stress? If so, explain.

f. What nutritional supplements are you currently taking (attach separate sheet if necessary)?

g. What are current health concerns are you seeking help for (attach separate sheet if necessary)?

h. What medications, medical procedures, supplements or therapies have you previously tried for your condition (attach separate sheet if necessary)? Were any of these supplements or therapies helpful? If so, please note which ones were helpful.

III. Medical Information

a. Are you under a medical doctor's care for your condition? _____

If so, what are you being treated for?

b. Are you currently taking any prescription or over-the-counter drugs?

If so, please list each drug and what it is for.

c. Have you been diagnosed by a licensed physician with any of the following? Check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Benign Prostatic Hyperplasia (BPH) | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Bipolar Mood Disorder (Manic Depressive Disorder) | <input type="checkbox"/> Graves Disease (Hyperthyroid) |
| <input type="checkbox"/> Arthritis (Rheumatoid) | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hashimoto's Disease (Thyroiditis) |
| <input type="checkbox"/> Arthritis (Osteo) | <input type="checkbox"/> Cancer, Specify type: | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arrhythmia (irregular heart beat) | <input type="checkbox"/> Cardiac Arrest (Heart Attack) | <input type="checkbox"/> High Blood Pressure (Hypertension) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Irritable Bowel Disorder (Crohn's or Colitis) |
| <input type="checkbox"/> Attention Deficit Disorder (ADD/ADHD) | <input type="checkbox"/> Chronic Obstructive Pulmonary Disorder (COPD) | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Autoimmune Disorders, Specify: | <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> Low Thyroid (Hypothyroid) |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Colitis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Arthritis (Rheumatoid) | <input type="checkbox"/> Depression | <input type="checkbox"/> Obsessive-Compulsive Disorder |
| <input type="checkbox"/> Arthritis (Osteo) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arrhythmia (irregular heart beat) | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Attention Deficit Disorder (ADD/ADHD) | <input type="checkbox"/> Epilepsy | Other, specify: |
| <input type="checkbox"/> Autoimmune Disorders, Specify: | <input type="checkbox"/> Fatty Liver Disease | |

IV. Specific Symptoms

a. Check any of the following emotions you find it difficult to deal with, either in yourself or others.

Emotion	Problem with Self	Problem with Others	Explain
Anger			
Irritability			
Frustration			
Anxiety			
Fear			
Sadness			
Depression			
Excitement			
Laughter			
Lack of enthusiasm			
Lack of joy			
Worry			

b. Digestive, Liver and Intestinal Symptoms. Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Abdominal pain or discomfort | <input type="checkbox"/> Food sits heavy on stomach after meals |
| <input type="checkbox"/> Acid indigestion, heartburn or acid reflux | <input type="checkbox"/> Groggy feelings in the morning |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Hard, dry stools |
| <input type="checkbox"/> Bloating, belching or intestinal gas | <input type="checkbox"/> Hemorrhoids or anal fistula |
| <input type="checkbox"/> Constipation (bowel movements less than once per day) | <input type="checkbox"/> Loss of appetite or poor appetite |
| <input type="checkbox"/> Cravings for sugary foods | <input type="checkbox"/> Loss of smell or taste |
| <input type="checkbox"/> Diarrhea or loose stools: | <input type="checkbox"/> Sensation of lump in throat |
| <input type="checkbox"/> Food allergies, specify foods that give you problems: | <input type="checkbox"/> Stomachache |
| | <input type="checkbox"/> Under weight or unable to gain weight |

c. Respiratory System Symptoms. Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Chronic or frequent cough | <input type="checkbox"/> Itchy nose or ears |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Post nasal drip |
| <input type="checkbox"/> Excess mucus production | <input type="checkbox"/> Sinus headaches |
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Sinusitis or chronic sinus congestion |
| <input type="checkbox"/> Hayfever and respiratory allergies | <input type="checkbox"/> Wheezing or shortness of breath |

d. Circulatory System Symptoms. Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High cholesterol, specify: |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> High triglycerides, specify: |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Irregular heart beat, arrhythmia |
| <input type="checkbox"/> Family history of heart disease | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Gingivitis or gum disease | <input type="checkbox"/> Swelling in lower extremities |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Varicose veins or spider veins |
| <input type="checkbox"/> High blood pressure, specify blood pressure numbers: | <input type="checkbox"/> Wounds that won't heal in the extremities |

e. Urinary and Fluid System Symptoms. Check all that apply.

- Bladder infections
- Blood in the urine
- Burning or painful urination
- Difficulty starting urination
- Excessive perspiration
- Frequent pale urine
- Frequent urination
- History of kidney stones
- Night sweats
- Pain in the mid to low back
- Puffiness under eyes
- Scant, dark urine
- Urinary incontinence (dribbling)
- Urinary tract infections (UTIs)
- Water retention or edema
- Swollen lymph nodes

f. Glandular System Symptoms. Check all that apply.

- Burning sensations in hands and feet
- Cold hands and feet
- Dark circles under eyes
- Dry skin
- Excess weight
- Excess weight around the abdomen
- Fatigue in the afternoons
- Fatigue, chronic or excessive
- Feeling chronically stressed
- Feeling exhausted, "burned-out"
- Frequent thirst
- Hair loss or thinning
- Lack of stamina
- Loss of short-term memory
- Low body temperature, easily chilled
- Mental sluggishness, "brain fog"
- Mood swings
- Muddled thinking, confusion
- Restless disturbed sleep
- Restless dreams or nightmares
- Waking up at night unable to go back to sleep
- Waking up frequently at night

Males Only

- Difficulty urination
- Erectile dysfunction
- Infertility
- Lack of sex drive
- Loss of self-confidence and drive
- Nighttime urination
- Prostate problems
- Urinating at night

Females Only

- Cravings for chocolate with periods
- Depression with periods
- Edema or bloating associated with periods
- Heavy menstrual bleeding
- Hot flashes and/or night sweats
- Infertility
- Irritability with periods
- Lack of sexual desire
- Menstrual cramps
- Nursing (currently)
- Painful menstruation
- PMS
- Post-menopausal
- Pregnant (currently)
- Vaginal discharge
- Vaginal dryness

g. Nervous System Symptoms. Check all that apply.

- Absent-mindedness
- Alcoholism
- Anxiety, nervousness
- Chronic muscle tension
- Difficulty getting to sleep
- Dizziness or light headedness.
- Excitability, difficulty relaxing
- Feeling depressed or discouraged
- Headaches
 - Tension headaches with tight, constricted feeling
- Pounding headaches (like head is exploding)
- Headaches around eyes or forehead
- Migraines
- Loss of memory
- Panic attacks
- Peripheral neuropathy
- Poor concentration
- Shaky hands

h. Structural System Symptoms. Check all that apply.

- Acne
- Arthritis
- Back pain
- Brittle fingernails
- Eczema
- Gout
- Itching, skin
- Joint pain
- Leg cramps or pains
- Multiple root canals
- Muscle cramps
- Neck pain
- Osteoporosis
- Rashes
- Rosacea
- Stiff, aching or painful muscles
- Teeth grinding
- Tense muscles
- Weak legs, knees or ankles

i. Add any additional information you feel may be helpful in evaluating your situation.