Confidential Patient Ouestionnaire

Dear Patient,

Welcome to Magnolia Natural Health. This form is designed to help us get the cause of your current health problem as quickly as possible. The more detailed and accurate you are the better care we can provide. Your overall health is just as important to us as your current major complaints. No symptom is insignificant. The more you tell us, the more we will be able to help you achieve your health goals.

Date: _____/_____/_____ Cell Phone: (_____)_____-_____ E-Mail: _____

Name: _____ Address: _____

Home Phone: (____)_____-_____ Business Phone: (_____)_____-_____ City: _____ State: ___ Zip Code: _____

Birthdate: _____/_____/_____ Age: ____ Sex: M F Height: _____ Weight: _____ S.S. #: _____-_____-_____

Employer: _____ Type of Work: _____ Are you/have you been disabled from work? Y / N

Check one: ❑ Married ❑ Single ❑ Divorced ❑ Separated Spouse's Name and Age: _____

Name(s) and Age(s) of Children: _____

Referred to this office by: _____ Your Driver's Lic. #: _____

Name/Phone # of nearest Emergency Contact: _____

How has this pain/discomfort affected your life? _____

What activities that are stopping you from doing? (playing with your kids, working, intimacy, etc.) _____

_____

_____

Financial & Insurance Information

Name of Party Responsible for Payment: _____

Method of Payment: ❑ Cash ❑ Insurance ❑ Personal Injury ❑ Workers' Compensation ❑ Medicare ❑ Medical ❑ Other: _____

Insurance: Company: _____ Address: _____

Phone #: (_____)_____-_____ Policy #: _____ Group #: _____

Name and Birthdate of Insured: _____ _____/_____/_____

Special Instructions: _____

Personal Injury/Workers' Compensation: See Receptionist for Further Information.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged indirectly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered will be immediately due and payable.

I hereby authorize the doctor to treat my conditions he/she deems appropriate through use of manipulation throughout my spine. It is understood and agreed the amount paid to the doctor is for examination and x-rays only. The x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature: X _____ Date: _____/_____/_____

Guardian's or Spouse's
Signature Authorizing Care: _____ Date: _____/_____/_____

Current Health Conditions

Please fill out one section for each major complaint and indicate them on the drawings, starting with the one you feel is most significant.

1. Major Complaint: _____ Date of onset: ____/____/____ ❑ Sudden ❑ Gradual

How bad is your pain or ache? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10

Describe your pain or complaint: No Pain unbearable pain

❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing
❑ Deep ❑ Superficial ❑ Spasm/Tension ❑ Numbness
❑ Tingling ❑ Burning ❑ Other: _____

Radiation: Does the pain go to other parts of the body?

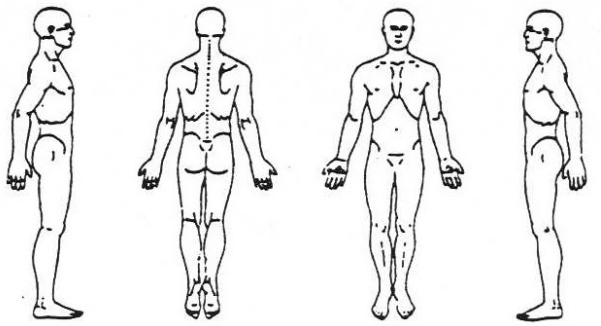
❑Yes ❑ No Where? _____

Frequency: ❑ Occasional ❑Intermittent ❑ Constant

Duration: How long does the pain last? _____

What makes the pain worse?

❑ Standing ❑ Sitting ❑ Bending ❑ Twisting
❑ Walking ❑ Lifting ❑ Sleeping ❑ Heat
❑ Cold ❑ Stooping ❑ Sex
❑ Other: _____



Other problems related to your main complaint: _____

What treatment have you received for this condition? _____

Office Use Only: _____

2. Major Complaint: _____ Date of onset: ____/____/____ ❑ Sudden ❑ Gradual

How bad is your pain or ache? Please circle a number: 0 1 2 3 4 5 6 7 8 9 10

Describe your pain or complaint: No Pain unbearable pain

❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing
❑ Deep ❑ Superficial ❑ Spasm/Tension ❑ Numbness
❑ Tingling ❑ Burning ❑ Other: _____

Radiation: Does the pain go to other parts of the body?

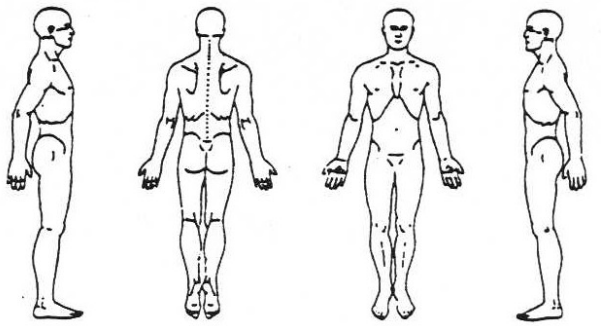
❑Yes ❑ No Where? _____

Frequency: ❑ Occasional ❑Intermittent ❑ Constant

Duration: How long does the pain last? _____

What makes the pain worse?

❑ Standing ❑ Sitting ❑ Bending ❑ Twisting
❑ Walking ❑ Lifting ❑ Sleeping ❑ Heat
❑ Cold ❑ Stooping ❑ Sex
❑ Other: _____



Other problems related to your main complaint: _____

What treatment have you received for this condition? _____

Office Use Only: _____

Medical History

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following diseases you have had

❑ Pneumonia	❑ Mumps	❑ Influenza	❑ Rheumatic fever	❑ Small Pox	❑ Pleurisy
❑ Polio	❑ Chicken pox	❑ Arthritis	❑ Tuberculosis	❑ Diabetes	❑ Epilepsy
❑ Cancer	❑ Anemia	❑ Lumbago	❑ Thyroid	❑ Eczema	❑ Measles
❑ Whooping Cough		❑ Mental Disorders		❑ Heart Disease	

Have you been tested HIV positive? ❑ Yes ❑ No

List all surgery with dates: _____

Any major or minor accidents (include "fender benders"), and falls (gymnastics, horse, etc.): _____

Hospitalization (other than above): _____

Previous chiropractic care: ❑ Yes ❑ No Dr. Name: _____ Date of Last Visit: ____/____/____

Condition Treated: _____ X-rays taken: _____

Last Medical Physical: _____ Most Recent Blood Work: _____

Check any of the following conditions you have experienced other than your current major complaints:

1. Musculo-Skeletal

	Past	Present	Mild	Moderate	Severe		Past	Present	Mild	Moderate	Severe
Low Back Pain	❑	❑	❑	❑	❑	General Stiffness	❑	❑	❑	❑	❑
Pain between shoulders	❑	❑	❑	❑	❑	Fractures	❑	❑	❑	❑	❑
Neck	❑	❑	❑	❑	❑	Foot/Ankle problems	❑	❑	❑	❑	❑
Arm pain/Numbness/Weakness	❑	❑	❑	❑	❑	Difficult chewing/Clicking jaw	❑	❑	❑	❑	❑
Joint pain/Stiffness	❑	❑	❑	❑	❑	Shoulder problems	❑	❑	❑	❑	❑
Walking problems	❑	❑	❑	❑	❑	Knee problems	❑	❑	❑	❑	❑
Muscle cramps	❑	❑	❑	❑	❑	Hip Problems	❑	❑	❑	❑	❑
Leg pain/Numbness/Weakness	❑	❑	❑	❑	❑						

2. Nervous System

❑ Nervousness:

Do you consider yourself to be a "nervous type" in general? _____
Are you feeling nervous about something specific? _____

❑ Forgetfulness:

Are you forgetting recent events? _____
Events from the distant past? _____
Do you forget other things? _____
Is memory worse with stress? _____

❑ Numbness:

Where? _____
When did it start? _____
Frequency: ❑ Occasional ❑ Intermittent ❑ Constant

❑ Dizziness: ❑ Past ❑ Present
❑ Fainting: ❑ Past ❑ Present
❑ Stress: ❑ Past ❑ Present
If present, what areas of your life do you consider to be stressful? _____

❑ Depression: ❑ Past ❑ Present
If present, how long have you been depressed? _____
Have you ever taken prescribed medications for depression? ❑ Yes ❑ No
If yes. list medications: _____
Are you getting professional counseling? ❑ Yes ❑ No Is there a family history of depression? ❑ Yes ❑ No
Is your current depression related to a specific situation? ❑ Yes ❑ No Is your depression: ❑ Mild ❑ Moderate ❑ Severe

♩ Cold or Tingling Extremities: ❑ Hands ❑ Feet ❑ Both Date of onset: _____/_____/_____
Frequency: ❑ Occasional ❑ Intermittent ❑ Constant

3. General

❑ Fatigue: ❑ Past ❑ Present If present: ❑ Mild ❑ Moderate ❑ Severe Daily? ❑ Yes ❑ No
Is there a pattern? Describe: _____

❑ Headaches: ❑ Past ❑ Present If present, how frequent: ❑ Daily ❑ Weekly ❑ Monthly
Degree: ❑ Mild ❑ Moderate ❑ Severe Location of pain: _____
Is there a pattern? Describe: _____
How long has this pattern of headaches existed (days/weeks/months/years)? _____
Do you have any idea what causes or triggers your headaches? _____
Females only: Is there a relationship to your menstrual cycle? ❑ Yes ❑ No
❑ Allergies: ❑ Airborne ❑ Food ❑ Unknown
List known allergies: _____
How often? Daily/weekly/monthly, or if seasonally, which seasons? _____

What kind of symptoms do you have with your allergies? _____

❑ Bleeding Tendencies: Where? _____ How often? _____
How severely? _____
How long have you had this problem? _____

❑ Loss of Sleep: ❑ Past ❑ Present If present, how frequently does this occur? _____
When did this patter begin? _____
Do you have difficulty falling asleep or staying asleep? (circle one or both) ❑ Yes ❑ No
What factors do you think cause or influence this condition? _____

❑ Skin conditions: ❑ Past ❑ Present
Describe condition: _____
List past treatments and effectiveness: _____

❑ Fever:
When was your last fever? _____
How often do you get fevers? _____
How severe do they get? _____

4. Genitourinary

❑ Bladder infections:
When was your last one? _____ How often do you have one? (per year) _____
What factors do you think cause or influence this condition? _____

❑ Frequent urination: (other than associated with bladder infections) - How frequent? (times per day) _____
❑ Discolored Urine: ❑ Past ❑ Present If present, when did it being? _____
❑ Incontinence: ❑ Past ❑ Present If present, when did it begin? _____
❑ Dribbling: ❑ Past ❑ Present If present, when did it begin? _____
❑ Blood in Urine: ❑ Past ❑ Present If present, when did it begin? _____

5. Cardiovascular/Respiratory

❑ Chest pain: ❑ Past ❑ Present If present, when does it occur? _____
Treatment? _____

❑ Shortness of Breath: ❑ Past ❑ Present
When does it occur? _____

❑ Heart disease: ❑ Past ❑ Present
Describe: _____

❑ Ankle swelling: ❑ Past ❑ Present
If present, is it constant? _____

❑ Blood Pressure Problems: ❑ Past ❑ Present ❑ High ❑ Low
Medication: _____

❑ Lung Problems/Congestion:
Describe: _____

❑ Stroke: When? _____
Residual Problems: _____

❑ Chronic Cough: When does it start? _____ Are you a smoker? _____

❑ Irregular Heartbeat/Murmurs (circle one or both):
Describe: _____
Have you seen a medical doctor for this? _____

❑ Varicose Veins: ❑ Past ❑ Present When did they start? _____ Are they painful? _____
What aggravates them? _____

6. Eyes, Ears, Nose, and Throat

❑ Vision Problems: ❑ Past ❑ Present Specify problem: _____ When did it begin? ___/___/___

List treatments: _____

❑ Ear Aches/Infections: ❑ Past ❑ Present When was the last episode? _____
How often do they occur? _____ Severity of the problem: _____
List treatment: _____

❑ Dental History:
List present problems: _____
List past problems: _____
Have you ever had braces/orthodontics? ❑ Yes ❑ No Did they pull teeth as part of your orthodontic treatment? ❑ Yes ❑ No
If yes, how many? _____ Who is your present dentist? _____

❑ Hearing Difficulty: ❑ Past ❑ Present
Please describe: _____
When did it begin? _____ List any treatment and its effectiveness: _____
_____

❑ Sore Throat: ❑ Past ❑ Present If present, when did it being? ___/___/___ How severe is it? _____
What do you think caused or influenced this condition? _____
List any treatment and its effectiveness: _____

❑ Nose and Sinus Problems: ❑ Past ❑ Present
Describe: _____
When did it begin? _____/_____/_____ How severe is it? _____
What do you think caused or influenced this condition? _____
List any treatment and its effectiveness: _____

❑ Noises in ear: ❑ Past ❑ Present
Describe: _____
When did this begin? _____
What do you think caused or influenced this condition? _____

7. Gastro-Intestinal

❑ Poor/Excessive Appetite (circle one or both): ❑ Past ❑ Present When did it start? _____
Do you feel you have an unhealthy relationship with food? ❑ Yes ❑ No Are you a compulsive eater? ❑ Yes ❑ No
Are you or have you ever been considered: ❑ Anorexic ❑ Bulimic
Do you feel over-concerned or obsessed with your weight and/or body image? ❑ Yes ❑ No

❑ Diarrhea: ❑ Past ❑ Present If present, frequency: ❑ Occasional ❑ Intermittent ❑ Constant
When did it start? _____
What do you think caused or influenced it? _____
_____
Is it related to: ❑ Specific foods ❑ Stress

❑ Gall Bladder Problems: ❑ Past ❑ Present If present, describe symptoms: _____

❑ Liver Problems: ❑ Past ❑ Present If present, describe symptoms: _____

❑ Heartburn frequency: ❑ Occasional ❑ Intermittent ❑ Constant
All foods? ❑ Yes ❑ No Certain foods only? ❑ Yes ❑ No
Is there at time of day when it's worse? _____

❑ Excessive Thirst: ❑ Past ❑ Present When did it begin? _____

❑ Constipation: ❑ Past ❑ Present If present, when did it begin? _____
Is this a lifetime pattern? ❑ Yes ❑ No
What do you think causes or influences this condition? _____
Do you take any medications or natural substances to assist in bowel function? (list) _____
_____

❑ Weight Change: As an adult, what has your weight range been? High: _____ Low: _____

❑ Black/Bloody Stool: ❑ Past ❑ Present When did it start? _____

❑ Ulcers: When? _____ Treatment? _____

❑ Nausea: ❑ Past ❑ Present If present, frequency? ❑ Occasional ❑ Intermittent ❑ Constant

Time of day: _____ Certain foods? _____ Other factors? _____

❑ Hemorrhoids: ❑ Past ❑ Past
What factors affect it? Intensity: ❑ Mild ❑ Moderate ❑ Severe

❑ Abdominal Cramps/Pain: ❑ Past ❑ Present If present, location: _____
When do they occur? Intensity: ❑ Mild ❑ Moderate ❑ Severe

❑ Hepatitis: ❑ Past ❑ Present When did it start? _____

❑Vomiting: ❑ Past ❑ Present If present, when did it start? _____

❑ Colitis: ❑ Past ❑ Present If present, when did it start? _____
What factors affect it? _____

❑ Gas/Bloating After Meals: ❑ Past ❑ Present If present, all meals? ❑ Yes ❑ No
Certain foods? _____

8. Female Problems

Your age at first period: _____ Most recent period began, date: _____/_____/_____

How many days do you flow? _____ How many days from period to period? _____

Last PAP smear? _____ History of abnormal PAP? ❑ Yes ❑ No

If abnormal, what class? _____
Treatment? _____

Contraception (present): _____

Past history of birth control pill use: How long? _____ Side effects? _____

Number of pregnancies? Live births: _____ Are you pregnant now? ❑ Yes ❑ No ❑ Unsure

❑ Menstrual Cramping: ❑ Mild ❑ Moderate ❑ Severe
Do you get cramps every month? ❑ Yes ❑ No
If not, how often? _____

❑ Spotting

❑ PMS (Pre-Menstrual Syndrome): ❑ Yes ❑ No If yes: ❑ Mild ❑ Moderate ❑ Severe
How many days of symptoms before your period? _____
Check Symptoms:
❑ Breast Tenderness ❑ Food cravings ❑ Irritability
❑ Crying easily ❑ Bloating/weight gain ❑ Suicidal
❑ Other: _____

❑ Painful Intercourse: ❑ Past ❑ Present

❑ Breast Lumps/Fibrocystic: ❑Past ❑ Present

❑ Vaginal Infections/Yeast: ❑ Past ❑ Present

Frequency, how many times per year? _____

❑ Sexual Dysfunction: ❑ Past ❑ Present Describe: _____

❑Ovarian, Vaginal, or Uterine Problems: ❑ Past ❑ Present

❑ Infertility: ❑ Past ❑ Present
Treatment: _____

9. Male Problems

❑ Prostate Problems: ❑ Past ❑ Present
If present, describe symptoms: _____ When did this begin? _____
List any treatment and its effectiveness: _____

❑ Incomplete Voiding of Urine: ❑ Past ❑ Present

If present, describe symptoms: _____
When did this begin? _____
List any treatment and its effectiveness: _____

❑ Pain during Urination: ❑ Past ❑ Present
If present, describe symptoms: _____ When did this begin? _____

❑ Sexual Dysfunction: ❑ Past ❑ Present
If present, describe symptoms: _____ When did this begin? _____
List any treatment and its effectiveness: _____

1. Have you been treated for any other condition not covered in the above questionnaire (describe)? _____
_____
When? _____

2. Sleep Habits: Average hours per night: _____ Restful Sleep? ❑ Yes ❑ No

3. Bowel Movements: Times per week: _____

4. Family History: List all past and present health problems and/or diseases in your family: grandparents, parents, brother(s), sister(s), aunt(s), uncle(s), etc.

Relationship	Problem
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. Diet: Please describe your diet by indicating how many times per day/week/month you have the following:

Eggs:	_____ times per	_____	Tea (caffeinated):	_____ times per	_____
Milk Products:	_____ times per	_____	Alcohol:	_____ times per	_____
Wheat Products:			Chocolate:	_____ times per	_____
Pasta	_____ times per	_____	Other Sweets:	_____ times per	_____
Bread	_____ times per	_____	Soft Drinks:	_____ times per	_____
Rolls/Muffins	_____ times per	_____	White flour Products:	_____ times per	_____
Red Meat:	_____ times per	_____	Water:	_____ times per	_____
Chicken:	_____ times per	_____	Fried food:	_____ times per	_____
Fish:	_____ times per	_____	Cigarettes:	_____ times per	_____
Fresh Vegetables:	_____ times per	_____	Grains:	_____ times per	_____
Fresh Fruits:	_____ times per	_____	Foods craved:	_____ times per	_____
Salad:	_____ times per	_____	Meals per day:	_____	
Coffee:	_____ times per	_____			

❑ Are you interested in our nutritional program? ❑ Yes ❑ No ❑ Possibly

6. Exercise: Type: _____ Frequency: _____ times per (day/week)

Type: _____ Frequency: _____ times per (day/week)

Type: _____ Frequency: _____ times per (day/week)

Why Chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.
❑ Relief Care ❑ Corrective Care ❑ Check here if you want the doctor to select the type of care appropriate for your condition.

Thank You, Magnolia Natural Health

MAGNOLIA NATURAL HEALTH

www.magnolianaturalhealth.com

Health Care Authorization Form

Patient's Name: _____

Patient's SS#_____ Date of Birth: _____

The patient identified above authorizes Magnolia Natural Health (MNH) to disclose protected health information in accordance with the following:

Specific Authorizations

I give permission to MNH to use my address and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives, or other health related information.

I give MNH permission to contact me by phone or email, to leave a messages or information on my answering machine or voice mail.

You may also contact me by email.

Other: Video and written testimonials, office referral boards, newsletters

By signing this form you are giving MNH permission to use and disclose your protected health information in accordance with the directives listed above.

Patient Signature: _____ Date: _____

Expiration

The authorization will expire 7 years from the date signed above.

MAGNOLIA NATURAL HEALTH

www.magnolianaturalhealth.com

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. MNH's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for MNH to provide treatment to me, and also necessary for MNH to obtain payment for that treatment and to carry out is health care operations. MNH explained to me that the Privacy Notice will be available to me in the future at my request. MNH has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. MNH reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by MNH: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. MNH may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for MNH to treat me and obtain payment for that treatment, and as necessary for MNH to conduct its specific health care operations.

5. I understand that I have a right to request that MNH restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, MNH is not required to agree to any restrictions that I have requested. If MNH agrees to a requested restriction, then the restriction is binding on MNH.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that MNH has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, MNH has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then MNH will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Date Signed ____/____/____ Witness: _____

MAGNOLIA NATURAL HEALTH

www.magnolianaturalhealth.com

DATE:_____

Patient:_____
Employer:_____
SS#/ID#:_____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

MAGNOLIA NATURAL HEALTH
2200 W. MAGNOLIA BOULEVARD
BURANK, CA 91506

OR

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O MAGNOLIA NATURAL HEALTH
2200 W. MAGNOLIA BOULEVARD
BURANK, CA 91506

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this day of _____, 20___

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder.

MAGNOLIA NATURAL HEALTH

www.magnolianaturalhealth.com

CONSENT FORM

I being the parent of _____ _____, a minor the age of _____ due hereby consent, authorize and request Dr. Alfred Sadanaga D.C. and/or staff to administer such examination, x-rays, and/or treatment deemed advisable necessary on the above request minor.

Date: ____ / ____ / ____ Signature: _____

2200 West Magnolia Boulevard | Burbank | CA 91506 | P 818 954 0884 | E magnolianaturalhealth@gmail.com

Nutritec Software Symptom Survey Form

NAME: _____ **DATE:** _____

DOB: ____/____/____ **SEX:** O Male O Female

HEIGHT: _____ **WEIGHT:** _____

BLOOD PRESSURE: Pulse: Sitting: _____ **Standing:** _____

BP Sitting: _____ **PB Lying:** _____ **BP Standing:** _____

pH INDICATORS: AM Saliva: _____ **AM Urine:** _____

PM Saliva: _____ **PM Urine:** _____

INSTRUCTIONS: Completely black out one of the three circles:
1-mild , 2-moderate, or 3-severe

● O O MILD symptoms (once or twice last 6 month)
O ● O MODERATE symptoms (once or twice last month)
O O ● SEVERE symptoms (Chronic, once or twice last wk)
O O O Leave circles BLANK if they do not apply to you!

	1	2	3	
				------ GROUP 1 SYMPATHETIC DOMINANCE ------
1	O	O	O	Acid foods upset
2	O	O	O	Feel chilled often
3	O	O	O	"Lump" in throat
4	O	O	O	Dry mouth-eyes-nose
5	O	O	O	Pulse speeds after meals
6	O	O	O	Keyed up; unable to feel calm
7	O	O	O	Cuts heal slowly
8	O	O	O	Gag easily
9	O	O	O	Unable to relax; startles easily
10	O	O	O	Extremities cold and/or clammy
11	O	O	O	Strong light irritates
12	O	O	O	Urine amount reduced
13	O	O	O	Heart pounds after retiring
14	O	O	O	"Nervous" stomach
15	O	O	O	Appetite reduced
16	O	O	O	Cold sweats often
17	O	O	O	Body temperature rises easily
18	O	O	O	Skin sensitive to touch
19	O	O	O	Staring, blinks little
20	O	O	O	Frequently have a sour stomach
				-- GROUP 2 PARASYMPATHETIC DOMINANCE--
21	O	O	O	Joint stiffness after arising
22	O	O	O	Muscle-leg-toe cramps at night
23	O	O	O	"Butterfly" stomach, cramps
24	O	O	O	Eyes or nose watery
25	O	O	O	Eyes blink often
26	O	O	O	Eyelids swollen or puffy
27	O	O	O	Indigestion soon after meals
28	O	O	O	Always seem hungry; 'lightheaded' often
29	O	O	O	Food digests rapidly
30	O	O	O	Vomit frequently
31	O	O	O	Frequently hoarse
32	O	O	O	Irregular breathing
33	O	O	O	Pulse slow or feels "irregular"
34	O	O	O	Slow gag reflex
35	O	O	O	Difficulty swallowing
36	O	O	O	Alternating constipation and diarrhea
37	O	O	O	"Slow starter"
38	O	O	O	Not easily chilled
39	O	O	O	Perspire easily
40	O	O	O	Poor circulation or sensitive to cold
41	O	O	O	Subject to colds, asthma, bronchitis
				------- GROUP 3 SUGAR HANDLING -------
42	O	O	O	Eat when nervous
43	O	O	O	Excessive appetite
44	O	O	O	Hungry between meals
45	O	O	O	Irritable before meals
46	O	O	O	Get "shaky" if hungry

	1	2	3	
				---- GROUP 3 SUGAR HANDLING continued ----
47	O	O	O	Feeling fatigued, eating relieves
48	O	O	O	"Lightheaded" if meals delayed
49	O	O	O	Heart palpitates if meals missed or delayed
50	O	O	O	Afternoon headaches
51	O	O	O	Upset feeling from excessive eating of sweets
52	O	O	O	Awaken after a few hours sleep, hard to get back to sleep
53	O	O	O	Crave candy or coffee in afternoons
54	O	O	O	Moods of depression, "blues", or melancholy
55	O	O	O	Abnormal craving for sweets or snacks
				------- GROUP 4 CARDIOVASCULAR -------
56	O	O	O	Hands and feet go to sleep easily, numbness
57	O	O	O	Sigh frequently, "air hunger"
58	O	O	O	Aware of "breathing heavily'
59	O	O	O	Discomfort at high altitude
60	O	O	O	Opens windows in closed room
61	O	O	O	Susceptible to colds and fevers
62	O	O	O	Afternoon "yawner"
63	O	O	O	Get "drowsy" often
64	O	O	O	Swollen ankles worse at night
65	O	O	O	Muscle cramps, worse during exercise; "charley-horses"
66	O	O	O	Shortness of breath on exertion
67	O	O	O	Dull pain in chest or radiating into left arm, worse on exertion
68	O	O	O	Bruise easily, "black/blue" spots on arms or legs
69	O	O	O	Tendency to anemia
70	O	O	O	Frequently have "nose bleeds"
71	O	O	O	"Ringing in ears" or noises in head
72	O	O	O	Tension under the breast-bone, or feeling of "tightness" in the chest, gets worse on exertion
				------- GROUP 5 LIVER/BILIARY -------
73	O	O	O	Dizziness
74	O	O	O	Dry skin
75	O	O	O	Burning feet
76	O	O	O	Blurred vision
77	O	O	O	Itching skin and feet
78	O	O	O	Excessive falling hair
79	O	O	O	Frequent skin rashes
80	O	O	O	Bitter or metallic taste in mouth in the mornings
81	O	O	O	Bowel movements painful or difficult
82	O	O	O	Feelings of worry, dread, or insecurity
83	O	O	O	Feeling queasy; headache over eyes
84	O	O	O	Greasy foods upset
85	O	O	O	Stools light-colored
86	O	O	O	Skin peels on foot soles
87	O	O	O	Pain between shoulder blades
88	O	O	O	Using laxatives
89	O	O	O	Stools alternate from soft to watery
90	O	O	O	History of gallbladder attacks or gall stones
91	O	O	O	Sneezing attacks
92	O	O	O	Dreaming, nightmare-type bad dreams
93	O	O	O	Bad breath (halitosis)
94	O	O	O	Milk products cause distress
95	O	O	O	Sensitive to hot weather
96	O	O	O	Burning or itching anus
97	O	O	O	Crave sweets
				------- GROUP 6 DIGESTION -------
98	O	O	O	Loss of taste for meat
99	O	O	O	Lower bowel gas several hours after eating
100	O	O	O	Burning stomach sensations, eating relieves
101	O	O	O	Coated tongue
102	O	O	O	Pass large amounts of foul smelling gas
103	O	O	O	Indigestion ½ -1 hour after eating; may be up to 3-4 hrs.
104	O	O	O	Mucus colitis or "irritable bowel"
105	O	O	O	Gas shortly after eating
106	O	O	O	Stomach "bloating" after eating

	1	2	3	------- GROUP 7A HYPERTHYROID -------
107	O	O	O	Insomnia
108	O	O	O	Nervousness
109	O	O	O	Can't gain weight
110	O	O	O	Intolerance to heat
111	O	O	O	Highly emotional
112	O	O	O	Flush easily
113	O	O	O	Night sweats
114	O	O	O	Skin is thin and moist
115	O	O	O	Inward trembling
116	O	O	O	Heart palpitates
117	O	O	O	Increased appetite without weight gain
118	O	O	O	Pulse races when resting
119	O	O	O	Eyelids and face twitch
120	O	O	O	Irritable and restless
121	O	O	O	Can't work under pressure
				------- GROUP 7B HYPOTHYROID -------
122	O	O	O	Noticable weight gain
123	O	O	O	Decrease in appetite
124	O	O	O	Easily fatigued
125	O	O	O	Ringing in ears
126	O	O	O	Sleepy during day
127	O	O	O	Sensitive to cold
128	O	O	O	Dry or scaly skin
129	O	O	O	Constipation
130	O	O	O	Mental sluggishness
131	O	O	O	Hair coarse, falls out
132	O	O	O	Headaches upon arising wear off during day
133	O	O	O	Slow pulse, below 65
134	O	O	O	Frequent urination
135	O	O	O	Impaired hearing
136	O	O	O	Reduced initiative
				------- GROUP 7C HYPERPITUITARY -------
137	O	O	O	Failing memory
138	O	O	O	Low blood pressure
139	O	O	O	Increased sex drive
140	O	O	O	Headaches, "splitting or rendering" type
141	O	O	O	Decreased sugar tolerance
				------- GROUP 7D HYPOPITUITARY -------
142	O	O	O	Abnormal thirst
143	O	O	O	Bloating of the abdomen
144	O	O	O	Weight gain around hips or waist
145	O	O	O	Sex drive reduced or lacking
146	O	O	O	Tendency toward ulcers and/or colitis
147	O	O	O	Increased sugar tolerance
148	O	O	O	(FEMALE) Menstrual disorders
149	O	O	O	(YOUNG GIRLS) Lack of menstrual function
				------- GROUP 7E HYPERADRENAL -------
150	O	O	O	Dizziness
151	O	O	O	Headaches
152	O	O	O	Hot flashes
153	O	O	O	Increased blood pressure
154	O	O	O	(FEMALE) Hair growth on face or body
155	O	O	O	Sugar in urine (not diabetes)
156	O	O	O	(FEMALE) Masculine tendencies
				------- GROUP 7F HYPOADRENAL -------
157	O	O	O	Weakness and/or dizziness
158	O	O	O	Chronic fatigue
159	O	O	O	Low blood pressure
160	O	O	O	Nails weak and/or ridged
161	O	O	O	Tendency toward hives
162	O	O	O	Arthritic tendencies
163	O	O	O	Perspiration increase
164	O	O	O	Bowel disorders
165	O	O	O	Poor circulation
166	O	O	O	Swollen ankles
167	O	O	O	Crave salt
168	O	O	O	Brown spots or bronzing of skin
169	O	O	O	Allergies - tendency to asthma
170	O	O	O	Weakness after colds or influenza
171	O	O	O	Muscular and nervous exhaustion
172	O	O	O	Respiratory disorders

	1	2	3	------- GROUP 8 FOUNDATIONAL ISSUES-------
173	O	O	O	Apprehension
174	O	O	O	Irritability
175	O	O	O	Morbid fears
176	O	O	O	Never seems to get well
177	O	O	O	Forgetfulness
178	O	O	O	Indigestion
179	O	O	O	Poor appetite
180	O	O	O	Craving for sweets
181	O	O	O	Muscular soreness
182	O	O	O	Depression; feelings of dread
183	O	O	O	Noise sensitivity
184	O	O	O	Acoustic hallucinations
185	O	O	O	Tendency to cry without reason
186	O	O	O	Hair is coarse and/or thinning
187	O	O	O	Weakness
188	O	O	O	Fatigue
189	O	O	O	Skin sensitive to touch
190	O	O	O	Tendency toward hives
191	O	O	O	Nervousness
192	O	O	O	Headache
193	O	O	O	Insomnia
194	O	O	O	Anxiety
195	O	O	O	Anorexia
196	O	O	O	Inability to concentrate; confusion
197	O	O	O	Frequent stuffy nose; sinus infections
198	O	O	O	Allergy to some foods
199	O	O	O	Loose joints
				------- FEMALE ONLY -------
200	O	O	O	Very easily fatigued
201	O	O	O	Premenstrual tension
202	O	O	O	Painful menses
203	O	O	O	Depressed feelings before menstruation
204	O	O	O	Excessive and prolonged menstruation
205	O	O	O	Painful breasts
206	O	O	O	Menstruate too frequently
207	O	O	O	Vaginal discharge
208			O	Hysterectomy /ovaries removed
209	O	O	O	Menopausal hot flashes
210	O	O	O	Menses scanty or missed
211	O	O	O	Acne, worse at menses
212	O	O	O	Long standing depression
				------- MALE ONLY -------
213	O	O	O	Prostate trouble
214	O	O	O	Urination difficult or dribbling
215	O	O	O	Frequent night time urination
216	O	O	O	Depression
217	O	O	O	Pain on inside of legs or heels
218	O	O	O	Feeling of incomplete bowel evacuation
219	O	O	O	Lack of energy
220	O	O	O	Migrating aches and pains
221	O	O	O	Too easily tired
222	O	O	O	Avoids activity
223	O	O	O	Leg nervousness at night
224	O	O	O	Diminished sex drive

IMPORTANT

List below your <u>five main physical complaints</u> in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Notes: