13. _____ Do you have chest pain or discomfort? _____
14. _____ Do you have post-nasal drip _____
15. _____ Do you spit up phlegm? _____
16. _____ Do you snore frequently or loudly? _____
17. _____ Do you have any other respiratory disorders? Explain: _____

CANCER SUPPORT

1. _____ Do have cancer or have you had it in the past? _____
2. _____ Do or did any of your immediate family members have cancer? If yes, describe in detail. _____

_____

CHILDREN

1. _____ Does your baby have colic? _____
2. _____ Does your child have problems with teething? _____
3. _____ Does your child wet the bed? _____
4. _____ Does your child have jaundice? _____
5. _____ Do you or your child have swollen tonsils? _____
6. _____ Does your child have swollen glands? Where? _____
7. _____ Does your child have attention deficit disorder? _____
8. _____ Is your child hyperactive? _____
9. _____ Does your child have any other learning disabilities? Explain: _____
10. _____ Does your child have recurring fears? _____
11. _____ Does your child have recurring fevers? _____
12. _____ Does your child have recurring nightmares? _____
13. _____ Does your child have recurring tummy aches? _____
14. _____ Does your child have abnormal growth patterns? _____
15. _____ Are there any other childhood disorders? Explain: _____
16. _____ Did or does your child have reactions from vaccinations? Explain: _____
17. _____ Does your child suffer from poor appetite? _____
18. _____ Does your child have excessive appetite? _____
19. _____ Is your child overweight? _____

CIRCULATION

1. _____ Do you have slurred or stuttered speech? _____
2. _____ Do you have confusion? _____
3. _____ Have you been diagnosed with a heart condition? _____
4. _____ Do you have low blood pressure? _____
5. _____ Do you have high blood pressure? _____
6. _____ Do you have circulatory problems? _____
7. _____ Are you often dizzy _____

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PERSONAL HEALTH APPRAISAL (P.H.A.)

Name _____ Phone (home/cell) _____ Address _____

Phone (business) _____ Occupation _____

Birthdate _____ Referred by _____

IMPORTANT The information requested In this form Is of vital importance to you and your health. It Is designed to help you understand your current state of health. Seeing your complete health picture helps you and your health care professional identify the natural medicines and therapies best suited to the dynamic restoration of YOUR health.

Read the questions carefully and score them on a 0 - 5 scale of intensity, 5 being the strongest.

If a question does not apply to you, score it a 0. If you are not sure and have a doubt about a question, or wish to clarify the answer, describe in the space available.

What priorities do you have for your health? List priorities, concerns, issues: _____

_____

_____

_____

Score the degree of severity of symptoms in each square below from 0 to 5.
0 - Never or No; 1 - Very mild or occasional; 2 - Mild; 3 - Moderate; 4 - Severe; 5 - Very severe or Yes

EXAMPLE: 3 Do you have headaches get hedaches on an empty stomach.

ALLERGY

1. _____ Do you have any allergies? If yes, please list: _____
2. _____ Do you live or work in a moldy environment? _____
3. _____ Are you sensitive to dairy products? _____
4. _____ Are you sensitive to fragrances or chemical smells? _____
5. _____ Are you sensitive to animal hair/dander? _____
6. _____ Do you have any food allergies? If yes, please list: _____
7. _____ Are your allergies worse in differenl areas of the country? Where? _____
8. _____ Do you have hay fever and/or seasonal allergies? _____
9. _____ Is your nose frequently stuffy? _____
10. _____ Have you been diagnosed with asthma? _____
11. _____ Have you been diagnosed with emphysema? _____
12. _____ Have you been diagnosed with bronchitis or pneumonia? _____

8. _____ Does your health suffer when the weather or seasons change? _____

DIGESTION

1. _____ Do you have problems with constipation? _____
2. _____ Do you use laxatives? _____
3. _____ Do you have frequent diarrhea? _____
4. _____ Do you have colitis _____
5. _____ Have you been diagnosed with a gall bladder condition? _____
6. _____ Do you have gall stones _____
7 _____ Do you have black stools? _____
8. _____ Do you have red or bloody stools? _____
9. _____ Do you have problems with heartburn? _____
10. _____ Do you have problems with hemorrhoids? _____
11. _____ Do you have problems with rectal fissures or polyps? _____
12. _____ Do you have indigestion? When _____
13. _____ Do you have problems with abdominal or lower GI gas? _____
14 _____ Do you have problems with bloating? _____
15. _____ Do you experience any pain or tenderness in your abdomen? _____
16. _____ Have you ever had intestinal worms, itchy nose or rectum? _____
17. _____ Are you frequently nauseated or vomit easily? _____
18. _____ Do you suffer from motion sickness? _____
19. _____ Have you been diagnosed with stomach ulcers? _____
20. _____ Do you have any other digestive disorders? _____
21. _____ Do you have frequent foul smelling lower gas? _____
22. _____ Do you have frequent foul smelling stools? _____
23. _____ Do you have frequent problems with upper gas, such as belching? _____

EYES

1. _____ Do you wear corrective lenses? _____
2. _____ Do you experience dry itchy, watery or red eyes? _____
3. _____ Do you have eye discomforts associated with allergies and hay fever? _____
4. _____ Are you troubled with conjunctivitis (pink eye)? _____
5. _____ Do you have styes? _____
6. _____ Do you have cataracts? _____
7. _____ Do you have eye stress? _____
8. _____ Do your eyes fatigue easily? _____
9. _____ Do you have macular degeneration? _____
10. _____ Do you have other eye conditions? Explain: _____

8. _____ Do you get light headed when standing quickly? _____
9. _____ Do you have cold hands or feet? _____
10. _____ Do you experience spells of rapid heart beat? _____
11. _____ Are you aware of your heart skipping beats? _____
12. _____ What is going on in your life when your heart skips beats? _____
13. _____ Do you have nosebleeds? _____
14. _____ Do you have varicose or spider veins? _____
15. _____ Have you been diagnosed with phlebitis? _____
16. _____ Do you have any other circulatory disorders? Explain: _____

CLEANSING & DETOX

1. _____ Does acid accumulate in your body? _____
2. _____ Do you have any tumors or abnormal growths? _____
3. _____ Have you been diagnosed with a liver condition? _____
4. _____ Have you ever had chemotherapy or radiation treatment? _____
5. _____ Do you have pain or sensitivity in the lower right portion of the abdomen? _____
6. _____ Have you worked or lived in any toxic environments that you are aware of? Explain: _____
7. _____ Do you have any other toxic condition? Explain: _____
8. _____ Have you been exposed to toxic metals (tooth fillings, old plumbing or paint, frequent seafood consumption, etc?) _____
9. _____ Do you live in an area of heavy outdoor pollution? _____
10. _____ Does breathing the air in your house or workplace aggravate your symptoms? _____
11 _____ Are you frequently in contact with household chemicals and/or topical cosmetics? _____
12. _____ Do you have food allergies_____
13. _____ Do you live/work in a moldy environment? _____
14. _____ Are you aware of exposure to pesticides or herbicides? _____
15. _____ Are you aware of any reactions to food additives or preservatives? _____
16. _____ Do you have excessive thirst? _____
17. _____ Have you ever had reactions from vaccinations? Explain: _____
18. _____ Do you have frequent earaches or discharge from the ears? _____
19. _____ Do you have ringing in the ears or a loss of hearing? _____

CONSTITUTION

1. _____ Have you reached a plateau in your progress towards better health? _____
2. _____ Please describe any known genetic weaknesses within you or your family. _____
3. _____ Do you have any immune system challenges? _____
4. _____ Do you have any adverse reactions that are aggravated by cold/damp environments? _____
5. _____ Do you have any adverse reactions that are aggravated by cold/dry environments? _____
6. _____ Do you have any adverse reactions that are aggravated by hot/humid environments? _____
7. _____ Do you have any adverse reactions that are aggravated by hot/dry environments? _____

22. _____ Have you had a hysterectomy? _____
23. _____ Are you pregnant? _____
24. _____ Do you experience morning sickness with pregnancy? _____
25. _____ Have you had a miscarriage or are you prone to miscarry? _____
26. _____ Do you have problems with fertility? _____
27. _____ Is intercourse painful for you? _____
28. _____ Do you have diminished sexual desire? _____
29. _____ Do you have difficulty controlling sexual desire? _____
30. _____ Do you have any other female disorders? Explain: _____
31. _____ Have you been diagnosed with osteoporosis or weakened bones? _____
32. _____ Do you have heel spurs? _____
33. _____ Do you feel shaky when hungry? _____
34. _____ Are you a diabetic? What type? _____
35. _____ Have you ever been diagnosed with low blood sugar problems? _____
36. _____ Do you have increased urination and constipation associated with sugar consumption? _____

ORAL HEALTH

1. _____ Do your jaws pop or ache when eating? _____
2. _____ Do you have halitosis/bad breath? _____
3. _____ Do you have bleeding gums? _____
4. _____ Describe any dental work you've had: _____
5. _____ Do you have excessive plaque and tartar build-up on your teeth? _____
6. _____ Do you have teeth and/or gum problems? Describe: _____
7. _____ Do you have amalgam/metal fillings? How many? _____

PAIN

1. _____ Have you been diagnosed with rheumatoid arthritis? _____
2. _____ Have you been diagnosed with osteoarthritis? _____
3. _____ Does any part of your body experience numbness or tingling? Where? _____
4. _____ Do you have back or neck problems? Where? _____
5. _____ Do you have a spinal curvature? _____
6. _____ Do you suffer from muscle cramps_____
7. _____ Do you suffer from muscle spasms? _____
8. _____ Are your muscles frequently sore? _____
9. _____ Do you have muscle weakness? _____
10. _____ Are your joints stiff in the morning? _____
11. _____ Do you suffer from painful feet? _____
12. _____ Have you been diagnosed with gout? _____
13. _____ Do you have headaches? Explain: _____
14. _____ Do you have migraine headaches? Explain: _____

IMMUNE

1. _____ Are you bothered with viruses at various times during the year? _____
2. _____ Are you sensitive to chemicals? Explain: _____
3. _____ Are you oversensitive to the environment? _____
4. _____ Do you have recurring infections, virus, bacteria, fungus or other? Explain: _____
5. _____ Do you have colds or flu often? How often? _____
6. _____ Do you cough frequently _____
7. _____ Have you been diagnosed with Lyme disease? _____
8. _____ Do you have frequent laryngitis or hoarseness? _____
9. _____ Do you have fevers frequently? _____
10. _____ Do you have frequent sinusitis? _____
11. _____ Do you have frequent sore throats? _____
12. _____ Are your glands often swollen? _____
13. _____ Are your tonsils often swollen _____
14. _____ Do you have sinus headaches? _____
15. _____ Do you have yeast or fungal overgrowths and/or candida albicans infections? _____
16. _____ Do you have any other immune disorders? _____

MEN/WOMEN

1. _____ Do you have signs of premature aging such as wrinkles, grey hair, and body aches? _____
2. _____ Do you have prostate enlargement? _____
3. _____ Do you have dribbling after urination? _____
4. _____ Do you have an urgency to urinate? _____
5. _____ Do you have erectile dysfunction? _____
6. _____ Do you have premature ejaculations? _____
7. _____ Do you have decreased sexual desire? _____
8. _____ Do you have difficulty controlling sexual desire? _____
9. _____ Do you have any other male disorders? Explain: _____
10. _____ Do you have pre-menstrual syndrome? _____
11. _____ Do you retain fluid during your period? _____
12. _____ Do you have menstrual pain, cramps or irregularities? _____
13. _____ Do you have feminine discharge? _____
14. _____ Do you have vaginal pain or discomforts? _____
15. _____ Have you been diagnosed with endometriosis? _____
16. _____ Do you have breast cysts or lumps? _____
17. _____ Do you have breast mastitis? _____
18. _____ Do you have tender or sore nipples? _____
19. _____ Do you have frequent yeast infections? _____
20. _____ Are you going through or have symptoms of menopause? _____
21. _____ Do you frequently feel hot or perspire? _____

URINARY

1. _____ Do you have frequent urination? _____
2. _____ Do you ever lose control of your bladder or dribble when sneezing or laughing? _____
3. _____ Do you have painful urination _____
4. _____ Do you have difficulty in starting the stream? _____
5. _____ Do you have frequent kidney or bladder infections? _____
6. _____ Do you have or have you ever had kidney stones? _____
7. _____ Do you have any other urinary tract disorders? _____

WEIGHT

1. _____ Are you overweight? Estimated lbs. overweight _____
2. _____ Are you underweight? Estimated lbs underweight _____
3. _____ How often do you exercise? ☐ Once a week ☐ Twice a week ☐ Three times a week ☐ Five times a week
   _____ More than 5 times a week
4. _____ What type of exercise do you do? ☐ Walking ☐ Running ☐ Jogging ☐ Aerobics ☐ Swimming
   _____ Other _____
5. _____ How much water do you drink daily? ☐ Less than 4 cups ☐ 4 - 8 cups ☐ More than 8 cups
6. _____ Do you crave sweets? _____
7. _____ Do you have an excessive appetite? _____
8. _____ Do you have a poor appetite? _____
9. _____ Do you desire to vomit after eating? _____
10. _____ Do you have an eating disorder? _____
11. _____ Do you eat when nervous _____
12. _____ Do you have edema or water retention? Where? _____
13. _____ Do you have any other weight disorders? Explain: _____

Please continue to the next page for your Mind & Body appraisal.

15. _____ Do you have sciatica? _____
16. _____ Do you bruise easily _____
17. _____ Have you been diagnosed with neurological disease? _____
18. _____ Do you have any other pain or injuries? Explain: _____
19. _____ Do you have tremors? _____
20. _____ Do you have tics (twitching)? _____
21. _____ Do you have ringing in the ears, hearing loss, or acute sensitivity to sounds? _____
22. _____ Do you suffer from restless leg syndrome? _____
23. _____ Do you suffer from leg cramps? _____

SKIN

1. _____ Do you have teenage acne? _____
2. _____ Do you have adult acne? _____
3. _____ Is your skin generally unhealthy and dry? _____
4. _____ Do you have any abnormal skin growths or discolorations? _____
5. _____ Do you have athlete's foot? _____
6. _____ Do you have insect bite reactions or allergies? _____
7. _____ Are insects attracted to you? _____
8. _____ Do you scar easily? _____
9. _____ Do you have any pain or discomfort in or around any scars? _____
10. _____ Do you have adhesions? Explain: _____
11. _____ Do you get cold sores _____
12. _____ Do you have warts? _____
13. _____ Do you have excess body perspiration? _____
14. _____ Do you have excess body odor? _____
15. _____ Do you have reactions to poison ivy, oak, or sumac? _____
16. _____ Do you have hair growth abnormalities? _____
17. _____ Do you have nail growth abnormalities? _____

SLEEP

1. _____ Do you feel weakness or exhaustion? _____
2. _____ Do you experience jet lag or problems with shift changes? _____
3. _____ Do you have insomnia? _____
4. _____ Do you have any abnormal sleep patterns? Describe: _____

SPORTS

1. _____ Are you interested in increasing muscular strength and/or bodybuilding? _____
2. _____ Do you have sports injuries? Explain: _____
3. _____ Do you have soreness, bruises, tightness and stiffness after sports activities? _____
4. _____ Are you interested in any sports enhancements? Explain: _____