

HEALTH ASSESSMENT

Name _____

Address _____

Home Phone _____

Cell Phone _____

Business Phone _____

Fax _____

E-Mail Address _____

Preferred Method of Contact: Home _____ Cell _____ Business _____ E-mail _____
(mark all that apply)

Date of Birth _____ Age _____

Family Status: Single _____ Married _____ Significant Other _____

Partner's Name _____

Number of Children Living at Home and Ages: _____

Occupation: _____

Employer: _____

Ethnicity: _____ Last Grade Completed: _____

Date _____

-2- Name:

When was the last time you saw a doctor for a check-up or illness? _____

In the past 12 months, how many times did you see a doctor about your health? _____

During the past year, how many days did you miss from work or have to curtail your regular activities due to illness? _____

In the past 12 months, how many days were you in the hospital? _____

Comparing your health to others of your age, how would you rate your health?

____ Excellent

____ Good

____ Fair

____ Poor

List Allergies to Medicine and describe allergic reaction:

List all medications, both prescription and over-the-counter:

Medication	Condition	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all supplements, vitamins, nutraceuticals: (You may copy labels and submit them)

Supplement	Condition	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

-3- Name:

List any diagnostic or surgical procedures you have had, including inpatient and outpatient procedures. List year of occurrence.

List hospitalizations, reason, and year.

List injuries, car accidents, fractures and year.

List environmental exposures and year.

Asbestos_____	Coal Dust_____
Chemicals_____	Sun exposure, tanning_____
Fumes, gases_____	Radon exposure_____
X-ray treatments_____	

Check the column that applies to you and your family:

Condition	Myself	Sibling	Mother	Father	Grandparents
1. Heart Disease_____					
2. Cancer (list type)_____					
3. Diabetes_____					
4. Arthritis_____					
5. Liver Disease_____					
6. Psychiatric Disease_____					
7. Autoimmune Disease_____					
8. Thyroid Disease_____					
9. Stroke_____					
10. Parkinsons_____					
11. Alzheimers_____					
12. Pulmonary Disease_____					
13. Sleep apnea, snoring_____					
14. Kidney Disease_____					
15. Stomach Disorders_____					
16. Bowel Disease_____					
17. Bladder Disease_____					
18. Obesity_____					
19. Osteoporosis_____					

Name:

Condition	Myself	Sibling	Mother	Father	Grandparents
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- 20. Migraine Headache _____
- 21. Anemia _____
- 22. HIV/AIDS _____
- 23. Allergies, environmental _____
- 24. Allergies, food _____

Please note the number and give an explanation for checked items:

REVIEW OF SYMPTOMS

<u>SKIN AND HAIR</u>	Mild	Moderate	Severe	N/A
-----------------------------	-------------	-----------------	---------------	------------

- Dry, brittle hair _____
- Dry skin _____
- Brittle nails _____
- Acne _____
- Age spots _____
- Puffy, wrinkled skin _____
- Dark circles under eyes _____
- Hair thinning or falling out _____
- Bumpy skin on face or back of arms _____
- Spider veins on nose or face _____
- Persistent skin rash _____
- Slow or poor wound healing _____
- Bruise easily _____
- Excess hair growth _____
- Skin tags _____

CARDIOPULMONARY

Mild Moderate Severe N/A

Chest pain at rest _____

Chest pain during exercise _____

Other pain in chest or sides _____

Frequent upper respiratory infections(colds) _____

Fluid retention (swollen ankles) _____

Difficulty exercising _____

Wheezing _____

Leg cramps or pain while walking _____

Palpitations, irregular heart beat _____

Rapid heart beat _____

Shortness of breath _____

Sleep apnea _____

Anemia or history of anemia _____

High cholesterol or lipids? _____

 On medication for cholesterol? ___yes ___no

High blood pressure _____

 On medication for blood pressure? ___yes ___no

METABOLIC AND IMMUNE SYSTEMS

Loss of outer portion of eyebrow _____

Cold intolerance _____

Heat intolerance _____

Cold hands and feet _____

Overweight problems _____

Difficulty gaining or maintaining weight _____

Diabetes _____

Overactive thyroid (hyperthyroid) _____

Underactive thyroid (hypothyroid) _____

Sweet cravings _____

Feel weak if missed meal _____

Feel irritable or shaky if missed meal _____

Increased thirst _____

Need to drink caffeine to “get going” _____

Increased abdominal fat _____

Decreased muscle tone or mass _____

Fatigue/low energy _____

URINARY SYSTEM

Mild Moderate Severe N/A

- Frequent urinary infections _____
- Frequent urination _____
- Night time urination _____
- Slow stream with urination _____
- Urinary urgency (feeling need to void) _____
- Loss of bladder control with urge _____
- Loss of bladder control with cough, laugh, sneeze _____
- Burning or pain with urination _____
- Blood in urine _____
- Diagnosed with overactive bladder or interstitial cystitis? yes no
- History of kidney infection (pyelonephritis)? yes no

GASTROINTESTINAL SYSTEM

Mild Moderate Severe N/A

- Abdominal pain _____
- Nausea and/or vomiting _____
- Heartburn, indigestion _____
- Chronic constipation _____
- Chronic diarrhea _____
- Alternating diarrhea and constipation _____
- Flatulence (gas) or bloating _____
- Blood in stool? yes no Annual exam for blood in stool? yes no
- Mucous in stool? yes no Annual rectal exam? yes no
- Gallstones/gall bladder pain? yes no
- Liver disease? yes no Colonoscopy date _____
- Inflammatory bowel disease (Crohn's or Ulcerative Colitis)? yes no

NEUROLOGICAL SYSTEM

Mild Moderate Severe N/A

- Migraine headaches _____
- Severe headaches weekly or more often _____
- Feel faint or weak _____
- Seizures (convulsions) _____
- Tremors _____
- Dizziness _____
- Tingling or numbness _____
- Balance problems _____
- Memory problems _____
- Lack of mental focus _____
- Problems with attention and concentration _____
- Lack of mental alertness _____

PSYCHO-PHYSIOLOGIC

Mild Moderate Severe N/A

Insomnia_____

Hypersomnia (sleeping too much)_____

Rapid Mood Swings_____

Impatient, moody, nervous_____

Depression_____

Anxiety_____

Personality changes_____

Excessive stress_____

Difficulty getting out of bed_____

Currently in psychotherapy? ____yes ____no

History of psychiatric disease? ____yes ____no

History of hospitalization for psychiatric disease? ____yes ____no

EYES, EARS, NOSE, THROAT

Mild Moderate Severe N/A

Change in vision_____

Blurry vision or tunnel vision_____

Hearing loss_____

Tinnitus (ringing in ears)_____

Nosebleeds_____

Sore throat/hoarseness_____

Sore or bleeding gums_____

Sores in the mouth or lips_____

Annual dental check ups? ____yes ____no

Annual teeth cleaning? ____yes ____no

Brush teeth twice a day? ____yes ____no

Use dental floss daily? ____yes ____no

MUSCULOSKELETAL

Mild Moderate Severe N/A

Joint pain/swelling/stiffness_____

Arthritis_____

Back pain_____

Limited range of motion of joint_____

Muscle spasms_____

Fibromyalgia_____

Carpal tunnel syndrome_____

FOR MEN ONLY

YES

NO

SYMPTOM:

- Difficulty maintaining/attaining an erection? _____
- Painful ejaculation? _____
- Underactive sex drive? _____
- Overactive sex drive? _____
- Premature ejaculation? _____
- Pain in genital area? _____
- Infertility? _____
- Varicose veins on scrotum? _____
- Low sperm count? _____
- Penile discharge? _____
- Early morning erections? _____
- Penile rash, fungal infection (Jock Itch)? _____
- Swollen genitals? _____
- Swelling in groin? _____
- Genital sores? _____
- Lump or mass in scrotum? _____
- History of sexually transmitted disease? _____
- Prostatic hypertrophy (enlarged prostate)? _____
- Prostate cancer? _____
- Vasectomy? When? _____
- History of sexual abuse? _____

MEDICATION

Have you used medication for erectile dysfunction? Which medications and how often?

Do you use anything else to enhance sexual function?

Have you used hormones such as testosterone, DHEA, or Human Growth Hormone?
Which ones and when?

LABORATORY

When was your last PSA test? _____ Was it normal _____ or abnormal _____

Name: _____

FOR WOMEN ONLY

Pregnancy History-List Number of:

Pregnancies	_____
Miscarriages	_____
Abortions	_____
Ectopic preg	_____
Live births	_____
Living children	_____

History of Infertility? _____yes _____no

Treatment for infertility? _____

History of Sexually Transmitted Disease? _____yes _____no

History of Uterine Fibroids? _____yes _____no

History of Endometriosis? _____yes _____no

History of Ovarian Cysts? _____yes _____no

Pelvic pain _____yes _____no

PCOS (polycystic ovarian syndrome) _____yes _____no

Menstrual History:

Last Normal Menstrual Period _____

Skipped Periods? _____yes _____no

Heavy Periods? _____yes _____no

Irregular Periods? _____yes _____no

Painful Periods? _____yes _____no

Premenstrual Symptoms:

Bloating _____yes _____no

Water retentions _____yes _____no

Sweets cravings _____yes _____no

Weight gain _____yes _____no

Moodiness _____yes _____no

Irritability _____yes _____no

Depression _____yes _____no

Breast Tenderness _____yes _____no

Headaches _____yes _____no

Name:

Contraception History (Circle any that apply):

Intrauterine Device Oral Contraceptives Vasectomy Condoms Diaphragm
Sponge Tubal Ligation

Gynecologic Symptoms

Mild Moderate Severe N/A

Hot flashes _____
Night sweats _____
Vaginal dryness _____
Lack of lubrication _____
Painful sex _____
Aversion to sex _____
Overactive sex drive _____
Underactive sex drive _____
Longer to orgasm _____
Weak or muffled orgasm _____
History of sexual abuse _____

Hormone Use

Have you used hormones such as estrogen, progesterone, testosterone, DHEA, other?
List names and types :

Laboratory Testing

When was your last mammogram? _____ Normal? _____ Abnormal? _____
When was your last pap test? _____ Normal? _____ Abnormal? _____

**WHAT ARE THE SYMPTOMS OR PROBLEMS YOU WANT ME
TO HELP YOU WITH?**

**FOR YOUR CARE TO BE A WIN, WHAT WOULD YOU LIKE TO
ACHIEVE?**

Life Style Assessment Questionnaire

Name: _____ Date _____

Primary cook in home _____

Numbers of hours worked daily _____ weekly _____

Please list the foods that you typically eat and the times you eat them

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages / Quantities _____

How many times a week do you:

Use tobacco/ quantity_____

Drink alcohol / quantity_____

Drink soda / quantity_____

Drink caffeinated beverages what and how much_____

Have dessert after a meal?_____

Eat at restaurants_____drive thrus_____take out_____

Prepare breakfast at home_____lunch_____dinner_____

Skip meals/ which one_____eat after 7:00 pm_____

Do you use recreational drugs / type_____

What type of regular exercise do you do? Type and length of time

Monday:_____

Tuesday:_____

Wednesday:_____

Thursday:_____

Friday:_____

Saturday:_____

Sunday:_____

How many hours of uninterrupted sleep to you get nightly? _____

How much time do you spend outdoors during the week? _____

And on the weekends? _____

How much time do you spend driving? _____

Do you use a seatbelt? ___yes ___no

What are your hobbies? _____

Do you travel outside the country? ___yes ___no

List the countries you have visited in the past 5 years: _____

Do you consider yourself to be under excessive stress? What are the sources of your stress? _____

Exercise Readiness Questionnaire (ERQ)

Regular exercise is associated with many health benefits. Increasing physical activity is safe for most people. However, some individuals should check with a physician before they become more physically active. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every question honestly:

Yes	No	1) Has a physician ever diagnosed you with a heart condition and indicated you should restrict your physical activity?
Yes	No	2) When you perform physical activity, do you feel pain in your chest?
Yes	No	3) When you were not engaging in physical activity, have you experienced chest pain in the past month?
Yes	No	4) Do you ever faint or get dizzy and lose your balance?
Yes	No	5) Do you have an injury or orthopedic condition (such as a back, hip, or knee problem) that may worsen due to a change in your physical activity?
Yes	No	6) Do you have high blood pressure or a heart condition in which a physician is currently prescribing a medication?
Yes	No	7) Are you pregnant?
Yes	No	8) Do you have insulin dependent diabetes?
Yes	No	9) Are you 69 years of age or older and not used to being very active?
Yes	No	10) Do you know of any other reason you should not exercise or increase your physical activity?

If you answered yes to any of the above questions, talk with your doctor **before** you become more physically active. Tell your doctor your plan to exercise and to which questions you answer yes.

If you honestly answered no to all questions you can be reasonably certain you can safely increase your level of physical activity **gradually**.

If your health changes so you then answer **yes** to any of the above questions, seek guidance from a physician.

Participant signature	Date
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LIFE BALANCE SURVEY

Name:

- | | | |
|--|---|---|
| 1) My health is a low priority | T | F |
| 2) I shop to relieve stress | T | F |
| 3) I exercise excessively | T | F |
| 4) I watch TV excessively | T | F |
| 5) I am addicted to the computer | T | F |
| 6) I am a workaholic | T | F |
| 7) I am a hoarder | T | F |
| 8) I am sexually compulsive | T | F |
| 9) I eat compulsively | T | F |
| 10) I am disorganized at home | T | F |
| 11) I smoke | T | F |
| 12) I drink excessive alcohol | T | F |
| 13) I use illicit drugs | T | F |
| 14) My spending is out of control | T | F |
| 15) I eat out frequently | T | F |
| 16) I eat fast food frequently | T | F |
| 17) I drink coffee excessively | T | F |
| 18) I am addicted to Starbucks drinks | T | F |
| 19) I am addicted to internet porn | T | F |
| 20) I drive aggressively or recklessly | T | F |

HORMONE HEALTH ASSESSMENT

Name: _____

OVERALL HEALTH

- | | | |
|--|---|---|
| Do you have reduced energy or are easily fatigued? | Y | N |
| Do you have insomnia or poor sleep quality? | Y | N |
| Do you lack a “sense of well-being?” | Y | N |

HEALING AND IMMUNITY

- | | | |
|--|---|---|
| Do you have increased healing time? | Y | N |
| Do you have decreased joint flexibility? | Y | N |
| Do you have chronic pain (e.g. arthritis)? | Y | N |
| Do you have increased susceptibility to illness? | Y | N |

BODY COMPOSITION

- | | | |
|---|---|---|
| Do you have increased body fat? | Y | N |
| Do you have reduced muscle mass or muscle strength? | Y | N |
| Do you have reduced exercise performance? | Y | N |

HAIR, SKIN, AND BONE

- | | | |
|--|---|---|
| Do you have decreased hair and nail growth? | Y | N |
| Do you have thinning skin or hair? | Y | N |
| Do you have dry hair or skin or brittle nails? | Y | N |
| Do you have wrinkles or redundant, loose skin? | Y | N |
| Do you have reduced bone density? | Y | N |

METABOLISM

- | | | |
|---|---|---|
| Do you have elevated blood sugar abnormalities (too high or too low)? | Y | N |
| Do you have high cholesterol levels? | Y | N |
| Do you have cold intolerance? | Y | N |
| Do you have heat intolerance? | Y | N |
| Have you been diagnosed with a thyroid problem? | Y | N |

MENTAL HEALTH

- | | | |
|--|---|---|
| Do you have reduced memory or concentration? | Y | N |
| Do you have mood swings? | Y | N |
| Do you have depression or anxiety? | Y | N |

SEXUAL AND REPRODUCTIVE FUNCTION

- | | | |
|---|---|---|
| Do you have low sex drive (libido)? | Y | N |
| Do you have low sexual arousal or orgasmic difficulty? | Y | N |
| Do you have vaginal dryness, or painful sexual intercourse? | Y | N |
| Do you have PMS? | Y | N |
| Do you have heavy menses? | Y | N |
| Do you have painful menses? | Y | N |
| Do you have hot flashes or night sweats? | Y | N |

TOTAL “YES” ANSWERS _____ X 3.3 = TOTAL SCORE _____ %

The higher your score, the greater the likelihood that hormone deficiencies are an underlying cause of your problems.

ADRENAL HEALTH ASSESSMENT

Name: _____

Do you frequently have low body temperature? (Less than 98 degrees F)	Y	N
Do you frequently get irritable?	Y	N
Do you have poor memory or concentration?	Y	N
Do you notice palpitations?	Y	N
Do you suffer from allergies or asthma?	Y	N
Do you bruise easily or find your wounds heal slowly?	Y	N
Do you get frequent, chronic infections?	Y	N
Do you have dry, thinning skin?	Y	N
Do you get headaches?	Y	N
Do you have unexplained hair loss?	Y	N
Do you skip meals?	Y	N
Do you have thyroid problems?	Y	N
Is low energy a problem?	Y	N
Do you need caffeine in the morning or after lunch?	Y	N
Do you get cravings for sugar, fat, or salt?	Y	N

Total Points for This Section _____ x 2 = _____%

Are you emotionally overstressed?	Y	N
Do you get tenderness across your lower back?	Y	N
Do you suffer from depression or down moods?	Y	N
Do you have low blood pressure?	Y	N
Do you experience a "second wind" (high energy) at bedtime?	Y	N
Do you get light-headed when sitting or standing from lying down?	Y	N

Total Points for This Section _____ x 5 = _____%

Do you suffer from chronic pain?	Y	N
Do you have hypoglycemia (low blood sugar) symptoms such as headaches, sleepiness, mood swings, or shakiness if skipping meals?	Y	N
Do you suffer from insomnia?	Y	N
Do you have PMS (premenstrual syndrome)?	Y	N
Are you menopausal or peri-menopausal?	Y	N

Total Points for This Section _____ x 8 = _____%

Add the totals for each section to get your GRAND TOTAL:

TOTAL SCORE _____%

The higher your score, the higher your likelihood of having Adrenal Fatigue as a cause of your problems.

HEART HEALTH ASSESSMENT Name:

Do you have a personal history of heart attack or stroke?	Y	N
Have you had bypass surgery or artery stenting procedures?	Y	N
Do you have hypertension (high blood pressure)?	Y	N
Do you have high serum cholesterol or triglycerides?	Y	N
Do you have a diet high in meat, dairy, and saturated fats?	Y	N
Do you have a diet high in carbohydrates (starches and sugar) or high in processed foods?	Y	N
Do you have a family history of premature (prior to age 50) heart disease?	Y	N
Do you have a personal history of diabetes?	Y	N
Do you have a family history of diabetes?	Y	N
Are you overweight?	Y	N
Is your waist measurement 35 inches or greater (for females)?	Y	N
Is your waist measurement 40 inches or greater (for males)?		
Is your fasting blood sugar greater than 110?	Y	N
Are you a smoker?	Y	N
Do you have high inflammatory blood markers such as CRP or homocysteine?	Y	N

SCORE _____ x 7 = TOTAL _____ %

The higher your score, the higher your risk of cardiovascular disease.

GASTROINTESTINAL AND LIVER HEALTH ASSESSMENT Name: _____

Circle the question number if your answer is YES:

- 1) Do you have GERD (Gastroesophageal Reflux) or Indigestion?
- 2) Do you have chronic Constipation?
- 3) Do you have chronic Diarrhea?
- 4) Do you have alternating Diarrhea and Constipation?
- 5) Do you have Abdominal Bloating?
- 6) Do you have Abdominal Gas?
- 7) Do you suffer from Abdominal Pain or Discomfort?
- 8) Have you had rashes such as Psoriasis, Hives, or Eczema?
- 9) Do you have Bloating or Belching after meals?
- 10) Do you have a feeling of uncomfortable fullness after meals, even if only eating a small amount of food?
- 11) Do you have Inflammatory Bowel Disease such as Crohn's or Colitis?
- 12) Do you have Bad Breath?
- 13) Do you have Brain Fog?
- 14) Do you have Fatigue or Low Energy?
- 15) Do you have Food Allergies?
- 16) Have you been diagnosed with Celiac Disease?
- 17) Have you used antacids such as Protonix, Pepcid, Zantac, Aciphex, or Nexium for longer than 6 months?
- 18) Have you been told you have Irritable Bowel Syndrome (IBS)?
- 19) Do you eat a diet high in refined and processed foods?
- 20) Do you have food allergies?
- 21) Do you avoid certain foods because you know they will cause discomfort?
- 22) Do you have a history of any type of hepatitis?
- 23) Has your gallbladder been removed?
- 24) Have you been diagnosed with a stomach ulcer?
- 25) Have you been diagnosed with an Autoimmune Disorder such as: Multiple Sclerosis, Lupus Erythematosus, Sjogren's Syndrome, Hashimoto's Thyroiditis, Rheumatoid Arthritis, Myasthenia Gravis, Scleroderma

Add the number of circles to obtain your score: _____

Total "YES" answers x 4 = TOTAL _____ %

The higher your score, the higher the likelihood that Gastrointestinal Problems are an important underlying cause of your health problems.

TOXICITY ASSESSMENT

Point Scale:

- 0 = Never or almost never have the symptom
- 1 = Occasionally have it, effect is not severe
- 2 = Occasionally have it, effect is severe
- 3 = Frequently have it, effect is not severe
- 4 = Frequently have it, effect is severe

HEAD

- Headaches
- Dizziness
- Insomnia
- Faintness

TOTAL _____

EARS

- Itchy ears
- Ringing in ears/ loss of hearing
- Earaches/ ear infections
- Drainage from ear

TOTAL _____

EYES

- Bags or dark circles under eyes
- Watery or itchy eyes
- Swollen, reddened, or sticky eyelids
- Blurred or tunnel vision

TOTAL _____

NOSE

- Stuffy nose
- Sinus congestion, sinus infection
- Constant sneezing Hay fever/allergies
- Excess mucus formation

TOTAL _____

MOUTH/THROAT

- Chronic coughing
- Sore throat, hoarseness, loss of voice
- Gagging, frequent need to clear throat
- Swollen tongue, gums, or lips
- Swollen lymph nodes
- Canker sores, mouth ulcers

TOTAL _____

ENERGY LEVEL

- Fatigue/low energy
- Restlessness
- Hyperactivity
- Feeling of weakness

TOTAL _____

HEART

- Chest pain
- Irregular or skipped heartbeat
- Rapid or pounding heartbeat

TOTAL _____

LUNGS

- Asthma, bronchitis
- Chest congestion
- Shortness of breath
- Difficulty breathing

TOTAL _____

SKIN

- Acne or brown "age/liver spots"
- Hives, rashes, cysts, boils
- Eczema or psoriasis
- Itchy skin/dermatitis
- Hair loss, hair thinning
- Body odor
- Excessive sweating

TOTAL _____

JOINTS/MUSCLES

- Pain or aches in joints or lower back
- Stiffness or limitation of movement ___Arthritis
- Pain or aches in muscles

TOTAL _____

MENTAL/EMOTIONAL

- Poor memory
- Difficulty concentrating
- Mood swings
- Depression
- Anxiety, fear, or nervousness
- Anger, irritability, or aggressiveness
- Insomnia

TOTAL _____

WEIGHT

- Underweight
- Overweight
- Difficulty losing weight
- Crave certain foods

TOTAL _____

OTHER

- PMS
- Frequent colds, flus
- Chemical or environmental sensitivities
- Food allergies/sensitivities

TOTAL _____

Please add the numbers from each section and write the section total in the spaces provided. Then add all the section totals together and put that total in the space below:

GRAND TOTAL _____

INTERPRETATION OF RESULTS:

- 15 or lower: You have a low level of toxicity.**
- 16 to 49: You have a moderate level of toxicity.**
- 50 or higher: You have a high level of toxicity.**