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HEALTH APPRAISAL QUESTIONNAIRE

Name: _____ Date ____/____/____

Telephone #: _____ E-mail Address _____

Part I – Circle any of the following medications you are presently taking

Antacids	Antidiabetic/insulin	Cortisone	High Blood Pressure
Antibiotics/antifungals	Aspirin/Tylenol	Anti-inflammatory Hormones	Laxatives
Antidepressants	Chemotherapy	Heart Meds	Sleeping Pills
Lithium	Oral Contraceptive	Radiation	Other _____
Recreation Drugs	Thyroid Meds	Ulcer Meds	_____

Circle if you eat, drink, or use

Alcohol	Coffee	Lunch Meat	Refined Sugar	Candy	Distilled Water
Margarine	Equal	Sweet/Low	Soda	Cigarettes	Fast Food
Cigars	Chew Tobacco	Fried Foods	Table Salt		

Circle if you

Diet often	Salt food without tasting	Are exposed to chemicals at work
Do not exercise regularly	Are under excess stress	Are exposed to cigarette smoke
Use commercial household cleaners		

INSTRUCTIONS: You will be asked to respond to symptoms you may experience. Circle the number which best describes the intensity of your symptoms. You will experience repeated questions in different sections of this form, please do not skip the question, answer all questions throughout the form. If you do not know the answer to a question leave it blank. The possible answers are as follows:

0 = No Symptoms 1 = Mild 2 = Often 3 = Severely No = 0 Yes = 3

<p>Part II</p> <p>Section A</p> <p>1. Burping..... 0 1 2 3</p> <p>2. Fullness after meals..... 0 1 2 3</p> <p>3. Bloating..... 0 1 2 3</p> <p>4. Poor appetite..... 0 1 2 3</p> <p>5. Stomach upsets easily..... 0 1 2 3</p> <p>6. History of constipation..... 0 1 2 3</p> <p>7. Known food allergies..... 0 1 2 3</p> <p>Section B</p> <p>1. Abdominal cramps..... 0 1 2 3</p> <p>2. Indigestion 1-3 hours after meals..... 0 1 2 3</p> <p>3. Fatigue after eating..... 0 1 2 3</p> <p>4. Lower bowel gas..... 0 1 2 3</p> <p>5. Alternating constipation and diarrhea.... 0 1 2 3</p> <p>6. Diarrhea..... 0 1 2 3</p> <p>7. Roughage and fiber cause constipation.0 1 2 3</p> <p>8. Mucous in your stools..... 0 1 2 3</p> <p>9. Shiny stools..... 0 1 2 3</p> <p>10. Stools poorly formed..... 0 1 2 3</p> <p>11. 3 or more bowel movements a day.... 0 1 2 3</p> <p>12. Foul smelling stools..... 0 1 2 3</p>	<p>13. Dr, flaky skin, dry brittle hair..... 0 1 2 3</p> <p>14. Pain in left side under rib cage..... 0 1 2 3</p> <p>15. Acne..... 0 1 2 3</p> <p>16. Food allergies..... 0 1 2 3</p> <p>17. Difficulty gaining weight..... 0 1 2 3</p> <p>Section C</p> <p>1. Stomach pain..... 0 1 2 3</p> <p>2. Stomach pain before or after meals..... 0 1 2 3</p> <p>3. Dependence on antacids..... 0 1 2 3</p> <p>4. Chronic abdominal pain.....0 1 2 3</p> <p>5. Butterfly sensation in stomach..... 0 1 2 3</p> <p>6. Difficulty belching..... 0 1 2 3</p> <p>7. Sudden acute indigestion..... 0 1 2 3</p> <p>8. Stomach pain when emotionally upset.. No Yes</p> <p>9. Relief of symptoms by sodas..... No Yes</p> <p>10. Relief of stomach pain (drink milk)..... No Yes</p> <p>11. History of ulcers/gastritis..... No Yes</p> <p>12. Current ulcer..... No Yes</p> <p>13. Black stools when taking iron Supplements..... No Yes</p>
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Part II (continued)				6. Toe and fingernail fungus.....	0	1	2	3	
Section D				7. Alternating diarrhea/constipation.....	0	1	2	3	
1. Seasonal diarrhea.....	0	1	2	3	8. Constipation.....	0	1	2	3
2. Frequent, recurring infections (colds)...	0	1	2	3	9. History of antibiotics use.....	No		Yes	
3. Bladder and kidney infection.....	0	1	2	3	10. Meat eater.....	No		Yes	
4. Vaginal yeast infection.....	0	1	2	3	11. Rapid failing vision.....	No		Yes	
5. Abdominal cramps.....	0	1	2	3					

Part III				24. Triglycerides above 115.....	No	Unknown	Yes		
Section A				Section B					
1. Intolerance to greasy foods.....	0	1	2	3	1. Swollen eyes (bulging).....	0	1	2	3
2. Headaches after eating.....	0	1	2	3	2. Strong smelling urine.....	0	1	2	3
3. Light colored stools.....	0	1	2	3	3. Thick skin and finger nails.....	0	1	2	3
4. Foul smelling stools.....	0	1	2	3	4. Dry skin.....	0	1	2	3
5. Less than 1 bowel movement a day....	0	1	2	3	5. Sensitive to the cold.....	0	1	2	3
6. Constipation.....	0	1	2	3	6. Cold hands and feet.....	0	1	2	3
7. Hard stools.....	0	1	2	3	7. Excessive menstrual bleeding.....	0	1	2	3
8. Sour taste in mouth.....	0	1	2	3	8. Chronic fatigue.....	0	1	2	3
9. Grey colored skin.....	0	1	2	3	9. Trouble waking up in the morning.....	0	1	2	3
10. Yellow in white of eyes.....	0	1	2	3	10. Depressed, apathetic.....	0	1	2	3
11. Bad breath.....	0	1	2	3	11. Low sex drive.....	0	1	2	3
12. Body odor.....	0	1	2	3	12. Puffy, wrinkled skin.....	0	1	2	3
13. Fatigue and sleepiness after eating...	0	1	2	3	13. Sugar causes irritability and mood swings.....	0	1	2	3
14. Pain in right side under rib cage.....	0	1	2	3	14. Premenstrual tension.....	0	1	2	3
15. Pain to pass stools.....	0	1	2	3	15. Constipation.....	0	1	2	3
16. Retain water.....	0	1	2	3	16. Thinning or loss of outside portion of eyebrows.....	No		Yes	
17. Big toe pain.....	0	1	2	3	17. Gain weight easily.....	No		Yes	
18. Pain radiates along side of leg.....	0	1	2	3	18. Anemia unaffected by iron.....	No		Yes	
19. Dry skin/hair.....	0	1	2	3	19. Armpit temperature below 97.6.....	No		Yes	
20. Red blood in stool.....	0	1	2	3	20. Slow reflexes.....	No		Yes	
21. Have had jaundice or hepatitis.....	No		Yes	(5)	21. Infertility.....	No		Yes	
22. High blood cholesterol/HDL.....	No	Unknown	Yes						
23. Cholesterol level above 200.....	No	Unknown	Yes						

Part IV				15. Catch colds/flu easily.....	0	1	2	3	
Section A				16. Bumpy skin on back of arms.....	0	1	2	3	
1. Sensation to exhaust fumes, smoke, smog, petrochemicals.....	0	1	2	3	Section C				
2. Periodic constipation.....	0	1	2	3	1. Itching nose or eyes.....	0	1	2	3 (5)
3. Cannot tolerate exercise.....	0	1	2	3	2. Itching of roof of mouth or throat.....	0	1	2	3 (5)
4. Depression or rapid mood swings.....	0	1	2	3	3. Migraine headache.....	No		Yes	(10)
5. Dark circles under eyes.....	0	1	2	3	4. Entire body aches, painful to touch.....	0	1	2	3
6. Dizziness upon standing.....	0	1	2	3	5. Swollen joints.....	0	1	2	3
7. Lack of mental alertness.....	0	1	2	3	6. Food sensitivity or allergy.....	0	1	2	3
8. Catch colds easily.....	0	1	2	3	7. Certain food make you sick.....	0	1	2	3
9. Headaches.....	0	1	2	3	8. Chronic pain.....	0	1	2	3
10. Difficulty breathing.....	0	1	2	3	9. Painful stomach or intestines.....	0	1	2	3
11. Water retention.....	0	1	2	3	10. Alternating constipation/diarrhea.....	0	1	2	3
12. Eyes sensitive to bright light.....	0	1	2	3	11. Mucous in throat.....	0	1	2	3
13. Feel weak and shaky.....	0	1	2	3	12. Post nasal drip.....	0	1	2	3
Section B				13. Discharge from eyes.....	0	1	2	3	
1. Inflamed or bleeding gums.....	0	1	2	3	14. Watery eyes.....	0	1	2	3
2. Running nose.....	0	1	2	3	15. Puffiness/dark circles under eyes.....	0	1	2	3
3. Get boils or sties.....	0	1	2	3	16. Ear discharge or ear stuffed up.....	0	1	2	3
4. Nose bleeds.....	0	1	2	3	17. Nasal congestion.....	0	1	2	3
5. Loss of smell.....	0	1	2	3	18. Running nose.....	0	1	2	3
6. Throat infections.....	0	1	2	3	19. Breathe through mouth.....	0	1	2	3
7. Cold sores, fever blisters.....	0	1	2	3	20. Swollen tongue.....	0	1	2	3
8. Loss of taste.....	0	1	2	3	21. Difficulty swallowing.....	0	1	2	3
9. Poor wound healing.....	0	1	2	3	22. Bedwetting.....	No		Yes	(5)
10. Hair falls out.....	0	1	2	3	23. Hyperactivity.....	0	1	2	3
11. Swollen lymph glands.....	0	1	2	3	24. Chronic lung congestion.....	0	1	2	3
12. Ear infection.....	0	1	2	3	25. Use aspirin/Tylenol regularly.....	No		Yes	
13. Hair grows slowly.....	0	1	2	3	26. Wheezing.....	0	1	2	3
14. Slow recovery from a cold.....	0	1	2	3	27. Skin rashes.....	0	1	2	3
					28. Sneezing.....	0	1	2	3

Part V				Section B					
Section A									
1. Difficulty breathing at night.....	0	1	2	3	2. Cold hands and feet.....	0	1	2	3
2. Chest pain while walking.....	0	1	2	3	2. Slurred speech.....	0	1	2	3
3. Heaviness in legs.....	0	1	2	3	3. Calf muscle cramps.....	0	1	2	3
4. Calf muscle cramps while walking.....	0	1	2	3	4. Headaches.....	0	1	2	3
5. Heart pounds easily.....	0	1	2	3	5. Numbness in extremities.....	0	1	2	3
6. Feel jittery.....	0	1	2	3	6. Poor concentration.....	0	1	2	3
7. Heart skips a beat.....	0	1	2	3	7. Ringing in ears.....	0	1	2	3
8. Swelling of feet and ankles.....	0	1	2	3	8. Ear canal hair.....	No		Yes	
9. Rapid beating heart.....	0	1	2	3	9. Tingling/burning in hand/feet.....	No		Yes	
10. Heartburn after eating.....	0	1	2	3	10. Spider veins on nose or face.....	No		Yes	
11. Pain in left arm.....	0	1	2	3	Section C				
12. Exhausted after minor activity.....	0	1	2	3	1. Pain when getting up in the morning				
13. Do you do aerobic exercise.....	No		Yes		in back of head and neck.....	0	1	2	3
14. Have you ever exercised regularly.....	No		Yes		2. Dizziness.....	0	1	2	3
15. Severe cough.....	No		Yes		3. Vertigo.....	0	1	2	3
16. Drink 5 or more cups of coffee a day.....	No		Yes		4. Blushing for no reason.....	0	1	2	3
17. Has a doctor told you that you have					5. Is you blood pressure high.....	No		Yes	
Heart problems.....	No		Yes						

Part VI				16. Forgetful.....				0	1	2	3
Section A				17. Calm after eating.....				No		Yes	
1. Dizziness when standing suddenly.....	0	1	2	3	Section B						
2. Loss of vision when standing suddenly.....	0	1	2	3	1. Night sweats.....	0	1	2	3		
3. Crave sweets.....	0	1	2	3	2. Increased thirst.....	0	1	2	3		
4. Headaches relieved by eating sweets					3. Lowered resistance to infection.....	0	1	2	3		
Or drinking alcohol.....	0	1	2	3	4. Fatigue.....	0	1	2	3		
5. Feel shaky or jittery.....	0	1	2	3	5. Boils and leg sores.....	0	1	2	3		
6. Irritable if you miss a meal.....	0	1	2	3	6. Lesions, cuts healing slow.....	0	1	2	3		
7. Wake up at night craving sweet.....	0	1	2	3	7. Overweight.....	0	1	2	3		
8. Feel tired or weak if you miss a meal.....	0	1	2	3	8. Feeling pick up from exercise.....	0	1	2	3		
9. Heart palpitation after eating sweets.....	0	1	2	3	9. Failing eyesight.....	0	1	2	3		
10. Need to drink coffee to get started.....	0	1	2	3	10. Crave sweets, but eating them						
11. Impatient, moody, nervous.....	0	1	2	3	does not end the craving.....	0	1	2	3		
12. Feeling tired 1-3 hrs. after eating.....	0	1	2	3	11. Family history of diabetes.....	0	1	2	3		
13. Poor memory.....	0	1	2	3	12. Sugar in urine.....	No		Yes			
14. Faint feeling.....	0	1	2	3							
15. Poor concentration.....	0	1	2	3							

Part VII				8. Rattling mucous when you breath.....				0	1	2	3				
1. Chest pain.....	0	1	2	3	9. Sensitive to smog.....							0	1	2	3
2. Chronic cough.....	0	1	2	3	10. Infections settle in lungs.....							0	1	2	3
3. Difficulty breathing.....	0	1	2	3	11. Live or work around people										
4. Coughing up blood.....	0	1	2	3	who smoke.....							0	1	2	3
5. Coughing up phlegm.....	0	1	2	3	12. Bronchitis.....							No		Yes	
6. Pain around ribs.....	0	1	2	3	13. Exposed to chemicals/radiation.....							No		Yes	
7. Shortness of breath.....	0	1	2	3	14. Smoke.....							No		Yes	

Part VIII				12. Back of leg pain associated with dripping								
1. Frequent urination.....	0	1	2	3	after urination.....				0	1	2	3
2. Frequent bladder infections.....	0	1	2	3	13. History kidney/bladder infection.....				No		Yes	
3. Rarely need to urinate.....	0	1	2	3	14. Have used antibiotics to control urinary							
4. Urination when you cough or sneeze.....	0	1	2	3	Tract infections.....				No		Yes	
5. Painful/burning urination.....	0	1	2	3	If Yes, when did you last use them? _____							
6. Difficulty passing urine.....	0	1	2	3	For how long? _____ days							
7. Dripping after urination.....	0	1	2	3	15. Back pain in kidney area.....				0	1	2	3
8. Can't hold urine.....	0	1	2	3	16. Water retention.....				0	1	2	3
9. Rose colored urine (blood).....	0	1	2	3								
10. Cloudy urine.....	0	1	2	3								
11. Strong smelling urine.....	0	1	2	3								

Part IX (FOR MALES ONLY)					2. Low sex drive..... 0 1 2 3				
Section A					3. Premature ejaculation..... 0 1 2 3				
1. Difficulty urinating..... 0 1 2 3					4. pain/coldness in genital area..... 0 1 2 3				
2. A sense of bladder fullness..... 0 1 2 3					5. Infertile.....No Yes				
3. Increase straining with smaller and Smaller amounts of urine..... 0 1 2 3					6. Varicose veins in scrotum.....No Yes				
4. Rose colored urine (blood)..... 0 1 2 3					7. Low sperm count.....No Yes				
5. Pain or burning while urinating..... 0 1 2 3					Section C				
6. Wake up to urinate at night..... 0 1 2 3					1. Discharge from penis..... 0 1 2 3				
7. Dripping after urination..... 0 1 2 3					2. Past or present rash on penis..... 0 1 2 3				
8. Pain or fatigue in the legs or back..... 0 1 2 3					3. Swollen genitals..... 0 1 2 3				
9. Lack of sex drive..... 0 1 2 3					4. Swollen in groin..... 0 1 2 3				
10. Ejaculation causes pain..... 0 1 2 3					5. Venereal disease.....No Yes				
Section B					Have had V.D. _____ Do You Have V.D. Now _____				
1. Difficulty attaining and maintaining An erection..... 0 1 2 3									

Part X (FOR FEMALES ONLY)					Section C (continued)				
Section A (If experienced during menstruation)					13. Light blood flow during period.....0 1 2 3				
1. Monthly weight gain..... 0 1 2 3					14. Pain and cramps without blood flow... 0 1 2 3				
2. Depression 0 1 2 3					15. Heavy menstrual bleeding.....0 1 2 3				
3. Moodiness/irritability..... 0 1 2 3					16. Anxiety about menstrual cycle.....0 1 2 3				
4. Bloating and swelling..... 0 1 2 3					17. Pain during period.....0 1 2 3				
5. Nausea and/or vomiting..... 0 1 2 3					Section D				
6. Suicidal feeling..... No Yes					1. Vaginal bumps and sores 0 1 2 3				
7. Anxiety..... 0 1 2 3					2. Pubic area sore.....0 1 2 3				
8. Leg cramps and tenderness..... 0 1 2 3					3. Ovarian cysts.....No Yes				
9. Asthma attack..... No Yes					4. Uterine cysts.....No Yes				
10. Headaches..... 0 1 2 3					5. Pain in ovaries.....0 1 2 3				
11. Easily distracted..... 0 1 2 3					6. Breast lumps.....No Yes				
12. Anger..... 0 1 2 3					7. Breast soreness.....0 1 2 3				
13. Tender Breasts..... 0 1 2 3					8. Breast painful.....0 1 2 3				
14. Low backache..... 0 1 2 3					9. Water retention.....0 1 2 3				
15. Other _____					10. Swollen feet.....0 1 2 3				
Section B					11. Premenstrual breast pain.....0 1 2 3				
1. Vaginal itching 0 1 2 3					12. Mother used hormones (pregnant).....No Yes				
2. Vaginal discharge.....0 1 2 3					13. Recent pap smear positive.....No Yes				
3. Low/No desire for sex.....0 1 2 3					14. Family history breast cancer.....No Yes				
4. Dislike for intercourse.....0 1 2 3					15. Form of birth control: _____None_____Pill_____IUD _____Sponge_____Daphram_____Foam_____Other				
5. Missed periods..... No Yes					Section E				
6. Over 15 yrs. of age w/no menstrual..... No Yes					1. Hot flashes..... 0 1 2 3				
7. Unable to get pregnant..... No Yes					2. Night sweats.....0 1 2 3				
8. Miscarriage..... No Yes How many _____					3. Hysterectomy..... No Yes				
9. Abortion..... No Yes How many _____					4. Depression/Mood swings.....0 1 2 3				
Section C (If experienced during menstruation)					5. Insomnia.....0 1 2 3				
1. Low abdominal pain 0 1 2 3					6. Craving sweets.....0 1 2 3				
2. dull ache in low back of legs.....0 1 2 3					7. Heavy bleeding (2 wks-month).....0 1 2 3				
3. Frequent urination.....0 1 2 3					8. Sweating throughout the day.....0 1 2 3				
4. Pelvic soreness.....0 1 2 3					9. Dryness of skin, hair, vagina..... 0 1 2 3				
5. Diarrhea.....0 1 2 3					10. Painful intercourse.....0 1 2 3				
6. Headaches.....0 1 2 3					11. Vaginal pain.....0 1 2 3				
7. Abdominal pain.....0 1 2 3					12. Vaginal itching.....0 1 2 3				
8. Menstrual pain.....0 1 2 3					13. Osteoporosis (Bone Loss).....No Yes				
9. Nausea or vomiting 0 1 2 3									
10. Have to lie down during period									
11. Craving sweets 0 1 2 3									
12. Insomnia.....0 1 2 3									

Part XI		4. Pain in arms/hands.....	0	1	2	3			
Section A		5. Leg cramps at night.....	0	1	2	3			
1. Pain in fingers.....	0	1	2	3	6. Stiff all over.....	0	1	2	3
2. Bones sore/painful.....	0	1	2	3	7. Stiff in the morning.....	0	1	2	3
3. Eat meat.....	0	1	2	3	8. Unable to sit straight.....	0	1	2	3
4. Cavities.....	0	1	2	3	9. Pain in neck and/or shoulders.....	0	1	2	3
5. Arthritis.....	0	1	2	3	10. Back pain.....	0	1	2	3
6. Drink carbonated soda.....	No	Yes							
7. Gum disease.....	No	Yes							
8. Bone loss.....	No	Yes							
9. Calcium deposits.....	No	Yes							
10. Use antacids.....	No	Yes							
11. Dentures.....	No	Yes							
12. Bone deformity.....	No	Yes							
13. Told you have osteoporosis.....	No	Yes							
14. Recent bone fracture.....	No	Yes							
15. Post menopausal.....	No	Yes							
Section B		Section C							
1. Muscle spasms.....	0	1	2	3	1. Over flexible joints.....	0	1	2	3
2. Tightness in shoulder muscles.....	0	1	2	3	2. Back pain.....	0	1	2	3
3. Muscle cramps.....	0	1	2	3	3. Swollen knees/elbows.....	0	1	2	3
		4. Athletic injury.....	0	1	2	3			
		5. Bursitis.....	0	1	2	3			
		6. Tendinitis.....	0	1	2	3			
		7. Joint pain.....	0	1	2	3			
		8. Slipped disc.....	No	Yes					
		9. Herniated disc.....	No	Yes					
		10. Loss in height.....	No	Yes					
		11. Injure easily.....	No	Yes					

Part XII		10. Loss of grip strength.....	0	1	2	3			
1. Head feels heavy.....	0	1	2	3	11. Tingling pain sensation.....	0	1	2	3
2. Lightheadedness/fainting.....	0	1	2	3	12. Convulsions.....	0	1	2	3
3. Loss of balance.....	0	1	2	3	13. Lack of coordination.....	0	1	2	3
4. Dizziness.....	0	1	2	3	14. Nervousness.....	0	1	2	3
5. Ringing/buzzing in ear.....	0	1	2	3	15. Accident prone.....	0	1	2	3
6. Trembling hands.....	0	1	2	3	16. Loss of muscle tone.....	0	1	2	3
7. Loss of feeling in hands/feet.....	0	1	2	3	17. Need for 10-12 hours sleep.....	0	1	2	3
8. Exhaustion on slightest effort.....	0	1	2	3	18. Have had shingles.....	0	1	2	3
9. Limbs feel heavy to hold up.....	0	1	2	3					

Part XIII		5. Restless, uneasy sleeper.....	0	1	2	3	
1. Nightmares.....	0	1	2	3	6. Awake frequently throughout the night....	No	Yes
2. Can't fall asleep.....	0	1	2	3	7. Wake up in the middle of the night and		
3. Intense dreams.....	0	1	2	3	Can't fall back to sleep	No	Yes
4. leg cramps/restless leg.....	0	1	2	3	8. Sleep walk.....	No	Yes

Do you have any other symptoms that have not been covered in this questionnaire? _____

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Registered Naturopath
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drcarl@naturopath@gmail.com

Client Nutritional Information

1. Name: _____ Date _____

2. Address _____ City/State _____

Zip _____ Phone _____ Email _____

3. Sex _____ D.O.B. ____/____/____ Height _____ Weight _____ Blood Type _____

4. Occupation _____

5. Diagnosis _____

Other conditions _____

6. Medications _____

7. Physician _____ Phone _____

8. Do you have any allergies _____

9. Have you ever had or been diagnosed with any of the following (Please check all that apply):

<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Spine/Back Problems
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Menopause
<input type="checkbox"/>	Cold/Flu	<input type="checkbox"/>	Edema	<input type="checkbox"/>	PMS
<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Blood Pressure	<input type="checkbox"/>	Menstrual Cramps
<input type="checkbox"/>	Nervous condition	<input type="checkbox"/>	Circulation	<input type="checkbox"/>	Heavy Menstruation
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	Ovaries
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Breast
<input type="checkbox"/>	Phobias	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Urinary Infection
<input type="checkbox"/>	Ulcers/H.Pylori	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Vaginitis
<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	Sinus Infection	<input type="checkbox"/>	Yeast Infection
<input type="checkbox"/>	Gas/Bloating	<input type="checkbox"/>	Skin Rashes	<input type="checkbox"/>	Heart Condition
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Acne/Boils	<input type="checkbox"/>	Liver
<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Gallbladder
<input type="checkbox"/>	Parasites	<input type="checkbox"/>	Throat problems	<input type="checkbox"/>	Kidney
<input type="checkbox"/>	Memory Problems	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	Spleen

	Alzheimer's		Ears		Bladder
	Epilepsy		Bad Breath		Pancreas
	Fainting		Cancer		Lungs
	Impotence		Cysts/Tumors		Prostate

10. How much water do you drink? _____

11. Do you eat dairy products? _____ Yes _____ No

If YES, how much _____

12. Do you get tired after eating? _____ Yes _____ No

13. When you miss a meal do you get light headed or shake? _____ Yes _____ No

14. Do you wake up in the middle of the night in a sweat or craving food

_____ Yes _____ No

15. Are allergic to any foods? _____ Yes _____ No

If Yes, what foods _____

16. Do you exercise? _____ Yes _____ No

If Yes, what kind of exercise do you do and how often _____

17. Are under a lot of stress? _____ Yes _____ No

If Yes, what do you do to relieve the stress _____

18. How many meals do you eat a day? _____

19. How many bowel movements do you have in a day? _____

20. Do you observe your stools? _____ Yes _____ No

21. If you observe your stools, what is the consistency of your stools:

_____ Hard and dry

_____ Firm and moist

_____ Thin and paste-like

_____ Loose like pudding

_____ Watery/Diarrhea

_____ Well formed but breaks up upon flushing

22. Is your energy level: _____ Poor _____ Fair _____ Good _____ Very Good

23. Is your sex drive: _____ Poor _____ Fair _____ Good _____ Very Good

24. Is your appetite: _____ Poor _____ Fair _____ Good _____ Very Good

25. Is your mood: _____ Poor _____ Fair _____ Good _____ Very Good

26. Is your sleep pattern: _____ Poor _____ Fair _____ Good _____ Very Good

27. Have you been diagnosed as having: _____ Atherosclerosis

_____ Arteriosclerosis

_____ Angina

28. What were your cholesterol and triglyceride measures on your last blood test?

_____ Cholesterol

_____ HDL

_____ LDL

_____ Triglycerides

29. Have you taken any antibiotics in the past five years? _____ Yes _____ No

30. Have you taken any steroids in the past five years? _____ Yes _____ No

31. Do you now or have you ever taken estrogen? _____ Yes _____ No

32. Do you have patches of rough or dry skin? _____ Yes _____ No

33. Do you have excess ear wax? _____ Yes _____ No

34. Do you get nosebleeds? _____ Yes _____ No

35. Do you have diminished sense of smell? _____ Yes _____ No

36. Do you have a diminished sense of taste? _____ Yes _____ No

37. Do you heal slowly from cuts, scrapes, or sores? _____ Yes _____ No

38. Do you have white spots on you finger nails? _____ Yes _____No
39. Are your fingernails brittle, cracking, or dry? _____ Yes _____No
40. Does sunlight hurt your eyes? _____ Yes _____No
41. Do you have a problem seeing at night? _____ Yes _____No
42. Do your gums bleeds when you brush your teeth? _____ Yes _____No
43. Is your tongue ever sore for no reason? _____ Yes _____No
44. Are your eyes often dry, red, and gritty? _____ Yes _____No
45. Do you hands ever tingle? _____ Yes _____No
46. Do your feet ever burn? _____ Yes _____No
47. Do you often get leg cramps? _____ Yes _____No
48. Are your hands and feet usually cold? _____ Yes _____No
49. Do you often feel cold when everyone else is warm? _____ Yes _____No
50. What conditions or diseases run in your family? _____

51. How did you learn about our health consultation service _____

I have completed this form regarding any existing physical conditions I may have to the best of my knowledge. I have listed all my known medical and physical limitations, and will keep the Naturopathic consulting service informed of any changes in my health. **I UNDERSTAND THAT THIS SERVICE IS NOT DIAGNOSING ANY ILLNESS, DISEASE, OR ANY OTHER MEDICAL, PHYSICAL, OR MENTAL DISORDER.** I also acknowledge that this information is note designed to take the place of regular medical care. I take full responsibility for carrying our any recommendations and do not hold the Naturopathic Consultant responsible for the results.

Client signature _____ Date _____

Naturopath Signature _____ Date _____