BALANCING BODY CHEMISTRY *HEALTH ASSESSMENT*

Name: _____ Sex: _____ Age: _____ Date: _____

Patient's Health Professional: _____

Part 1 - *Circle any of the following medications you are taking:*

- Antacids
- Antibiotic/Antifungal
- Antidepressants
- Antidiabetic/Insulin
- Aspirin/Tylenol
- Chemotherapy
- Cortisone
- Anti-Inflammatories
- Diuretics
- Heart Medication's
- High Blood Pressure
- Hormones
- Laxatives
- Lithium
- Oral Contraceptives
- Radiation
- Relaxants/Sleeping Pills
- Recreational Drugs Specify: _____
- Thyroid
- Ulcer Medications
- Other: _____

Circle if you eat, drink or use:

- Alcohol
- Candy
- Carbonated Beverages
- Cigarettes
- Coffee
- Distilled Water
- Fluoridated/Chlorinated Water
- Fast Food (Regularly)
- Fried Foods
- Refined (White) Flour Products
- Luncheon Meats
- Margarine
- Refined Sugar
- Milk Products
- Artificial Sweetners
- Non-Herbal Teas
- Chew Tobacco
- Vitamins/Minerals
- Other: _____

Circle if you:

- Diet often
- Salt food without tasting
- Exercise less than 3 times weekly
- Are under excessive stress
- Are exposed to chemicals at work
- Are exposed to cigarette smoke

DIRECTIONS: Please read each description and circle the number which best describes the frequency of your symptoms within the past year. If you do not understand a symptom, put a ? before the symptom's number.

KEY: 0 = Never 1 = Mild (Occurs once a month or less) 2 = Moderate (Occurs several times monthly) 3 = Severe (Aware of it almost constantly)

PART II

IMPORTANT!

Dear Patient, Please list your 5 major health concerns in order of importance.

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

PART III

CATEGORY 1, Section A:

1. Bad breath, halitosis 0 1 2 3
2. Loss of taste for high protein foods (meat, etc).. 0 1 2 3
3. Burning ("acid") or nervous stomach, relieved by eating..... 0 1 2 3
4. Gas shortly after eating 0 1 2 3
5. Indigestion 1/2-1 hour after eating, may last 3-4 hours..... 0 1 2 3
6. Difficulty digesting fruits and/or vegetables; undigested foods found in stools 0 1 2 3
7. Acid or spicy foods upset stomach..... 0 1 2 3

Section B:

8. Lower bowel gas and/or bloating several hours after eating 0 1 2 3
9. Feel burn 0 1 2 3
10. "Whites" of eyes (sclera) are yellow 0 1 2 3
11. Dry skin, itchy feet and/or skin peels on feet 0 1 2 3
12. Brown spots or bronzing of skin 0 1 2 3
13. Bitter metallic taste in mouth 0 1 2 3
14. Blurred vision 0 1 2 3
15. Headache over eyes 0 1 2 3
16. Feel nauseous, queasy or gag easily 0 1 2 3
17. Color of stools light brown or yellow 0 1 2 3
18. Greasy or high fat foods cause distress 0 1 2 3
19. Pain between shoulder blades 0 1 2 3
20. Dark circles under eyes 0 1 2 3
21. "Acid" breath 0 1 2 3
22. History of gallbladder attacks or gallstones

Section B continued:

23. Appetite reduced 0 1 2 3

Section C:

24. Coated tongue or "fuzzy" debris on tongue 0 1 2 3
25. Pass large amounts of foul smelling gas 0 1 2 3
26. Irritable bowel or mucous colitis 0 1 2 3
27. Constipation, diarrhea alternating or stools alternate from soft to watery 0 1 2 3
28. Bowel movements painful or difficult, constipation, and/or laxatives used 0 1 2 3
29. Burning and/or itching anus 0 1 2 3

CATEGORY II:

30. Head congestion/"sinus fullness" 0 1 2 3
31. Sneezing attacks 0 1 2 3
32. Dreaming, nightmare-like bad dreams 0 1 2 3
33. Milk products and/or wheat products cause distress 0 1 2 3
34. Eyes and/or nose watery 0 1 2 3
35. Eyes swollen and puffy 0 1 2 3
36. Pulse speeds after meals and/or pounds after retiring 0 1 2 3

CATEGORY III, Section A:

37. Crave sweets or coffee in afternoon or mid morning 0 1 2 3
38. Hungry between meals or excessive appetite 0 1 2 3
39. Overeating sweets upsets 0 1 2 3
40. Eat when nervous 0 1 2 3
41. Irritable before meals 0 1 2 3
42. Get "Shaky" or light-headed if meals delay 0 1 2 3
43. Fatigue, eating relieves 0 1 2 3
44. Heart palpitates if meals missed or delayed 0 1 2 3
45. Awaken a few hours after sleep, hard to get back to sleep 0 1 2 3

Section B:

46. Muscle soreness after moderate exercise 0 1 2 3
47. Vulnerability to insect bites (especially fleas and mosquitoes)..... 0 1 2 3
48. Loss of muscle tone or "heaviness" in arms or legs 0 1 2 3
49. Enlarged heart and/or heart failure 0 1 2 3
58. Weight gain around hips and/or waist 0 1 2 3
59. Tendency to ulcers or colitis 0 1 2 3
60. Increased ability to eat sugar without symptoms..0 1 2 3
61. Menstrual disorders (women) 0 1 2 3
62. Lack of menstruation (young girls) 0 1 2 3

Section C:

63. Difficulty gaining weight, even if large appetite ... 0 1 2 3
64. Heart palpitations 0 1 2 3
65. Nervous, emotional, and/or can't work under pressure 0 1 2 3
66. Insomnia 0 1 2 3
67. Inward trembling 0 1 2 3
68. Night sweats 0 1 2 3
69. Fast pulse at rest 0 1 2 3
70. Intolerant to high temperatures 0 1 2 3
71. Easily flushed 0 1 2 3

Section D:

72. Difficulty losing weight 0 1 2 3
73. Reduced initiative and/or mental sluggishness 0 1 2 3
74. Easily fatigued, sleepy during the day 0 1 2 3
75. Sensitive to cold, poor circulation (cold hands and feet) 0 1 2 3
76. Dry or scaly skin 0 1 2 3
77. "Ringing" in ears/noises in head 0 1 2 3
78. Hearing impaired 0 1 2 3
79. Constipation 0 1 2 3
80. Excessive falling hair and/or coarse hair 0 1 2 3
81. Headaches when awaken/wear off during day 0 1 2 3

Section E:

82. Blood pressure increased 0 1 2 3
83. Headaches 0 1 2 3
84. Hot flashes 0 1 2 3
85. Hair growth on face or body (females only) 0 1 2 3
86. Masculine tendencies (females only) 0 1 2 3

Section F:

87. Blood pressure low 0 1 2 3
88. Crave salt 0 1 2 3
89. Chronic fatigue/get drowsy 0 1 2 3
90. Afternoon yawning 0 1 2 3
91. Weakness/dizziness 0 1 2 3

CATEGORY V, Section A:

103. Frequent skin rashes and/or hives 0 1 2 3
104. Muscle-leg-toe cramping at rest and/or while sleeping 0 1 2 3
105. Fever easily raised/fevers common 0 1 2 3
106. Crave chocolate 0 1 2 3
107. Feet have bad odor 0 1 2 3
108. Hoarseness frequent 0 1 2 3
109. Difficulty swallowing 0 1 2 3
110. Joint stiffness after rising 0 1 2 3
111. Vomiting frequent 0 1 2 3
112. Tendency to anemia 0 1 2 3
113. "Whites" of eyes (sclera) blue 0 1 2 3
114. "Lump" in throat 0 1 2 3
115. Dry mouth-eyes-nose 0 1 2 3
116. White spots on fingernails 0 1 2 3
117. Cuts heal slowly and/or scar easily 0 1 2 3
118. Reduced or "lost" sense of taste and/or smell 0 1 2 3
119. Susceptible to colds, fevers and/or infections 0 1 2 3
120. Strong light irritates eyes 0 1 2 3
121. Noises in head or ringing in ears 0 1 2 3
122. Burning sensations in mouth 0 1 2 3
123. Numbness in hands and feet (extremities "go to sleep") 0 1 2 3
124. Intolerant to monosodium glutamate (MSG) 0 1 2 3
125.Cannot recall dreams 0 1 2 3
126. Nose bleeds frequent 0 1 2 3
127. Bruise easily "black & blue" spots 0 1 2 3
128. Muscle cramps, worse with exercise ("charley horses") 0 1 2 3

CATEGORY VI

129. Aware of heavy and/or irregular breathing 0 1 2 3
130. Discomfort in high altitudes 0 1 2 3
131. "Air hunger"/sigh frequently 0 1 2 3
132. Swollen ankles/worse at night 0 1 2 3
133. Shortness of breath with exertion 0 1 2 3
134. Dull pain in chest and/or pain radiating into left arm, worse on exertion 0 1 2 3

CATEGORY VII

Females Only

135. Premenstrual tension 0 1 2 3
136. Painful menses (cramping, etc.) 0 1 2 3

CATEGORY VIII

Males only

147. Prostate trouble 0 1 2 3
148. Urination difficult or dribbling 0 1 2 3
149. Night urination frequent 0 1 2 3
150. Pain on inside of legs or heels 0 1 2 3
151. Feeling of incomplete bowel evacuation 0 1 2 3
152. Leg nervousness at night 0 1 2 3
153. Tire easily/avoid activity 0 1 2 3
154. Reduced sex drive 0 1 2 3
155. Depression 0 1 2 3
156. Migrating aches and pains 0 1 2 3

CHECK ALL THAT APPLY:

Yes	Problem
___	Acne
___	Alcoholism
___	Allergies
___	Anemia - Other
___	Anemia - Sickle Cell
___	Appendicitis
___	Arthritis - Degenerative
___	Arthritis - Osteoarthritis
___	Asthma
___	Back strain
___	Bladder infection - Cystitis
___	Bronchitis - Chronic
___	Cancer - Breast
___	Cancer - Cervix
___	Cancer - Colon
___	Cancer - Lung
___	Cancer - Other
___	Cancer - Prostate
___	Cancer - Skin
___	Cancer - Uterus
___	Cirrhosis, Liver
___	Colitis, Spastic or Ulcerative
___	Concussion
___	Congenital Defect
___	Depression
___	Diabetes
___	Diabetes, Uncontrolled
___	Emphysema
___	Endometriosis
___	Epilepsy
___	Fibrocystic Breasts
___	Gonorrhea
___	Gout
___	Hay fever
___	Hearing loss - Left ear
___	Hearing loss - right ear
___	Hemorrhoids
___	Hepatitis
___	Herpes (Fever blisters, shingles, genital)
	Hiatal hernia

Name: _____

Date: _____

Yes	Problem
___	Acne
___	Nervous stomach
___	Obesity - more than 20 lbs
___	Ovarian Cyst
___	Pelvic infection
___	Peptic ulcer - gastric, duodenal
___	Phlebitis
___	Pneumonia
___	Polyps in colon
___	Prostate infection
___	Regional lieitis
___	Rheumatic fever
___	Rheumatoid arthritis
___	Serious injury with permanent damage
___	Sinus trouble, chronic
___	Stroke
___	Suicide attempt
___	Syphilis
___	Tension headaches
___	Thyroid - overactive, underactive
___	Tuberculosis
___	Vaginitis, Chronic
	***Other Problem not listed: _____
	_____

HEART

Yes	Problem
___	Coronary disease
___	Enlarged heart
___	Heart Rhythm problem
___	Heart murmur
___	Heart valve problem
___	Other heart problem (list)
___	Rheumatic heart disease
___	Calf pain when walking, relieved by rest
___	Varicose veins
___	Easy bleeding/bruising

URINARY

Yes	Problem
	Trouble getting urine started

Name: _____

Date: _____

DIGESTIVE (In the past year have you had. . .)

Yes	Problem
___	Frequent nausea or vomiting?
___	Vomiting blood?
___	Vomiting "coffee grounds" material?
___	Difficulty swallowing?
___	Hot burning fluid in throat or chest?
___	Black tarry stools?
___	Frequent diarrhea or watery stools?
___	Frequent constipation?
___	Unexplained rectal bleeding?
___	Frequent or severe heartburn or indigestion?
___	Frequent or severe abdominal pain?
___	Weight loss/gain?

HEAD

Yes	Problem
___	Frequent or severe headaches
___	Balance problems
___	Dizziness, light headedness
___	Fainting/blackout spells
___	Seizures or convulsions
___	TMJ problems
___	Head injury - Describe: _____
	_____

EYES, EARS, NOSE, THROAT, SKIN

Yes	Problem
___	Frequent sore throat
___	Sore tongue
___	Sore gums
___	Swollen glands in neck
___	Eye pain
___	Watery, itchy eyes
___	Dry eyes
___	Dark circles under eyes
___	Red, sore eyelids
___	Double vision
___	Halos around lights
___	Blurring vision
___	Cataract or cataract surgery
___	Loss of vision
___	Glaucoma
	Date of last eye exam:

___	Crying spells?
___	Considered suicide?
___	Sleeping difficulties?
___	Excessive nervousness?
___	Still tired after full night's sleep?
___	Difficulty relaxing?
___	Psychological/Psychiatric Counseling?

DENTAL

Yes	Problem
___	Do you have silver fillings? Year: _____
___	Had a root canal? Year: _____
___	Gum or teeth infection (Frequent?) _____
___	Currently seeing a dentist?
___	Had your amalgams removed? Year: _____
	Did this improve your health or make you worse? _____
	Explain: _____

WOMEN

Yes	Problem
___	Date of last period: _____
___	Age of onset of period: _____
___	Been pregnant? _____
	# of live births? _____
	# of miscarriages? _____
___	Take birth control pills
___	Had hard lumps or cysts in breasts
___	Routine annual breast exams
	Date of last mammogram: _____
	Date of last exam: _____
	Date of last Pelvic exam: _____
___	Irregular periods
___	Excessive pain, bleeding with periods
___	Bleeding/Spotting between periods
___	Age at time of menopause: _____
___	Vaginal bleeding after menopause
___	Persistent vaginal itching or dryness
___	Treatment for vaginal itching/discharge
___	Problem with sexual dysfunction
___	Endometriosis
___	Hormone replacement therapy
___	Ovarian cysts
	Sexually transmitted diseases

MEDICATIONS (Do you take medications frequently? Name/Dosage)

Yes	Problem
___	Allergy shots
___	Antacid
___	Antibiotic
___	Antidepressant
___	Antihistamine
___	Anti-inflammatory medications
___	Anti-viral
___	Arthritis medicine
___	Asthma medicine
___	Barbiturates
___	Beta blockers
___	Birth control pill
___	Blood pressure
___	Blood thinners
___	Blood vessel dilator
___	Bone medication
___	Calcium channel blockers
___	Chemotherapy
___	Cholesterol medications
___	Coronary heart medicine
___	Cortisone steroid
___	Cough medicine
___	Diabetic pills
___	Diet pills
___	Digitalis
___	Diuretic
___	Epilepsy or seizure medicine
___	Estrogen hormone
___	Headache medicine
___	Heart rhythm medicine
___	Hepatitis medicine
___	Herpes medication
___	Inhaler
___	Insulin
___	Iron
___	Laxatives
___	Muscle relaxants
___	Nasal sprays
___	Natural hormones
___	Nerve medicine
___	Nitroglycerine

Name: _____

Date: _____

___	Tranquilizer
___	Vitamins & herbal supplements

FAMILY MEDICAL HISTORY (check items that apply to your blood relatives)

Do not know my family medical history: _____

Illness:	Relationship:
Alcoholism	_____
Anemia	_____
Bleeding trait	_____
Cancer	_____
Diabetes	_____
Epilepsy	_____
Heart disease	_____
High blood pressure	_____
Hyperlipidemia	_____
Mental illness	_____
Obesity	_____
Peptic ulcer	_____
Polycystic kidney	_____
Rheumatoid arthritis	_____
Stroke	_____
Suicide	_____
Thyroid overactive	_____
Thyroid underactive	_____
Tuberculosis	_____
Ulcerative colitis	_____
Other:	_____

OPERATIONS

Yes

___ Have you had any operations? If yes, print year and circle organs:

Year		Year	
___	Appendix	___	Hysterectomy
___	Back	___	Joint
___	Bone	___	Kidney
___	Brain	___	Lung
___	Breast	___	Neck
___	Colon	___	Nose
___	C-Section	___	Ovary
___	Cystoscopy	___	
	D and C		Spleen

HOSPITALIZATIONS

Yes

___ Have you had any?

Year	Reason	Doctor
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____

CHILDREN ONLY

The following questions pertain specifically to children. This information will help to ascertain an overall picture of the child's medical problems.

Yes Does the child have?

___ Chronic ear aches/infections
___ Chronic red, itchy eyes
___ Chronic runny nose
___ Chronic sneezing spells
___ Chronic Tonsillitis/Tonsillectomy
___ Crying spells without reason
___ Difficulty learning simple tasks
___ Disciplinary problems
___ Drainage from eyes or ears
___ Episodes of hyperactivity
___ Few friends
___ Finicky/picky eating habits
___ Night sweats
___ Periods of fatigue/lethargy
___ Problems gaining weight
___ Problems in school
___ Problems reading
___ Problems with bedwetting
___ Problems with being shy/timid
___ Problems with bowel or urine incontinence
___ Problems with frequent diarrhea or constipation
___ Problems with sluggishness in the morning
___ Problems writing
___ Recurrent episodes of areas of patchy, dry, scaly skin
___ Sleeping problems or nightmares

Name: _____

Date: _____

HEALTH PROVIDER INFORMATION

Yes 1. Primary Care Provider

_____

2. OBGYN

_____

Yes 3. Are you being treated by an Alternative Medicine health provider?

_____

_____

Yes 4. What type of service are you receiving? (Massages, Herbs, Homeopathic, etc?)

_____

_____

_____

_____

Yes 5. Are you under treatment at this time?

_____

Yes 6. Describe treatment and results: _____

_____

_____

_____

_____

Yes 7. Other health care specialists: _____

_____