DEATAILED HEALTH AND WELLNESS SURVEY

Patient Name _____ Age_____ DOB_____ Date _____
Calcium Cuff _____ pH _____ Zinc Test_____ Candida ST_____ Iodine _____
BP Laying _____ BP Standing_____ Ragland's_____ Pulse _____ O2_____
Weight _____Height_____ Frame_____ Resistance _____ Reactance_____ Body Fat%_____ PA_____

Posture Neuro Scan:

Nutritional Exam:

HEADACHES	Base of Skull/Temples/Crown of Head/TMJ/Sinus/Migraine
EARS	Noise (Ring/Hiss/Pound) Plug/Pop/Itch/Hearing Loss/Dizzy
EYES	Tear/Ache/Red/Dry/Film/Itch/Blurry Vision/Floaters/Spots/Puffy/Twitch/Circles
SINUS	Dry/Draining/Plugged/Postnasal Drip/ Smell Loss/Taste Loss/Excessive Thirst/ (white/yellow/green/gray/brown/blood/clear) Sneezing
THROAT	Sore Throat/Cough (Dry/Productive)/Allergies/Fever/Chills/Bad Breath/Blisters/Flu/Halitosis/ Upper Respiratory
MOUTH	Canker Sores/Fever Blisters/Cold Sores/Bleeding Gums/Painful Gums/ Cracking Corners of Mouth
TONGUE	Thick/White Coated/Dark Veins Underside of Tongue
NECK STIFFNESS	Shoulder Tension/Dry Mouth/Cold or Sweaty Hands-Feet/ Swollen Glands/Difficulty Swallowing (Dysphagia)
CHEST	Tension/Tightness/Heavy Chest/Anxiety/Chest Congestion/Sternum Pain or Pressure
HEART	Sharp Pain/Mitral-Valve Prolapse/Mitral-Valve Regurgitation/Tachycardia/Heart Murmur/Arm Pain
BREATHING	Short of Breath/On Exertion?/Asthma/Wheezing/Air Hunger or Frequent Sighing/Yawning
HEARTBURN	Indigestion/Stomach Aches/Cramps/Nausea/Queasy/Bloating/Belching/Gas/Ulcer/Hiatal Hernia
FECAL CONSISTENCY	Soft/Ribbons/Mucous/Normal/Hard Pebbles/Dry/Painful/Diarrhea/Constipation
BOWELS	Regular/Incomplete Evacuation/Sluggish/Move Every _____Days/Cramps/Laxative Use/Enema's/Colonics
HEMORRHOIDS	History/Current = (swollen/burn/blood/distended/itch/sting/ache/cramp)
NAILS	Fungus/Spots/Lines/Weak/Rigid
BLADDER	Nocturnal/Times you go per night _____/Weak Stream/ Frequency/Urgent/Burn/ Pain/Odor/Spasm/Leak/Urinary Tract Infection
SLEEP	Difficulty Falling Asleep/Interrupted Sleep (_____times per night) /Insomnia/Sleep Cravings/ Jolts/Dreams/Nightmares/Night Sweats/Restlessness/ _____hrs. interrupted per night spent awake
MOOD	Anxiety/Sad/Grief/Moodiness/Irritability/Worrisome/Nervous/Frustrated/Panic/Cry/Fears/ Morbid Fears/Shame/Guilt/Stress
APPETITE	0-10/Low/High/Sweet Cravings/Salt Cravings
BEVERAGES CONSUMED	Coffee/Tea/Beer/Wine/Alcohol/Soda/ Ice Cream/Chocolate
SEXUALITY	0-10_____Desire 0-10_____Org Flat/Low/Normal
ENERGY	0-10/Low/Variable/Up/Slow to Start (improving/worse) Exercise: Yes/No _____times per week
MALE ONLY: Prostate	History/Current (burn/ache/pain/restrict/dribble/emission/swell)/Impotent
FEMALE ONLY: Vaginal	Burn/Itch/Dry/Blood/Discharge: Clear/White/Yellow/Green/Brown/Odor
FEMALE ONLY: Menses	Regular/Irregular (Early/Late/Skip)/Birth Control Pill/Last Menstrual Period _____ Flow: Heavy/Moderate/Light/Long/Brief/Spotting/Clots Cramps: Mild/Moderate/Severe/Back Cramps / Acne PMS: Mood Swing/Irritable/Depression/Tired Bloating/Fluid Retention in: Face/Hands/Feet/Body Breast: Tenderness Pre/Mid/Post Menstrual Cycle Menopause: Natural/Hysterectomy - Complete/Partial Hormones: Patch/Hot flashes Ovulation: Pains/Cysts/Discharge/Regular/Irregular/Breast Feeding/Fibrosis/Lump/Breast Reduction