



Health Assessment Form

Patient Information		Visit Information	
Name:		Date:	
Address:		Visit Number:	
City/State/Zip Code:		Current Weight:	
Phone Number:		Current Height:	
Email Address:			
Date of Birth:	Age:		
Patient Vitals		Office Information	
Blood Pressure:		Taking any Medications? Yes or No	
Pulse:		If yes, please list them:	
Temperature:		1.	
Lab Work to be Ordered:		2.	
		3.	
		4.	
		5.	
		6.	

Section One		Section Three	
1. Bad breath, halitosis	Y or N	30. Head congestion / sinus fullness	Y or N
2. Loss of taste for high protein foods (meat, etc	Y or N	31. Sneezing attacks	Y or N
3. Burning ("acid") or nervous stomach, eating relieves	Y or N	32. Dreaming, nightmare-like bad dreams	Y or N
4. Gas shortly after eating	Y or N	33. Eyes or nose watery	Y or N
5. Indigestion ½ to 1 hour after eating, may last 3-4 hours	Y or N	34. Eyes swollen or puffy	Y or N
6. Difficulty digesting fruits or vegetables; undigested food found in stool	Y or N	35. Milk products and / or wheat products cause distress	Y or N
7. Acid or spicy foods upset stomach	Y or N	36. Pulse and / or heart speeds after meals	Y or N
Section Two		Section Four	
8. Lower bowel gas and or bloating several hours after eating	Y or N	37. Awaken a few hours after sleep, hard to get to get back to sleep	Y or N
9. Feet burn	Y or N	38. Crave sweets or coffee in afternoon	Y or N
10. "Whites" of eyes (sclera) yellow	Y or N	39. Overeating sweets upsets	Y or N
11. Dry skin, itchy feet and/or skin peels on feet	Y or N	40. Eat when nervous	Y or N
12. Brown spots or bronzing of skin	Y or N	41. Irritable before meals	Y or N
13. Bitter metallic taste in mouth	Y or N	42. Get "shaky" or light-headed if meals late	Y or N
14. Blurred vision	Y or N	43. Fatigue, eating relieves	Y or N
15. Headache over the eyes	Y or N	44. Heart palpitates if meals missed or late	Y or N
16. Feel nauseous, queasy or gag easily	Y or N	45. Hungry between meals/excessive appetite	Y or N
17. Color of stools light brown or yellow	Y or N	46. Muscle soreness after moderate exercise	Y or N
18. Greasy or high fat foods cause distress	Y or N	47. Loss of muscle tone or "heaviness" felt	Y or N
19. Pain between shoulder blades	Y or N	48. Enlarged heart and / or heart failure	Y or N
20. Dark circles under eyes	Y or N	49. Worrier, feel insecure and / or emotional	Y or N
21. "Acid" breath	Y or N	50. Pulse slow/below 65 or irregular pulse	Y or N
22. History of gallbladder attacks or gallstones OR gallbladder removed	Y or N	51. Vulnerability to insect bites (especially fleas and mosquitoes)	Y or N
23. Appetite reduced	Y or N	52. Blood pressure low	Y or N
24. Coated tongue or "fuzzy" debris on tongue	Y or N	52. Crave salt	Y or N
25. Pass large amounts of foul smelling gas	Y or N	53. Chronic fatigue/get drowsy	Y or N
26. Irritable bowel or mucous colitis	Y or N	54. Afternoon yawning	Y or N
27. Constipation, diarrhea alternating or stool alternates from soft to watery	Y or N	55. Subject to colds, asthma, bronchitis (respiratory disorders)	Y or N
28. Bowel movements painful or difficult, constipation, and / or laxatives used	Y or N	56. Difficulty maintaining a manipulative correction	Y or N
29. Burning or itching anus	Y or N	57. Weakness/dizziness	

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Section Four Continued:		Section Nine (Female Only)	
58. Weakness after colds/slow recovery	Y or N	103. Premenstrual tension	Y or N
59. Circulation is poor	Y or N	104. Painful menses (cramping etc.)	Y or N
60. Muscular and nervous exhaustion	Y or N	105. Menstruation excessive or prolonged	Y or N
61. Allergies and / or hives	Y or N	106. Painful / tender breasts	Y or N
62. Arthritic tendencies	Y or N	107. Menstruate too frequently	Y or N
63. Nails weak, ridged	Y or N	108. Acne, worse at menses	Y or N
64. Perspire easily	Y or N	109. Depressed feelings before menstruation	Y or N
65. Slow starter in the morning	Y or N	110. Vaginal discharge	Y or N
66. Afternoon headaches	Y or N	111. Menses scanty or missed	Y or N
Section Five		112. Hysterectomy / ovaries removed	Y or N
67. Sex drive increased	Y or N	113. Menopausal hot flashes	Y or N
68.. "Splitting" type headache	Y or N	114. Depression	Y or N
70. Tolerance to sugar reduced	Y or N	Section Ten (Men Only)	
71. Sex drive reduced or absent	Y or N	115. Prostate trouble	Y or N
72. Abnormal thirst	Y or N	116. Urination difficult or dribbling	Y or N
73. Weight gain around hips or waist	Y or N	117. Night urination frequent	Y or N
74. Tendency to ulcers or colitis	Y or N	118. Pain on inside of legs or heels	Y or N
75. Increased ability to eat sugar without symptoms	Y or N	119. Feeling of incomplete bowel evacuation	Y or N
76. Menstrual disorders (women)	Y or N	120. Leg nervousness at night	Y or N
77. Lack of menstruation (young girls)	Y or N	121. Tire easily / avoid activity	Y or N
Section Six		122. Reduced sex drive	Y or N
78. Difficulty gaining weight, even if large appetite	Y or N	123. Depression	Y or N
79. Heart palpitations	Y or N	124. Migrating aches and pains	Y or N
80. Nervous, emotional and / or can't work under pressure	Y or N		
81. Insomnia	Y or N		
82. Inward Trembling	Y or N		
83. Night Sweats	Y or N		
84. Fast pulse at rest	Y or N		
85. Intolerant to high temperatures	Y or N		
86. Easily flushed	Y or N		
Section Seven			
87. Difficulty losing weight	Y or N		
88. Reduced initiative and / or mental sluggishness	Y or N		
89. Easily fatigued, sleepy during the day	Y or N		
90. Sensitive to cold, poor circulation (cold hands & feet)	Y or N		
91. Dry or scaly skin	Y or N		
92. "Ringing" in ears/noises in head	Y or N		
93. Hearing impaired	Y or N		
94. Constipation	Y or N		
95. Excessive hair falling out and / or coarse hair	Y or N		
96. Headaches when awoken / wear off during day	Y or N		
Section Eight			
97. Blood pressure increased	Y or N		
98. Headaches	Y or N		
99. Hot flashes	Y or N		
100. Hair growth on face or body (Question for Females)	Y or N		
101. Masculine tendencies (Question to Females)	Y or N		
102. "Air hunger" and / or Sigh frequently	Y or N		