## Patient Intake Form

Welcome to our office! Thank you for taking a moment to fill in our Patient Intake Form. Please fill this form out completely and to the best of your knowledge. Let our staff know if you have any questions. Once completed please return completed forms to our office with the Authorization Agreement box checked and paper work signed.

## Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

SSN#: _____ Birthday: _____ Height: _____ Weight: _____

Sex: F ◯ M ◯ Married/Civil Union: Married ◯ Single ◯ Spouse Name: _____

Home #: _____ Work #: _____ Cell #: _____ Preferred Contact #: _____

E-mail: _____ Who were you Referred by: _____

Address: _____

City: _____ State: _____ Zip: _____

## Employer Information

Employed: Full Time ◯ Part-time ◯ Home-maker ◯ Unemployed ◯ Retired ◯

Employer Name: _____

Employer Address: _____

Employer City: _____ Employer State: _____ Employer Zip: _____

Occupation: _____ Work Supervisor: _____ Supervisor# : _____

Physical Work Duties: _____

## History

List Current Medications: _____

_____

(Name, Amounts, Frequency or attach copy of medication list)

List Current Vitamins, minerals, supplements, or herbs: _____

## History Continued

**Have You Ever:**

**Broken Bones:** ◯ Yes ◯ No **Treatment:** ◯ Yes ◯ No **Explain:**_____

**Sprains/Strains:** ◯ Yes ◯ No **Treatment:** ◯ Yes ◯ No **Explain:**_____

**Hospitalized:** ◯ Yes ◯ No **Explain:**_____

**Surgery:** ◯ Yes ◯ No **Explain:**_____

**Auto Accident:** ◯ Yes ◯ No **Treatment:** ◯ Yes ◯ No **Explain:**_____

**Struck Unconscious:** ◯ Yes ◯ No **Treatment:** ◯ Yes ◯ No **Explain:**_____

**Eating Disorder:** ◯ Yes ◯ No **Explain:**_____

**Stroke:** ◯ Yes ◯ No **Explain:**_____

**Family History:** _____

_____

**Example: Arthritis, Cancer, Diabetes, Heart Disease, Kidney Disease, High Cholesterol, etc.**

## Reason for this Visit

**Describe the reason for this visit:**_____

**Wellness** ◯ **Sports** ◯ **Auto** ◯ **Fall** ◯ **Home Injury** ◯ **Job** ◯ **Chronic Discomfort** ◯ **Other** ◯

**When did this concern begin?** _____

**Has this concern? Gotten Worse** ◯ **Stayed Constant** ◯ **Come and Gone**

**Does this concern interfere with:** ◯ **Work** ◯ **Sleep** ◯ **Daily Routine** ◯ **Other Activities**

**Briefly explain:** _____

**Has this concern occurred before?** ◯ **Yes** ◯ **No Briefly explain:** _____

**Have you seen Other Doctors for this concern?** ◯**Yes** ◯ **No Doctors Name:**_____

**Type of Treatment:** _____

**Results:** ◯ **Good** ◯ **Bad** ◯ **Indifferent**

## Women

Are you pregnant? ◯ Yes ◯ No Are you taking birth control? ◯ Yes ◯ No Do you have irregular cycles? ◯ Yes ◯ No

Are you nursing? ◯ Yes ◯ No Do you have breast implants? ◯ Yes ◯ No Do you experience painful periods? ◯ Yes ◯ No

## Goals for Your care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will tailor your recommended care program based on your needs and desires.

Check the appropriate concerns for care:

◯ Relief Care: Symptomatic relief of pain or discomfort.

◯ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms.

◯ Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic & nutritional counseling.

## Were you aware that...

Doctors of Chiropractic work with the nervous system?

◯ Yes ◯ No

The nervous system controls all bodily functions and systems?

◯ Yes ◯ No

Chiropractic is the largest natural healing profession in the world?

◯ Yes ◯ No

## Authorization

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between insurance companies and me. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Check this circle: ◯ I agree with this statement of authorization.

Name of the insured: _____

Patient Signature:_____ Date:_____


**PATHWAYS TO HEALING**
**1022 Founders Row**
**Greensboro, Georgia 30642**
**(706) 454-2040**
**Fax (706) 454-2050**

__ I hereby request and consent to the performance of chiropractic adjustments or other chiropractic procedures if necessary. I understand that as in all health care there are some slight risks to treatment and do not expect the doctor to be able to anticipate or explain all risks. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts at the time, are in my best interest.

__ Appointments are required. If you are late you may have to wait for the next available appointment or reschedule. Multiple appointments are recommended to minimize waiting and facilitate incorporating these appointments into you daily routine.

__ Keeping your appointment is extremely important. Frequency of visits count. Therefore, it is your obligation to make up missed appointments within 24 hours. We reserve the right to charge for missed appointments if we are not notified within 24 hours of your scheduled appointment time.

__ This is a fee for service office. Payment is expected when services are rendered. We accept cash, checks, Visa, Discover, MasterCard and Debit cards. There will be a $25 fee for returned checks. There is a fee charged for any reports required by any third party members. Patients may not carry a balance at any time.

__I would like to receive email notices from Pathways To healing.

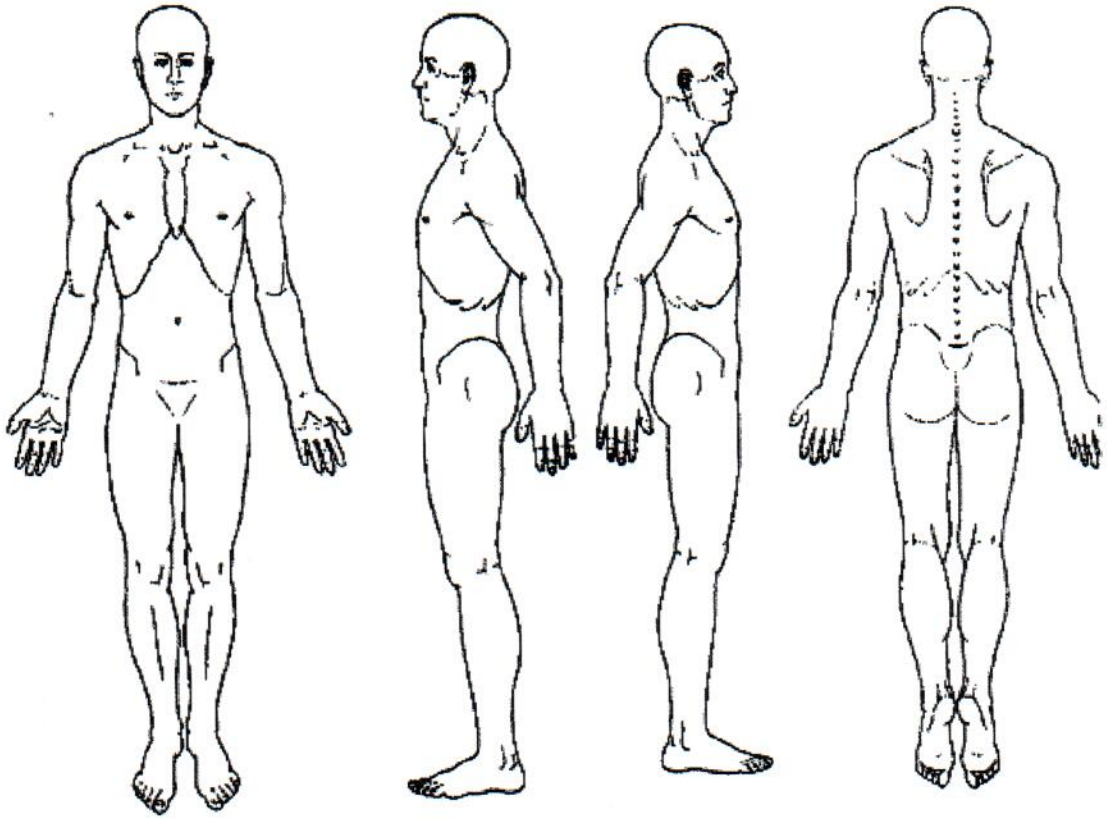
__ All information that is obtained from you by this office is protected and kept confidential in accordance with HIPAA mandated standards. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced. Your signature below acknowledges that you have received a copy of our Notice of Privacy practices.

I have read, understand and agree to all the above.

**Signature**_____**Date**_____

# PATIENT HISTORY

## PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

| | |
|---|---|
| PPP | Where you experience Pain |
| NNN | Where you experience Numbness |
| TTT | Where you experience Tingling |
| BBB | Where you experience Burning |
| CCC | Where you experience Cramping |

PATIENT SIGNATURE _____ DATE _____

# Nutritional Assessment Questionnaire 1.5

Name: _____ Date: ____/____/____

Birth Date: _____ Gender: _____

**Please list your five major health concerns in order of importance:**

_____

_____

_____

_____

_____

**Notes:**

## PART I

Read the following questions and circle the number that applies:

**KEY:** **0 = Do not consume or use** **2 = Consume or use weekly**
**1 = Consume or use 2 to 3 times monthly** **3 = Consume or use daily**

### DIET

58

**1.** 0 1 2 3 Alcohol
**2.** 0 1 2 3 Artificial sweeteners
**3.** 0 1 2 3 Candy, desserts, refined sugar
**4.** 0 1 2 3 Carbonated beverages
**5.** 0 1 2 3 Chewing tobacco
**6.** 0 1 2 3 Cigarettes
**7.** 0 1 2 3 Cigars/pipes
**8.** 0 1 2 3 Caffeinated beverages
**9.** 0 1 2 3 Fast foods
**10.** 0 1 2 3 Fried foods
**11.** 0 1 2 3 Luncheon meats
**12.** 0 1 2 3 Margarine
**13.** 0 1 2 3 Milk products
**14.** 0 1 Radiation exposure (0=no, 1=yes)
**15.** 0 1 2 3 Refined flour/baked goods
**16.** 0 1 2 3 Vitamins and minerals
**17.** 0 1 2 3 Water, distilled
**18.** 0 1 2 3 Water, tap
**19.** 0 1 2 3 Water, well
**20.** 0 1 2 3 Diet often for weight control

### LIFESTYLE

12

**21.** 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
**22.** 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
**23.** 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
**24.** 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

### MEDICATIONS

**Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes):** 54

**25.** 0 1 Antacids
**26.** 0 1 Antianxiety medications
**27.** 0 1 Antibiotics
**28.** 0 1 Anticonvulsants
**29.** 0 1 Antidepressants
**30.** 0 1 Antifungals
**31.** 0 1 Aspirin/Ibuprofen
**32.** 0 1 Asthma inhalers
**33.** 0 1 Beta blockers
**34.** 0 1 Birth control pills/implant contraceptives
**35.** 0 1 Chemotherapy
**36.** 0 1 Cholesterol lowering medications
**37.** 0 1 Cortisone/steroids
**38.** 0 1 Diabetic medications/insulin
**39.** 0 1 Diuretics
**40.** 0 1 Estrogen or progesterone (pharmaceutical, prescription)
**41.** 0 1 Estrogen or progesterone (natural)
**42.** 0 1 Heart medications
**43.** 0 1 High blood pressure medications
**44.** 0 1 Laxatives
**45.** 0 1 Recreational drugs
**46.** 0 1 Relaxants/Sleeping pills
**47.** 0 1 Testosterone (natural or prescription)
**48.** 0 1 Thyroid medication
**49.** 0 1 Acetaminophen (Tylenol)
**50.** 0 1 Ulcer medications
**51.** 0 1 Sildenafil citrate (Viagra)

## PART II (See key at bottom of page)

### Section 1 – Upper Gastrointestinal System

55

**52.** 0 1 2 3 Belching or gas within one hour after eating
**53.** 0 1 2 3 Heartburn or acid reflux
**54.** 0 1 2 3 Bloating within one hour after eating
**55.** 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes)
**56.** 0 1 2 3 Bad breath (halitosis)
**57.** 0 1 2 3 Loss of taste for meat
**58.** 0 1 2 3 Sweat has a strong odor
**59.** 0 1 2 3 Stomach upset by taking vitamins
**60.** 0 1 2 3 Sense of excess fullness after meals
**61.** 0 1 2 3 Feel like skipping breakfast
**62.** 0 1 2 3 Feel better if you don't eat
**63.** 0 1 2 3 Sleepy after meals
**64.** 0 1 2 3 Fingernails chip, peel or break easily
**65.** 0 1 2 3 Anemia unresponsive to iron
**66.** 0 1 2 3 Stomach pains or cramps
**67.** 0 1 2 3 Diarrhea, chronic
**68.** 0 1 2 3 Diarrhea shortly after meals
**69.** 0 1 2 3 Black or tarry colored stools
**70.** 0 1 2 3 Undigested food in stool

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

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## Section 2 – Liver and Gallbladder

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| | | | | | |
|---|---|---|---|---|---|
| **71.** | 0 1 2 3 | Pain between shoulder blades | **85.** | 0 1 | Easily hung over if you were to drink wine (0=no, 1=yes) |
| **72.** | 0 1 2 3 | Stomach upset by greasy foods | **86.** | 0 1 2 3 | Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14) |
| **73.** | 0 1 2 3 | Greasy or shiny stools | **87.** | 0 1 | Recovering alcoholic (0=no, 1=yes) |
| **74.** | 0 1 2 3 | Nausea | **88.** | 0 1 | History of drug or alcohol abuse (0=no, 1=yes) |
| **75.** | 0 1 2 3 | Sea, car, airplane or motion sickness | **89.** | 0 1 | History of hepatitis (0=no, 1=yes) |
| **76.** | 0 1 | History of morning sickness (0 = no, 1 = yes) | **90.** | 0 1 | Long term use of prescription/recreational drugs (0=no, 1=yes) |
| **77.** | 0 1 2 3 | Light or clay colored stools | **91.** | 0 1 2 3 | Sensitive to chemicals (perfume, cleaning agents, etc.) |
| **78.** | 0 1 2 3 | Dry skin, itchy feet or skin peels on feet | **92.** | 0 1 2 3 | Sensitive to tobacco smoke |
| **79.** | 0 1 2 3 | Headache over eyes | **93.** | 0 1 2 3 | Exposure to diesel fumes |
| **80.** | 0 1 2 3 | Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months) | **94.** | 0 1 2 3 | Pain under right side of rib cage |
| **81.** | 0 1 | Gallbladder removed (0=no, 1=yes) | **95.** | 0 1 2 3 | Hemorrhoids or varicose veins |
| **82.** | 0 1 2 3 | Bitter taste in mouth, especially after meals | **96.** | 0 1 2 3 | NutraSweet (aspartame) consumption |
| **83.** | 0 1 | Become sick if you were to drink wine (0=no, 1=yes) | **97.** | 0 1 2 3 | Sensitive to NutraSweet (aspartame) |
| **84.** | 0 1 | Easily intoxicated if you were to drink wine (0=no, 1=yes) | **98.** | 0 1 2 3 | Chronic fatigue or Fibromyalgia |

## Section 3 – Small Intestine

47

| | | | | | |
|---|---|---|---|---|---|
| **99.** | 0 1 2 3 | Food allergies | **108.** | 0 1 2 3 | Crohn's disease (0 =no, 1=yes in the past, 2=currently mild condition, 3=severe) |
| **100.** | 0 1 2 3 | Abdominal bloating 1 to 2 hours after eating | **109.** | 0 1 2 3 | Wheat or grain sensitivity |
| **101.** | 0 1 | Specific foods make you tired or bloated (0=no, 1=yes) | **110.** | 0 1 2 3 | Dairy sensitivity |
| **102.** | 0 1 2 3 | Pulse speeds after eating | **111.** | 0 1 | Are there foods you could not give up (0=no, 1=yes) |
| **103.** | 0 1 2 3 | Airborne allergies | **112.** | 0 1 2 3 | Asthma, sinus infections, stuffy nose |
| **104.** | 0 1 2 3 | Experience hives | **113.** | 0 1 2 3 | Bizarre vivid dreams, nightmares |
| **105.** | 0 1 2 3 | Sinus congestion, "stuffy head" | **114.** | 0 1 2 3 | Use over-the-counter pain medications |
| **106.** | 0 1 2 3 | Crave bread or noodles | **115.** | 0 1 2 3 | Feel spacey or unreal |
| **107.** | 0 1 2 3 | Alternating constipation and diarrhea | | | |

## Section 4 – Large Intestine

58

| | | | | | |
|---|---|---|---|---|---|
| **116.** | 0 1 2 3 | Anus itches | **126.** | 0 1 2 3 | Stools have corners or edges, are flat or ribbon shaped |
| **117.** | 0 1 2 3 | Coated tongue | **127.** | 0 1 2 3 | Stools are not well formed (loose) |
| **118.** | 0 1 2 3 | Feel worse in moldy or musty place | **128.** | 0 1 2 3 | Irritable bowel or mucus colitis |
| **119.** | 0 1 2 3 | Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months) | **129.** | 0 1 2 3 | Blood in stool |
| **120.** | 0 1 2 3 | Fungus or yeast infections | **130.** | 0 1 2 3 | Mucus in stool |
| **121.** | 0 1 2 3 | Ring worm, "jock itch", "athletes foot", nail fungus | **131.** | 0 1 2 3 | Excessive foul smelling lower bowel gas |
| **122.** | 0 1 2 3 | Yeast symptoms increase with sugar, starch or alcohol | **132.** | 0 1 2 3 | Bad breath or strong body odors |
| **123.** | 0 1 2 3 | Stools hard or difficult to pass | **133.** | 0 1 2 3 | Painful to press along outer sides of thighs (Iliotibial Band) |
| **124.** | 0 1 | History of parasites (0=no, 1=yes) | **134.** | 0 1 2 3 | Cramping in lower abdominal region |
| **125.** | 0 1 2 3 | Less than one bowel movement per day | **135.** | 0 1 2 3 | Dark circles under eyes |

## Section 5 – Mineral Needs

75

| | | | | | |
|---|---|---|---|---|---|
| **136.** | 0 1 | History of carpal tunnel syndrome (0=no, 1=yes) | **150.** | 0 1 | History of bone spurs (0=no, 1=yes) |
| **137.** | 0 1 | History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes) | **151.** | 0 1 2 3 | Morning stiffness |
| **138.** | 0 1 | History of stress fracture (0=no, 1=yes) | **152.** | 0 1 2 3 | Nausea with vomiting |
| **139.** | 0 1 2 3 | Bone loss (reduced density on bone scan) | **153.** | 0 1 2 3 | Crave chocolate |
| **140.** | 0 1 | Are you shorter than you used to be? (0=no, 1=yes) | **154.** | 0 1 2 3 | Feet have a strong odor |
| **141.** | 0 1 2 3 | Calf, foot or toe cramps at rest | **155.** | 0 1 2 3 | History of anemia |
| **142.** | 0 1 2 3 | Cold sores, fever blisters or herpes lesions | **156.** | 0 1 2 3 | Whites of eyes (sclera) blue tinted |
| **143.** | 0 1 2 3 | Frequent fevers | **157.** | 0 1 2 3 | Hoarseness |
| **144.** | 0 1 2 3 | Frequent skin rashes and/or hives | **158.** | 0 1 2 3 | Difficulty swallowing |
| **145.** | 0 1 | Herniated disc (0=no, 1=yes) | **159.** | 0 1 2 3 | Lump in throat |
| **146.** | 0 1 2 3 | Excessively flexible joints, "double jointed" | **160.** | 0 1 2 3 | Dry mouth, eyes and/or nose |
| **147.** | 0 1 2 3 | Joints pop or click | **161.** | 0 1 2 3 | Gag easily |
| **148.** | 0 1 2 3 | Pain or swelling in joints | **162.** | 0 1 2 3 | White spots on fingernails |
| **149.** | 0 1 2 3 | Bursitis or tendonitis | **163.** | 0 1 2 3 | Cuts heal slowly and/or scar easily |
| | | | **164.** | 0 1 2 3 | Decreased sense of taste or smell |

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

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## Section 6 – Essential Fatty Acids

22

165. 0 1 Experience pain relief with aspirin (0=no, 1=yes)
166. 0 1 2 3 Crave fatty or greasy foods
167. 0 1 2 3 Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently)
168. 0 1 2 3 Tension headaches at base of skull
169. 0 1 2 3 Headaches when out in the hot sun
170. 0 1 2 3 Sunburn easily or suffer sun poisoning
171. 0 1 2 3 Muscles easily fatigued
172. 0 1 2 3 Dry flaky skin or dandruff

## Section 7 – Sugar Handling

39

173. 0 1 2 3 Awaken a few hours after falling asleep, hard to get back to sleep
174. 0 1 2 3 Crave sweets
175. 0 1 2 3 Binge or uncontrolled eating
176. 0 1 2 3 Excessive appetite
177. 0 1 2 3 Crave coffee or sugar in the afternoon
178. 0 1 2 3 Sleepy in afternoon
179. 0 1 2 3 Fatigue that is relieved by eating
180. 0 1 2 3 Headache if meals are skipped or delayed
181. 0 1 2 3 Irritable before meals
182. 0 1 2 3 Shaky if meals delayed
183. 0 1 2 3 Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4)
184. 0 1 2 3 Frequent thirst
185. 0 1 2 3 Frequent urination

## Section 8 – Vitamin Need

81

186. 0 1 2 3 Muscles become easily fatigued
187. 0 1 2 3 Feel exhausted or sore after moderate exercise
188. 0 1 2 3 Vulnerable to insect bites
189. 0 1 2 3 Loss of muscle tone, heaviness in arms/legs
190. 0 1 2 3 Enlarged heart or congestive heart failure
191. 0 1 2 3 Pulse below 65 per minute (0=no, 1=yes)
192. 0 1 2 3 Ringing in the ears (Tinnitus)
193. 0 1 2 3 Numbness, tingling or itching in hands and feet
194. 0 1 2 3 Depressed
195. 0 1 2 3 Fear of impending doom
196. 0 1 2 3 Worrier, apprehensive, anxious
197. 0 1 2 3 Nervous or agitated
198. 0 1 2 3 Feelings of insecurity
199. 0 1 2 3 Heart races
200. 0 1 2 3 Can hear heart beat on pillow at night
201. 0 1 2 3 Whole body or limb jerk as falling asleep
202. 0 1 2 3 Night sweats
203. 0 1 2 3 Restless leg syndrome
204. 0 1 2 3 Cracks at corner of mouth (Cheilosis)
205. 0 1 2 3 Fragile skin, easily chaffed, as in shaving
206. 0 1 2 3 Polyps or warts
207. 0 1 2 3 MSG sensitivity
208. 0 1 2 3 Wake up without remembering dreams
209. 0 1 2 3 Small bumps on back of arms
210. 0 1 2 3 Strong light at night irritates eyes
211. 0 1 2 3 Nose bleeds and/or tend to bruise easily
212. 0 1 2 3 Bleeding gums especially when brushing teeth

## Section 9 – Adrenal

78

213. 0 1 2 3 Tend to be a "night person"
214. 0 1 2 3 Difficulty falling asleep
215. 0 1 2 3 Slow starter in the morning
216. 0 1 2 3 Tend to be keyed up, trouble calming down
217. 0 1 2 3 Blood pressure above 120/80
218. 0 1 2 3 Headache after exercising
219. 0 1 2 3 Feeling wired or jittery after drinking coffee
220. 0 1 2 3 Clench or grind teeth
221. 0 1 2 3 Calm on the outside, troubled on the inside
222. 0 1 2 3 Chronic low back pain, worse with fatigue
223. 0 1 2 3 Become dizzy when standing up suddenly
224. 0 1 2 3 Difficulty maintaining manipulative correction
225. 0 1 2 3 Pain after manipulative correction
226. 0 1 2 3 Arthritic tendencies
227. 0 1 2 3 Crave salty foods
228. 0 1 2 3 Salt foods before tasting
229. 0 1 2 3 Perspire easily
230. 0 1 2 3 Chronic fatigue, or get drowsy often
231. 0 1 2 3 Afternoon yawning
232. 0 1 2 3 Afternoon headache
233. 0 1 2 3 Asthma, wheezing or difficulty breathing
234. 0 1 2 3 Pain on the medial or inner side of the knee
235. 0 1 2 3 Tendency to sprain ankles or "shin splints"
236. 0 1 2 3 Tendency to need sunglasses
237. 0 1 2 3 Allergies and/or hives
238. 0 1 2 3 Weakness, dizziness

## Section 10 – Pituitary

29

239. 0 1 Height over 6' 6" (0=no, 1=yes)
240. 0 1 Early sexual development (before age 10) (0=no, 1=yes)
241. 0 1 2 3 Increased libido
242. 0 1 2 3 Splitting type headache
243. 0 1 2 3 Memory failing
244. 0 1 Tolerate sugar, feel fine when eating sugar (0=no, 1=yes)
245. 0 1 Height under 4' 10" (0=no, 1=yes)
246. 0 1 2 3 Decreased libido
247. 0 1 2 3 Excessive thirst
248. 0 1 2 3 Weight gain around hips or waist
249. 0 1 2 3 Menstrual disorders
250. 0 1 Delayed sexual development (after age 13) (0=no, 1=yes)
251. 0 1 2 3 Tendency to ulcers or colitis

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

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## Section 11 – Thyroid

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**252.** 0 1 2 3 Sensitive/allergic to iodine
**253.** 0 1 2 3 Difficulty gaining weight, even with large appetite
**254.** 0 1 2 3 Nervous, emotional, can't work under pressure
**255.** 0 1 2 3 Inward trembling
**256.** 0 1 2 3 Flush easily
**257.** 0 1 2 3 Fast pulse at rest
**258.** 0 1 2 3 Intolerance to high temperatures
**259.** 0 1 2 3 Difficulty losing weight
**260.** 0 1 2 3 Mentally sluggish, reduced initiative
**261.** 0 1 2 3 Easily fatigued, sleepy during the day
**262.** 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet)
**263.** 0 1 2 3 Constipation, chronic
**264.** 0 1 2 3 Excessive hair loss and/or coarse hair
**265.** 0 1 2 3 Morning headaches, wear off during the day
**266.** 0 1 2 3 Loss of lateral 1/3 of eyebrow
**267.** 0 1 2 3 Seasonal sadness

## Section 12 – Men Only

27

**268.** 0 1 2 3 Prostate problems
**269.** 0 1 2 3 Difficulty with urination, dribbling
**270.** 0 1 2 3 Difficult to start and stop urine stream
**271.** 0 1 2 3 Pain or burning with urination
**272.** 0 1 2 3 Waking to urinate at night
**273.** 0 1 2 3 Interruption of stream during urination
**274.** 0 1 2 3 Pain on inside of legs or heels
**275.** 0 1 2 3 Feeling of incomplete bowel evacuation
**276.** 0 1 2 3 Decreased sexual function

## Section 13 – Women Only

60

**277.** 0 1 2 3 Depression during periods
**278.** 0 1 2 3 Mood swings associated with periods (PMS)
**279.** 0 1 2 3 Crave chocolate around periods
**280.** 0 1 2 3 Breast tenderness associated with cycle
**281.** 0 1 2 3 Excessive menstrual flow
**282.** 0 1 2 3 Scanty blood flow during periods
**283.** 0 1 2 3 Occasional skipped periods
**284.** 0 1 2 3 Variations in menstrual cycles
**285.** 0 1 2 3 Endometriosis
**286.** 0 1 2 3 Uterine fibroids
**287.** 0 1 2 3 Breast fibroids, benign masses
**288.** 0 1 2 3 Painful intercourse (dysparenia)
**289.** 0 1 2 3 Vaginal discharge
**290.** 0 1 2 3 Vaginal dryness
**291.** 0 1 2 3 Vaginal itchiness
**292.** 0 1 2 3 Gain weight around hips, thighs and buttocks
**293.** 0 1 2 3 Excess facial or body hair
**294.** 0 1 2 3 Hot flashes
**295.** 0 1 2 3 Night sweats (in menopausal females)
**296.** 0 1 2 3 Thinning skin

## Section 14 – Cardiovascular

30

**297.** 0 1 2 3 Aware of heavy and/or irregular breathing
**298.** 0 1 2 3 Discomfort at high altitudes
**299.** 0 1 2 3 "Air hunger" or sigh frequently
**300.** 0 1 2 3 Compelled to open windows in a closed room
**301.** 0 1 2 3 Shortness of breath with moderate exertion
**302.** 0 1 2 3 Ankles swell, especially at end of day
**303.** 0 1 2 3 Cough at night
**304.** 0 1 2 3 Blush or face turns red for no reason
**305.** 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
**306.** 0 1 2 3 Muscle cramps with exertion

## Section 15 – Kidney and Bladder

13

**307.** 0 1 2 3 Pain in mid-back region
**308.** 0 1 2 3 Puffy around the eyes, dark circles under eyes
**309.** 0 1 History of kidney stones (0=no, 1=yes)
**310.** 0 1 2 3 Cloudy, bloody or darkened urine
**311.** 0 1 2 3 Urine has a strong odor

## Section 16 – Immune system

30

**312.** 0 1 2 3 Runny or drippy nose
**313.** 0 1 2 3 Catch colds at the beginning of winter
**314.** 0 1 2 3 Mucus producing cough
**315.** 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
**316.** 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
**317.** 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)
**318.** 0 1 2 3 Acne (adult)
**319.** 0 1 2 3 Itchy skin (Dermatitis)
**320.** 0 1 2 3 Cysts, boils, rashes
**321.** 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

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