

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

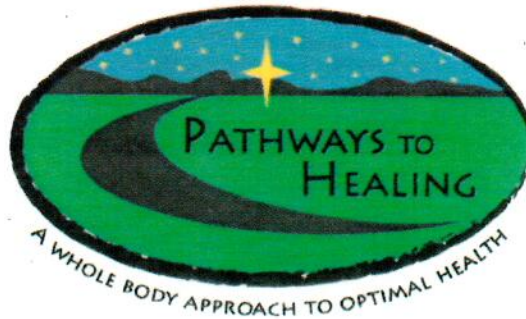
I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.

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 your 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.

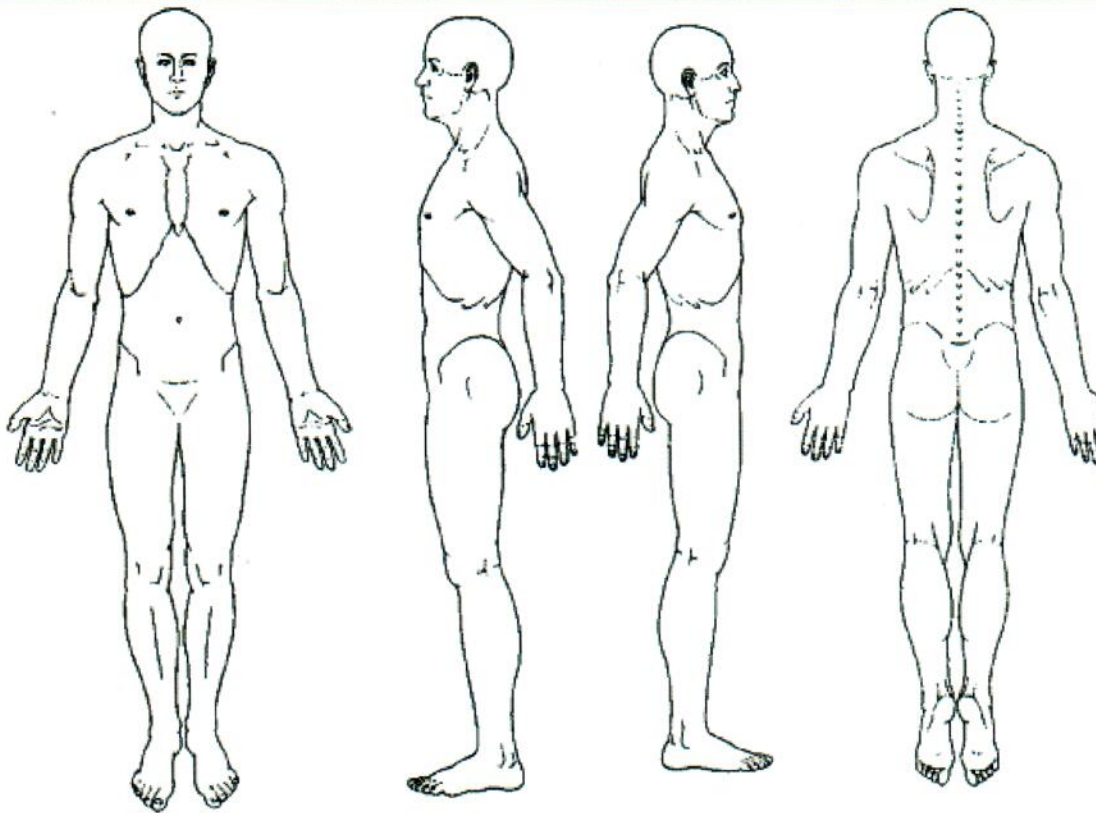
☐ All information that is obtained from you by this office is protected and kept confidential in accordance with HIPAA mandated standards. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced. Your signature below acknowledges that you have received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

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

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

PART II (See key at bottom of page)

Section 1 – Upper Gastrointestinal System

55

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|---|--|
| 52. 0 1 2 3 Belching or gas within one hour after eating | 61. 0 1 2 3 Feel like skipping breakfast |
| 53. 0 1 2 3 Heartburn or acid reflux | 62. 0 1 2 3 Feel better if you don't eat |
| 54. 0 1 2 3 Bloating within one hour after eating | 63. 0 1 2 3 Sleepy after meals |
| 55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes) | 64. 0 1 2 3 Fingernails chip, peel or break easily |
| 56. 0 1 2 3 Bad breath (halitosis) | 65. 0 1 2 3 Anemia unresponsive to iron |
| 57. 0 1 2 3 Loss of taste for meat | 66. 0 1 2 3 Stomach pains or cramps |
| 58. 0 1 2 3 Sweat has a strong odor | 67. 0 1 2 3 Diarrhea, chronic |
| 59. 0 1 2 3 Stomach upset by taking vitamins | 68. 0 1 2 3 Diarrhea shortly after meals |
| 60. 0 1 2 3 Sense of excess fullness 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 2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly) 3=Severe symptom, occurs frequently (daily)

Section 2 – Liver and Gallbladder

68

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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

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|------|---------|--|------|---------|--|
| 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

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|------|---------|---|------|---------|--|
| 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

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|------|---------|--|------|---------|-------------------------------------|
| 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	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

Section 6 – Essential Fatty Acids

22

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

Section 7 – Sugar Handling

39

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

Section 8 – Vitamin Need

81

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

Section 9 – Adrenal

78

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

Section 10 – Pituitary

29

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|------|---------|---|------|---------|---|
| 239. | 0 1 | Height over 6' 6" (0=no, 1=yes) | 245. | 0 1 | Height under 4' 10" (0=no, 1=yes) |
| 240. | 0 1 | Early sexual development (before age 10) (0=no, 1=yes) | 246. | 0 1 2 3 | Decreased libido |
| 241. | 0 1 2 3 | Increased libido | 247. | 0 1 2 3 | Excessive thirst |
| 242. | 0 1 2 3 | Splitting type headache | 248. | 0 1 2 3 | Weight gain around hips or waist |
| 243. | 0 1 2 3 | Memory failing | 249. | 0 1 2 3 | Menstrual disorders |
| 244. | 0 1 | Tolerate sugar, feel fine when eating sugar (0=no, 1=yes) | 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	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

Section 11 – Thyroid

48

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

Section 12 – Men Only

27

268.	0 1 2 3	Prostate problems	272.	0 1 2 3	Waking to urinate at night
269.	0 1 2 3	Difficulty with urination, dribbling	273.	0 1 2 3	Interruption of stream during urination
270.	0 1 2 3	Difficult to start and stop urine stream	274.	0 1 2 3	Pain on inside of legs or heels
271.	0 1 2 3	Pain or burning with urination	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	287.	0 1 2 3	Breast fibroids, benign masses
278.	0 1 2 3	Mood swings associated with periods (PMS)	288.	0 1 2 3	Painful intercourse (dysparenia)
279.	0 1 2 3	Crave chocolate around periods	289.	0 1 2 3	Vaginal discharge
280.	0 1 2 3	Breast tenderness associated with cycle	290.	0 1 2 3	Vaginal dryness
281.	0 1 2 3	Excessive menstrual flow	291.	0 1 2 3	Vaginal itchiness
282.	0 1 2 3	Scanty blood flow during periods	292.	0 1 2 3	Gain weight around hips, thighs and buttocks
283.	0 1 2 3	Occasional skipped periods	293.	0 1 2 3	Excess facial or body hair
284.	0 1 2 3	Variations in menstrual cycles	294.	0 1 2 3	Hot flashes
285.	0 1 2 3	Endometriosis	295.	0 1 2 3	Night sweats (in menopausal females)
286.	0 1 2 3	Uterine fibroids	296.	0 1 2 3	Thinning skin

Section 14 – Cardiovascular

30

297.	0 1 2 3	Aware of heavy and/or irregular breathing	302.	0 1 2 3	Ankles swell, especially at end of day
298.	0 1 2 3	Discomfort at high altitudes	303.	0 1 2 3	Cough at night
299.	0 1 2 3	"Air hunger" or sigh frequently	304.	0 1 2 3	Blush or face turns red for no reason
300.	0 1 2 3	Compelled to open windows in a closed room	305.	0 1 2 3	Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
301.	0 1 2 3	Shortness of breath with moderate 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	310.	0 1 2 3	Cloudy, bloody or darkened urine
308.	0 1 2 3	Puffy around the eyes, dark circles under eyes	311.	0 1 2 3	Urine has a strong odor
309.	0 1	History of kidney stones (0=no, 1=yes)			

Section 16 – Immune system

30

312.	0 1 2 3	Runny or drippy nose	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)
313.	0 1 2 3	Catch colds at the beginning of winter	318.	0 1 2 3	Acne (adult)
314.	0 1 2 3	Mucus producing cough	319.	0 1 2 3	Itchy skin (Dermatitis)
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)	320.	0 1 2 3	Cysts, boils, rashes
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)	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 2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly) 3=Severe symptom, occurs frequently (daily)