

# CENTER FOR NATURAL HEALTH HEALTH INFORMATION FORM

NAME \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
HOME TELEPHONE \_\_\_\_\_  
CELL PHONE \_\_\_\_\_  
DATE OF FIRST APPOINTMENT \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_  
OCCUPATION \_\_\_\_\_  
WORK TELEPHONE \_\_\_\_\_  
PERSONAL MEDICAL DOCTOR \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
E-Mail Address \_\_\_\_\_  
Blood Type \_\_\_\_\_

## PRIMARY GOALS FOR CONSULTATION OR TREATMENT

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

## HOW WERE YOU REFERRED TO US?

\_\_\_\_\_

Are you interested in being on our mailing list for programs & workshops?

\_\_\_\_\_yes \_\_\_\_\_no



# SYMPTOMS SURVEY I

If you have had any of these symptoms within the past year, check the box next to them:

- Coughed up blood or vomited blood.
- Noticed black or bloody stool, brown black or bloody urine.
- Noticed a yellowing in the whites of your eyes.
- Have had a nagging cough, hoarseness, or a sore throat that did not heal within 10 days.
- Have had a breast lump, or unexplained lump or cyst anywhere in the body.
- Have had unexplained thickening anywhere in the body.
- Have experienced marked unexplained weight loss, shortness of breath or any dramatic change in normal body functioning.
- Have had a crushing pain in the center of your chest, that may have been accompanied by pain radiating down the left arm, severe nausea, clammy skin, difficulty breathing or an irregular heartbeat.
- Have had a cut sore or lesion that hasn't healed or an obvious enlargement or change in warts and moles.
- Have experienced unexplained rapid or irregular heartbeats.
- Have experienced unexplained dizziness, blurring or distorted vision, fainting spells or blackouts or prolonged fatigue or exhaustion.
- Have experienced a blow to the head that caused unconsciousness.
- Have had abdominal pain that lasts for 12 hours or more and is very intense for several hours.
- Have had an obvious blockage of the intestinal tract.
- Have swallowed any dangerous, poisonous chemicals, drugs or highly toxic substances.
- Have been in an accident and suffered lacerations, serious abrasions, broken bones, possible whiplash or other injuries known or suspected.
- Have had a great tightness in the chest or great difficulty swallowing.
- Have had an oral temperature over 102 degrees fahrenheit for more than 48 hours.
- Have a hernia.
- Have taken prescription drug, Zelnorm.
- Oversensitivity to drugs, herbs or supplements.

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# SYMPTOMS SURVEY II

If you are presently experiencing any of these symptoms, check the box next to them. This survey provides health history information and considerations for your health and healing program.

## General Notes

- general fatigue or weariness
- shortness of breath with normal activities.
- trembling
- numbness
- dizziness
- lack of endurance
- loss of balance
- loss of memory
- loss of weight
- gain in weight
- loss of appetite
- excessive appetite
- difficulty sleeping
- fever or chills
- fainting
- motion sickness
- other notes: \_\_\_\_\_
- 1 Number of bowel movements per day \_\_\_\_\_
- 1 Number of hours sleep per night \_\_\_\_\_
- 1 Quality of sleep per night \_\_\_\_\_
- 1 Number of times you awaken to urinate \_\_\_\_\_
- 1 How do you feel when you awaken? \_\_\_\_\_
- 1 Do you live in peaceful surroundings? \_\_\_\_\_

## Skin

- Rashes, flaking, itching, burning skin
- lesions, cysts, calluses, lumps
- cold/warm hands or feet
- swelling edema. swollen feet or ankles
- excessive perspiration
- dry or oily skin
- acne, pimples
- cracked or chapped lips
- scalp problems
- hair loss
- cracking or discolored nails
- other notes \_\_\_\_\_

Other symptoms \_\_\_\_\_

## Senses

- wear glasses or contacts
- wear sunglasses
- eyesight worsening
- seeing double
- see halos or lights
- eye pains or itching
- watering eyes or dry eyes
- redness in eyes
- hearing difficulties
- earaches
- noises in ears
- other notes: \_\_\_\_\_

## Respiratory System

- congested nose
- sinus problems
- running nose
- sneezing spells
- head colds
- chest colds
- difficulty breathing deeply
- nosebleeds
- sore throat
- difficulty swallowing
- hoarse voice
- wheezing or gasping
- excessive mucous /phlegm
- frequent coughing
- other notes: \_\_\_\_\_

## Urinary System

- frequent urination
- involuntary escape of urine
- burning or discharge
- weak urine stream
- difficulty starting urine
- constant urge to urinate
- bedwetting

o other notes: \_\_\_\_\_

### Cardiovascular System

- o rapid or skipped heartbeats
- o varicose veins
- o bruise easily
- o chest pains
- o frequently colder than others
- o frequently warmer than others
- o other notes: \_\_\_\_\_

### Neuromusculoskeletal System

- o headaches: frequency \_\_\_\_\_ severity \_\_\_\_\_
- o neck or shoulder pain
- o back or hip pain
- o arm or hand pain
- o leg or foot pain
- o muscle cramping
- o weakness in arms or legs
- o swollen joints
- o joint stiffness
- o other notes \_\_\_\_\_

### Dental System

- o dental problems
- o sore or bleeding gums
- o halitosis or bad breath
- o sore tongue
- o canker sores
- o jaw pain or tension
- o other notes: \_\_\_\_\_

### Men Only

- o burning or discharge on urination
- o lumps or swelling on testicles
- o pain in prostrate or testicles
- o hernias      o impotence
- o other notes: \_\_\_\_\_

### Stress

- o nervousness or anxiety      o
- o difficulty making decisions      o
- o lack of concentration      o
- o sought psychiatric help      o
- o frightening dreams /thoughts      o
- o change of sexual energy      o
- o feeling of desperation      o

### Endocrine System

- o swollen glands
- o swelling in armpits or groin
- o excessive thirst, hunger, urination
- o slow or fast metabolism
- o blood sugar imbalances
- o night sweats
- o hot flashes
- o other notes: \_\_\_\_\_

### Digestive System

- o recurring indigestion, heartburn
- o flatulence or gas
- o nausea, vomiting
- o cramping in abdomen
- o bloated abdomen
- o constipation
- o diarrhea
- o grey or whitish stools
- o pain or itching in rectum
- o excessive appetite /lack of appetite
- o other notes: \_\_\_\_\_

### Women Only

- o bleeding between periods
- o tension or pain before periods
- o vaginal discharge
- o rash, irritation /pain in genital area
- o pain on intercourse
- o swelling or soreness in breasts
- > age menstruation began: \_\_\_\_\_
- > age at menopause: \_\_\_\_\_
- > frequency of periods \_\_\_\_\_
- > amount of bleeding during periods:
  - regular    little    excessive    sporadic
  - \_\_\_\_ number of pregnancies      \_\_\_\_ cesareans
  - \_\_\_\_ miscarriages      \_\_\_\_ abortions
  - \_\_\_\_ premature births
  - \_\_\_\_ number of births

- o nail biting      o
- o loss of memory      o
- o problems at work      o
- o considered suicide      o
- o difficulty relaxing      o
- o sexual difficulties      o
- o frequent crying      o

- o lonely
- o annoyed easily
- o depressed/moody
- o angered easily
- o worry a lot
- o hopeless outlook
- o shy or sensitive

## Assessing Your Exposure Risk~

- Your mother took prescription diethylstilbestrol (DES), the first synthetic estrogen ever marketed, or another synthetic hormone when she was pregnant with you?
- You consume a diet low in animal fats ?
- You consume nonorganic dairy products.
- You have town chlorinated water.
- You use hair coloring or permanent hair dye
- You dry clean some clothes.
- You eat nonorganic, commercially grown foods.
- You eat canned foods and drinks.
- You microwave food in plastic containers or cover foods with plastic cling wrap.
- You use pesticides on your lawn and garden or bombs in your home.
- You use sun screens and insect repellent on your skin.
- Your pets wear flea collars.
- You use regular washing detergent.
- You use air fresheners in your home or car or deodorizers in your bathroom.
- You use solvents or chemicals in your work, home or hobbies or have been exposed to them in the past.
- You use synthetic sweeteners such as nutri-sweet, aspartame, etc. o  
You drink diet soda, regular soda or sport drinks
- Served in the military in Vietnam.
- Had a blood transfusion before 1992.
- You have been exposed to chemicals other than those listed above.  
Explain: \_\_\_\_\_  
\_\_\_\_\_