UPPER CERVICAL Wellness Center
LEARNING HOW TO HEAL

To Our Newest Patient,

Thank you for choosing Upper Cervical Wellness Center. I am excited for you to start your healing journey with us! Enclosed are your application forms. Please note that ALL pages must be returned to the office at least 24 hours prior to your consultation appointment for your case to be considered. If you are unable to complete these forms online, you may also e-mail completed forms to: admin@LearningHowtoHeal.com, fax to (704)-882-1448, or bring them by the office.

Once we receive your application forms we will review the information thoroughly in order to make the best use of your time during consultation, where we'll gather any other details to help determine if our practice is a great fit for you. If we believe we can help you, we will accept your case and be very excited to support your start on a program specifically designed for your healing and wellness! I truly look forward to reviewing your application.

Keep Breathing!

Dr. Corinne Weaver, DC

14015-D E. Independence Blvd. Indian Trail, NC 28079
p: 704-882-1488 f: 704-882-1448 admin@LearningHowtoHeal.com
LearningHowtoHeal.com

MOTIVATIONAL QUESTIONNAIRE

Please answer these questions on a scale on 1 to 10, with 1 being the least likely and 10 being the most likely to make a lifestyle change.

1. Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

   1 2 3 4 5 6 7 8 9 10

2. Do you feel like you are coach-able and would enjoy a mentor in helping you?

   1 2 3 4 5 6 7 8 9 10

3. How important is it for you to resolve your health concerns?

   1 2 3 4 5 6 7 8 9 10

4. How many potential barriers do you for see that would prevent these things from happening?

   1 2 3 4 5 6 7 8 9 10

5. Do you feel it is possible to eliminate or prevent these potential barriers?

   1 2 3 4 5 6 7 8 9 10

Confidential Patient Admittance Form

(PLEASE PRINT AND FILL IN EVERY SPACE)

Name _____ Date _____

Street _____

City _____ State _____ Zip Code _____

Email _____

By documenting your email address on this page you are agreeing that health information for yourself can be freely shared via email between yourself and the Upper Cervical Wellness Center. While usually considered safe, email is not the most secure method of sharing personal information.

Home Phone _____ Work Phone _____ Cell _____

Birthdate _____ Age _____ SS Number _____

Whom may we thank for referring you to us? _____

No. of Children _____ Ages of Children _____ Sex ☐ M ☐ F

Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced Pregnant ☐ Yes ☐ No

Your Employer _____ Occupation _____

Spouse or Guardian Name _____

Spouse or Guardian Employer _____ Occupation _____

Person designated to access protected health information without additional signed authorization

Name _____ Phone _____ Email _____

In case of emergency, whom shall we contact? Same as above ☐

Name _____ Phone _____ Email _____

Is your condition due to an accident? ☐ Yes ☐ No Date of accident _____

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information. Please refer to Upper Cervical Wellness Center's Notice of Privacy for a more complete description of such disclosures.

Patient's Signature _____ Date _____

Guardian's Signature _____ Date _____
(for minors)

LIST YOUR PROBLEMS OR COMPLAINTS ACCORDING TO SEVERITY OF PAIN	DATE & HOW LONG	HAVE YOU HAD THE CONDITION BEFORE	IS THIS AN INJURY?
1.			
2.			
3.			
4.			

HEALTH HISTORY

Name _____ Date _____

List all current health problems:

_____

List any other doctors seen, treatments and results obtained:

_____

Your current physician(s)/therapist(s):

_____

List all surgeries and their dates:

_____

List any medications you are taking:

_____

List any traumas and their dates:

_____

Please check any conditions you have or have had in the past:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Chronic fatigue
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Hypoglycemia
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Tuberculosis
- ☐ Venereal disease

Please check all present symptoms:

CARDIOVASCULAR

- ☐ General swelling
- ☐ Swelling in legs
- ☐ Swelling in face
- ☐ Swelling around eyes
- ☐ Chest pain
- ☐ Pounding heart beat
- ☐ Rapid heart beat
- ☐ Irregular heart beat
- ☐ Blue or purple skin
- ☐ Blue or purple nail beds
- ☐ Cold hands/feet

VERTEBROBASILAR

- ☐ Double vision
- ☐ Loss of coordination
- ☐ Loss of memory
- ☐ Ringing in ears
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Muscle weakness
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Stroke
- ☐ Hypertension

- ☐ Inability to form words
- ☐ Burning sensations
- ☐ Blindness
- ☐ Previous head injury
- ☐ Previous neck injury
- ☐ Taking birth control pills
- ☐ Family history of stroke
- ☐ Blood vessel disease
- ☐ Check if you smoke
- ☐ Fainting
- ☐ Area of numbness

Please check all present symptoms:

MUSCULOSKELETAL SYSTEM

HEAD

- [ ] Frequent headaches
- [ ] Severe headaches
- [ ] Head feels heavy
- [ ] Vertigo
- [ ] Dizziness
- [ ] Light-headedness
- [ ] Loss of taste
- [ ] Loss of smell
- [ ] Loss of hearing
- [ ] Loss of balance

NECK

- [ ] Pain in neck
- [ ] Pain with movement
- [ ] Swelling in neck
- [ ] Stiffness in neck
- [ ] Pinched nerve in neck
- [ ] Neck feels out of place
- [ ] Muscle spasms in neck
- [ ] Grinding sounds in neck
- [ ] Popping sounds in neck
- [ ] Limited neck movement

MID-BACK

- [ ] Mid-back pain
- [ ] Pain between shoulder blades
- [ ] Sharp stabbing pain
- [ ] Dull ache
- [ ] Pain from front to back
- [ ] Pain over kidney area
- [ ] Muscle spasms

LOWER BACK

- [ ] Lower back pain
- [ ] Lower back feels out of place
- [ ] Muscle spasms

SHOULDERS

- [ ] Pain in shoulders
- [ ] Pain across shoulders
- [ ] Muscle spasms
- [ ] Can’t raise arm
- [ ] Above shoulder
- [ ] Above head

ARMS AND HANDS

- [ ] Pain in upper arm
- [ ] Pain in forearm
- [ ] Pain in hands
- [ ] Pain in fingers
- [ ] Pins & needles in arms
- [ ] Pins & needles in fingers
- [ ] Fingers go to sleep
- [ ] Cold hands
- [ ] Swollen fingers
- [ ] Loss of grip strength

HIPS, LEGS AND FEET

- [ ] Pain in buttocks
- [ ] Pain in hip
- [ ] Pain down leg
- [ ] Knee pain
- [ ] Leg cramps
- [ ] Pins & needs in legs
- [ ] Numbness in legs
- [ ] Numbness in toes
- [ ] Cold feet
- [ ] Swollen ankles
- [ ] Swollen feet

HEALTH REVIEW

Please check all present

symptoms: SKIN, HAIR, NAILS

- [ ] Eczema
- [ ] Itchy skin
- [ ] Rough scaly skin
- [ ] Dry skin
- [ ] Oily skin
- [ ] Yellow skin
- [ ] Bruise easily
- [ ] Baldness
- [ ] Paper thin nails
- [ ] Nail biting

EYES

- [ ] Blurred vision
- [ ] Double vision
- [ ] Eye fatigue
- [ ] Excessive tearing
- [ ] Lack of tearing
- [ ] Light bothers eyes
- [ ] Excessive itching
- [ ] Pain in eyeball

EARS

- [ ] Loss of hearing
- [ ] Not sufficient
- [ ] Pain in ear(s)
- [ ] Discharge from ear(s)
- [ ] Vertigo
- [ ] Ringing in the ear(s)

NOSE AND SINUSES

- [ ] Nose bleeds
- [ ] Pressure over eyes
- [ ] Nose obstruction
- [ ] Frequent colds
- [ ] Sinusitis
- [ ] Loss of smell
- [ ] Allergies

RESPIRATORY

- [ ] Shortness of breath
- [ ] Dry cough
- [ ] Coughing up blood
- [ ] Wheezing
- [ ] Productive cough

GASTROINTESTINAL

- [ ] Poor appetite
- [ ] Constant nibbling
- [ ] Difficulty swallowing
- [ ] Indigestion
- [ ] Nausea and vomiting
- [ ] Abdominal pain
- [ ] Change in bowel habits
- [ ] Diarrhea
- [ ] Constipation
- [ ] Hemorrhoids

GENITOURINARY

Urination is:

- [ ] Frequent
- [ ] Not sufficient

The amount is:

- [ ] High
- [ ] Moderate
- [ ] Low
- [ ] Frequent urination at night
- [ ] Intense desire to urinate
- [ ] Difficulty urinating
- [ ] Lack of control
- [ ] Pain with urination
- [ ] Dribbling
- [ ] Bloody urine
- [ ] Cloudy urine

VENEREAL DISEASE

- [ ] Syphilis

WOMEN ONLY

- [ ] Painful periods
- [ ] Spotting
- [ ] Premenstrual symptoms
- [ ] Irregular periods
- [ ] Lumps in breast
- [ ] Vaginal discharge

Number of pregnancies? _____

Number of deliveries? _____

SOCIAL HISTORY

- [ ] Smoking
- [ ] Other tobacco use
- [ ] Alcohol use
- [ ] Drink coffee or tea

DIET IS…

- [ ] Balanced
- [ ] Not balanced

REST IS…

- [ ] Sufficient
- [ ] Not sufficient

RECREATION IS:

- [ ] Sufficient
- [ ] Not sufficient

FAMILY STRESS IS…

- [ ] Severe
- [ ] High
- [ ] Moderate
- [ ] Minimal
- [ ] None

MY JOB STRESS IS…

- [ ] Severe
- [ ] Moderate
- [ ] Minimal
- [ ] None

OTHER

MOUTH AND THROAT

- [ ] Pain in throat
- [ ] Bleeding gums
- [ ] Abscessed teeth
- [ ] Dentures
- [ ] Difficulty swallowing

- [ ] Gonorrhea
- [ ] Other: _____

- [ ] Nervousness
- [ ] Irritability
- [ ] Fatigue
- [ ] Depression
- [ ] Panic attacks
- [ ] Problems sleeping
- [ ] Generally feel run down

Brain Health and Nutrition Assessment Form™ (BHNAF)

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION 1

- Low brain endurance for focus and concentration **0 1 2 3**
- Cold hands and feet **0 1 2 3**
- Must exercise or drink coffee to improve brain function **0 1 2 3**
- Poor nail health **0 1 2 3**
- Fungal growth on toenails **0 1 2 3**
- Must wear socks at night **0 1 2 3**
- Nail beds are white instead of pink **0 1 2 3**
- The tip of the nose is cold **0 1 2 3**

SECTION 2

- Irritable, nervous, shaky, or light-headed between meals **0 1 2 3**
- Feel energized after meals **0 1 2 3**
- Difficulty eating large meals in the morning **0 1 2 3**
- Energy level drops in the afternoon **0 1 2 3**
- Crave sugar and sweets in the afternoon **0 1 2 3**
- Wake up in the middle of the night **0 1 2 3**
- Difficulty concentrating before eating **0 1 2 3**
- Depend on coffee to keep going **0 1 2 3**

SECTION 3

- Fatigue after meals **0 1 2 3**
- Sugar and sweet cravings after meals **0 1 2 3**
- Need for a stimulant, such as coffee, after meals **0 1 2 3**
- Difficulty losing weight **0 1 2 3**
- Increased frequency of urination **0 1 2 3**
- Difficulty falling asleep **0 1 2 3**
- Increased appetite **0 1 2 3**

SECTION 4

- Always have projects and things that need to be done **0 1 2 3**
- Never have time for yourself **0 1 2 3**
- Not getting enough sleep or rest **0 1 2 3**
- Difficulty getting regular exercise **0 1 2 3**
- Feel that you are not accomplishing your life's purpose **0 1 2 3**

SECTION 5

- Dry and unhealthy skin **0 1 2 3**
- Dandruff or a flaky scalp **0 1 2 3**
- Consumption of processed foods that are bagged or boxed **0 1 2 3**
- Consumption of fried foods **0 1 2 3**
- Difficulty consuming raw nuts or seeds **0 1 2 3**
- Difficulty consuming fish (not fried) **0 1 2 3**
- Difficulty consuming olive oil, avocados, flax seed oil, or natural fats **0 1 2 3**

SECTION 6

- Difficulty digesting foods **0 1 2 3**
- Constipation or inconsistent bowel movements **0 1 2 3**
- Increased bloating or gas **0 1 2 3**
- Abdominal distention after meals **0 1 2 3**
- Difficulty digesting protein-rich foods **0 1 2 3**
- Difficulty digesting starch-rich foods **0 1 2 3**
- Difficulty digesting fatty or greasy foods **0 1 2 3**
- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Abnormal gag reflex **Yes or No**

SECTION 7

- Brain fog (unclear thoughts or concentration) **Yes or No**
- Pain and inflammation **Yes or No**
- Noticeable variations in mental speed **Yes or No**
- Brain fatigue after meals **0 1 2 3**
- Brain fatigue after exposure to chemicals, scents, or pollutants **0 1 2 3**
- Brain fatigue when the body is inflamed **0 1 2 3**

SECTION 8

- Grain consumption leads to tiredness **0 1 2 3**
- Grain consumption makes it difficult to focus and concentrate **0 1 2 3**
- Feel better when bread and grains are avoided **0 1 2 3**
- Grain consumption causes the development of any symptoms **0 1 2 3**
- A 100% gluten-free diet **Yes or No**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Brain Health and Nutrition Assessment Form™ (BHNAF)

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION 9

- A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease — **Yes or No**
- Family members who have been diagnosed with an autoimmune disease — **Yes or No**
- Family members who have been diagnosed with celiac disease or gluten sensitivity — **Yes or No**
- Changes in brain function with stress, poor sleep, or immune activation — **0 1 2 3**

SECTION 10

- A loss of pleasure in hobbies and interests — **0 1 2 3**
- Feel overwhelmed with ideas to manage — **0 1 2 3**
- Feelings of inner rage or unprovoked anger — **0 1 2 3**
- Feelings of paranoia — **0 1 2 3**
- Feelings of sadness for no reason — **0 1 2 3**
- A loss of enjoyment in life — **0 1 2 3**
- A lack of artistic appreciation — **Yes or No**
- Feelings of sadness in overcast weather — **0 1 2 3**
- A loss of enthusiasm for favorite activities — **0 1 2 3**
- A loss of enjoyment in favorite foods — **0 1 2 3**
- A loss of enjoyment in friendships and relationships — **0 1 2 3**
- Inability to fall into deep, restful sleep — **0 1 2 3**
- Feelings of dependency on others — **0 1 2 3**
- Feelings of susceptibility to pain — **0 1 2 3**

SECTION 11

- Feelings of worthlessness — **0 1 2 3**
- Feelings of hopelessness — **0 1 2 3**
- Self-destructive thoughts — **0 1 2 3**
- Inability to handle stress — **0 1 2 3**
- Anger and aggression while under stress — **0 1 2 3**
- Feelings of tiredness, even after many hours of sleep — **0 1 2 3**
- A desire to isolate yourself from others — **0 1 2 3**
- An unexplained lack of concern for family and friends — **0 1 2 3**
- An inability to finish tasks — **0 1 2 3**
- Feelings of anger for minor reasons — **0 1 2 3**

SECTION 12

- A decrease in visual memory (shapes and images) — **Yes or No**
- A decrease in verbal memory — **0 1 2 3**
- Occurrence of memory lapses — **0 1 2 3**
- A decrease in creativity — **0 1 2 3**
- A decrease in comprehension — **0 1 2 3**
- Difficulty calculating numbers — **0 1 2 3**
- Difficulty recognizing objects and faces — **0 1 2 3**
- A change in opinion about yourself — **0 1 2 3**
- Slow mental recall — **0 1 2 3**

SECTION 13

- A decrease in mental alertness — **0 1 2 3**
- A decrease in mental speed — **0 1 2 3**
- A decrease in concentration quality — **0 1 2 3**
- Slow cognitive processing — **0 1 2 3**
- Impaired mental performance — **0 1 2 3**
- An increase in the ability to be distracted — **0 1 2 3**
- Need coffee or caffeine sources to improve mental function — **0 1 2 3**

SECTION 14

- Feelings of nervousness or panic for no reason — **0 1 2 3**
- Feelings of dread — **0 1 2 3**
- Feelings of a “knot” in your stomach — **0 1 2 3**
- Feelings of being overwhelmed for no reason — **0 1 2 3**
- Feelings of guilt about everyday decisions — **0 1 2 3**
- A restless mind — **0 1 2 3**
- An inability to turn off the mind when relaxing — **0 1 2 3**
- Disorganized attention — **0 1 2 3**
- Worry over things never thought about before — **0 1 2 3**
- Feelings of inner tension and inner excitability — **0 1 2 3**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating Pain,	0	1	2	3
tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Lowered gastrointestinal motility, constipation	0	1	2	3
Raised gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes		No	

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes		No	

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions: