NATURAL HEALING INTAKE FORM

Health Questionnaire

Please answer the following questions to the best of your ability

Name:	**Date of Birth:**
Phone Number:	**Email:**
Date:	

Thyroid/Parathyroid (Glandular System)

Are you overweight?	Yes	No	Do you have osteoporosis?	Yes	No
Do you get cold hands and feet?	Yes	No	Do you have, or have you ever had, a hernia?	Yes	No
Do you have hair loss or are you bald or going bald?	Yes	No	Do you have scoliosis?	Yes	No
Is it easy to put on weight and hard to lose it?	Yes	No	Do you get irritable easily?	Yes	No
Are your fingernails rigid, brittle or weak?	Yes	No	Do you suffer from symptoms of depression?	Yes	No
Do you have varicose or spider veins?	Yes	No	Do you have or have you ever had a goiter?	Yes	No
Do you, or have you had hemorrhoids?	Yes	No	Did you score low on a bone density test?	Yes	No
Do you get cramping in your muscles?	Yes	No	Do your tests comes back showing low calcium levels?	Yes	No
Is your bladder strong?	Yes	No	Do you have spinal deterioration or herniated discs?	Yes	No
Do you have an irregular heartbeat?	Yes	No	Have you or any family member been diagnosed with Hashimoto or Reidel disease?	Yes	No
Do you have mitral valve prolapse (heart murmur)?	Yes	No	Do you sweat profusely or hardly at all?	Yes	No
Do you get headaches or migraines?	Yes	No			

Adrenal Glands (Glandular System)		
Do you have MS, Parkinson's or palsy?	Yes	No
Do you have anxiety attacks or feel overly anxious?	Yes	No
Do you feel excessive shyness or inferiority?	Yes	No
Do you have low blood pressure (below 118 systolic)?	Yes	No
Do you have tremors, nervous legs, etc.?	Yes	No
Do you have tinnitis (ringing of the ears)?	Yes	No
Do you have shortness of breath or is it hard to take deep breaths?	Yes	No
Do you have heart arrythmias?	Yes	No
Do you have a hard time sleeping?	Yes	No
Do you have Chronic Fatigue Syndrome?	Yes	No
Do you get tired easily?	Yes	No
Have you ever been diagnosed with Addison's Disease or with congenital adrenal hyperlapsia?	Yes	No
Do you have elevated blood cholesterol levels?	Yes	No
Do you have lower back weakness?	Yes	No
Do you have, or have you ever had, sciatica?	Yes	No
Do you have arthritis or bursitis?	Yes	No
Do you have any inflammatory conditions? If yes, please explain:	Yes	No

Pancreas		
Do you get gas after you eat?	Yes	No
Do you have acid reflux?	Yes	No
Do you see any undigested food in your stools?	Yes	No
Do you have hypoglycemia (low blood sugar)?	Yes	No
Do you have diabetes? If yes, type 1 or type 2?	Yes	No
Are you thin and have a hard time putting on weight?	Yes	No
Do you have gastritis or enteritis?	Yes	No
Do you have diarrhea?	Yes	No
Do you have moles?	Yes	No
Do you have "liver" or brown spots on your skin? (not freckles)	Yes	No
Do you have any skin pigmentation changes?	Yes	No
Do you have any skin problems? If so, what type?	Yes	No
Are you anemic?	Yes	No
Do you, or have you ever had, hepatitis? A, B, or C?	Yes	No

Heart and Circulation		
Do you have any gray hair?	Yes	No
Do you have a hard time remembering things?	Yes	No
Do your legs get tired or cramp after walking?	Yes	No
Do you bruise easily?	Yes	No
Do you get chest pain or angina?	Yes	No
Have you ever had a heart attack?	Yes	No
Do you have heart arrhythmias? If yes, what kind?	Yes	No
Do you have a heart murmur?	Yes	No
Do you ever feel pressure on your chest?	Yes	No
Do you get “prickly” pains anywhere, especially in the heart area?	Yes	No
Do you have, or have you ever had high blood pressure?	Yes	No
Your average blood pressure is:		

Liver/Gallbladder/Blood		
Do you have a problem digesting fats?	Yes	No
Do fats or dairy foods cause bloating and/or pain in the stomach area?	Yes	No
Are your stools white or very light brown in color?	Yes	No
Do you get pain behind the right, lower rib area?	Yes	No

Gastrointestinal Tract		
Is your tongue coated (white, yellow, green or brown), especially in the morning	Yes	No
Do you have a hiatal hernia?	Yes	No
Do you have gastritis?	Yes	No
Do you have enteritis?	Yes	No
Do you have colitis?	Yes	No
Do you have diverticulitis?	Yes	No
Do you get or have diarrhea?	Yes	No
How often do you have bowel movements? Are your movements loose or firm?		
Do you have or have you ever had any type of gastrointestinal cancers: stomach, colon, rectal, etc. If yes, explain	Yes	No
Do you have Crohn’s Disease?	Yes	No
Do you have gas problems?	Yes	No
Other GI problems:		

Lymphatic System		
Are you allergic to anything? If yes, what?	Yes	No
Do you ever get cold or flu-like symptoms?	Yes	No
Do you have sinus problems?	Yes	No
Do you have or get sore throats?	Yes	No
Do you have swollen lymph nodes?	Yes	No
Do you have or had tumors? Fatty, benign or cancerous? Where?	Yes	No
Do you have a low platelet count (blood)?	Yes	No
Is your immune system low or sluggish?	Yes	No
Have you had appendicitis or an appendectomy? When?	Yes	No
Do you get boils, pimples, and the like?	Yes	No
Do you have allergies?	Yes	No
Have you ever had abscesses?	Yes	No
Have you ever had toxemia?	Yes	No
Do you have, or have you had, cellulitis?	Yes	No
Have you ever had gout?	Yes	No

Skin		
Do you get or have skin rashes?	Yes	No
Do you get skin blemishes?	Yes	No
Do you have eczema or dermatitis?	Yes	No
Do you have psoriasis?	Yes	No
Do you itch anywhere? If yes, where?	Yes	No
Is your skin dry?	Yes	No
Is your skin excessively oily?	Yes	No
Do you get or have dandruff?	Yes	No

Kidneys and Bladder		
Have you ever had a urinary tract infection?	Yes	No
Have you ever had “burning” upon urination?	Yes	No
Do you have problems holding your bladder (parathyroid)?	Yes	No
Have you ever had kidney stones?	Yes	No
Do you have bags under your eyes (especially in the morning)?	Yes	No
Is your urine flow restricted?	Yes	No
Do you get cramping or pain on the either side of your mid-to-lower back?	Yes	No
Do you or did you ever had nephritis?	Yes	No
Do you or did you ever have cystitis?	Yes	No

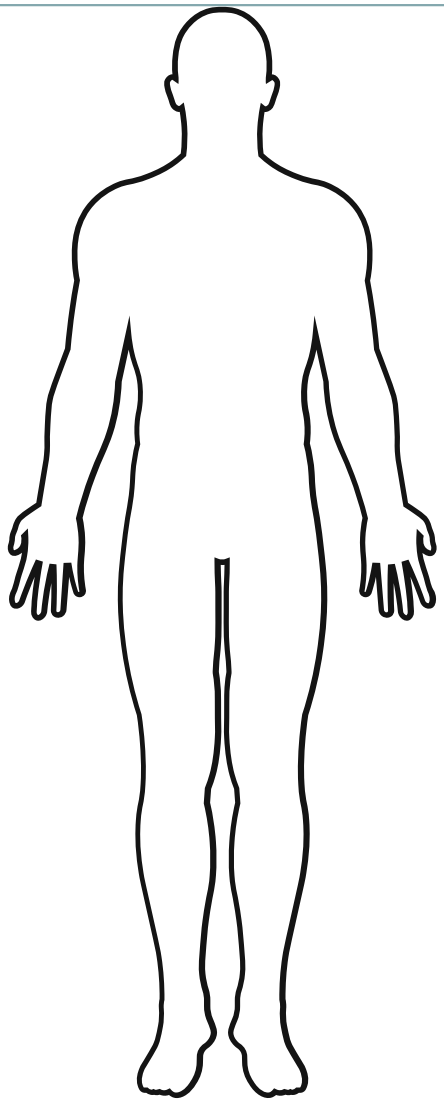
Lungs		
Do you get or have (or have you had) bronchitis?	Yes	No
Do you get or have (or have you had) emphysema?	Yes	No
Do you get or have (or have you had) asthma?	Yes	No
Do you get or have (or have you had) C.O.P.D?	Yes	No
Are you on inhalers or nebulizers? How often? What type?	Yes	No
Do you get pain when you breathe?	Yes	No
Do you get pain when you take deep breaths?	Yes	No
Did you ever or do you have lung cancer?	Yes	No

Do you have a collapsed lung?	Yes	No
Are you a smoker? If yes, how often do you smoke? What do you smoke?	Yes	No
Do you Vape ?		
Have you ever worked around toxic chemicals, in coal mines or around asbestos?	Yes	No
Do you cough a lot?	Yes	No
Do you get any mucus when you cough? If yes, what color is it?	Yes	No
What is your oxygen saturation?		
Do you get pain when you breathe?	Yes	No
Do you get pain when you take deep breaths?	Yes	No
Have you ever had pneumonia?	Yes	No
Do you cough a lot?	Yes	No

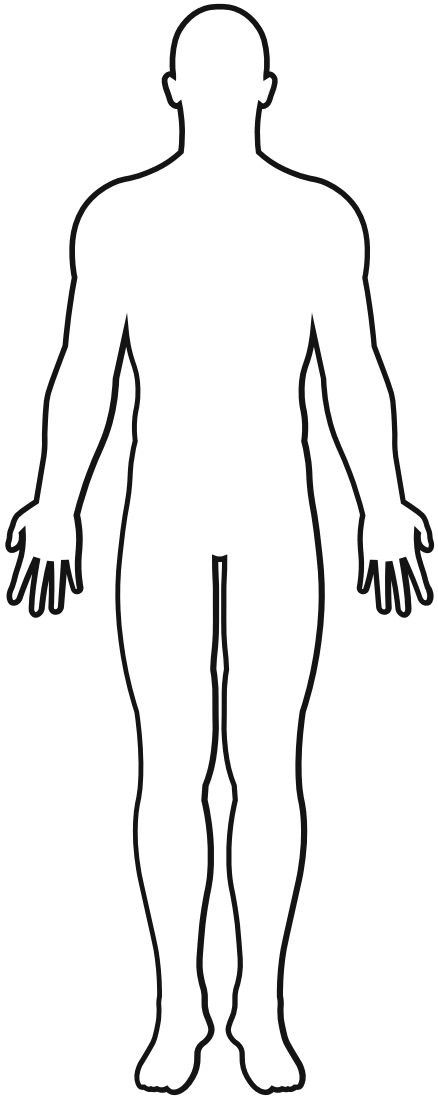
Female Only		
Are your menstruations irregular?	Yes	No
Do you get excessive bleeding during menstruation?	Yes	No
Do you have or have you had ovarian cysts?	Yes	No
Do you have or did you have fibroids?	Yes	No
Do you have or did you have endometriosis or A-typical cells?	Yes	No
Do you have fibromyalgia or scleroderma?	Yes	No
Do you have low or excessive sex drive?	Yes	No
Do you get sore breasts, especially during menstruation?	Yes	No
Have you had a hysterectomy? If yes, partial or complete? When?	Yes	No
Have you had a D and C?	Yes	No
Have you had a miscarriage?	Yes	No
Have you had difficulty conceiving children?	Yes	No
Did you ever use a chemical birth control?	Yes	No
Have ever had an IUD?	Yes	No
How many live births did you have and the dates:		
Did you give brith vaginally ?	Yes	No

Male Only		
Do you have prostatitis (frequent urination, especially at night)?	Yes	No
If yes, how often?		
Do you have prostate cancer? PSA counts.	Yes	No
Do you have testicular hypertrophy (enlargement)?	Yes	No
Do you have low or excessive sex drive?	Yes	No
Do you have erection problems?	Yes	No
Do you have premature ejaculation?	Yes	No
Other:		

Muscular and Skeletal
Use the figures below,
Please circle any areas of concern and using a pain scale of 1-10 rate your pain level in that area.
(1 being next to no pain and 10 being max)



PRONE (BACKSIDE)



SUPINE (FRONTSIDE)

What else can you tell us about these pains ? Any past or recent injuries?

Other

Please list and elaborate on any conditions or symptoms that this questionnaire has not covered or asked you:

Past Surgeries

Surgery:

When:

Chemical Medications

Medication:

Reason:

Natural Supplements

Supplements:

Vitamins and minerals:

Allergies:
Genetic History (major health conditions of family)
Mother:
Father:
(Maternal) Grandfather:
(Maternal) Grandmother:
(Fraternal) Grandfather:
(Fraternal) Grandmother:
Siblings:
Please describe in detail your daily eating habits. If you drink coffee, alcohol, carbonated beverages, energy drinks, green or black tea please include them.