COMPLETE HEALTH ASSESSMENT

SYMPTOMATOLOGY QUESTIONNAIRE

DATE__________________ NAME____

ADDRESS____

POSTAL CODE______________________ DATE OF BIRTH_____________________________

HOME TELEPHONE______________________ MOBILE PHONE______________________

SEX_______ AGE________ HEIGHT_____________WEIGHT_____________

EMAIL ADDRESS____

HOW DID YOU FIND OUT ABOUT
JOANNE BROPHY, Registered Nutritional Consulting Practitioner?

____ Friend/Relative (Name person)____
____ Health Practitioner Referral (name)_______________________________________
____ Newsletter ____ Lecture ____ Health Fair
____ Health Food Store ____ Fiddleheads
____ Flyer/Poster ____ Brochure ____ Business Card
____ Newspaper ____ WEBSITE
____ Other (state where) ____

INSTRUCTIONS

Please complete this Health Assessment Questionnaire. Your answers will help you and our Natural Nutritional Consultants understand the cause of your troubles. It will also help you to pay attention to your body and observe its symptoms so that you can be more "in-tune" with your body.

Record an appropriate number 1, 2, or 3according to the following scale, beside each symptom that you have been experiencing during the past couple of months.
Leave blank if you do not have that symptom. Do not use 0 or check-mark!!

1	2	3
Occasionally	Moderately	Severely

You can write comments beside any of the symptoms.
You can also add symptoms at the bottom of the list.

THIS QUESTIONNAIRE IS CONFIDENTIAL.

EYES

______ Difficulty reading without glasses
______ Difficulty seeing things at a distance
______ Eyesight blacks out
______ See floaters in vision
______ Eyes continually blink or water
______ Blurred vision
______ Pains in eyes
______ Styes in eyes
______ See spots in front of eyes
______ Thinning of eyelashes
______ Itchy eyes
______ Burning eyes
______ Swollen eyelids
______ Crusty eyelids
______ Feeling of "sand" under eyelids
______ Eye strain or fatigue
______ Gluacoma
______

EARS

______ Difficulty hearing
______ Noises in ear
______ Ringing in ears
______ Pounding in ears
______ Ear discharge
______ Wax in ears
______ Vertigo or dizziness
______ Flushed, red earlobes
______ Tenderness around ear area
______ Ear infections
______ Itchy ears
______ Pluggy ears
______ Water in ears
______ Noise sensitivity
______ Cold ears
______ Sore glands under ears
______
______

MOUTH & TONGUE

______ Bleeding gums
______ Cankers in mouth
______ Cold sores on lips
______ Chapped lips
______ Red or whitish lips
______ Cracks in corners of mouth
______ Dry mouth
______ Cracks on edges of tongue
______ Crack down center of tongue

______ Dark circles under eyes
______ Puffiness under eyes
______ Red blood vessels bleed in eyes
______ Yellow in whites of eyes
______ Redness on eyelids
______ Loss of balance
______ Poor night vision
______ Sensitivity to light
______ Eye inflammation
______ Eye twitches
______ Eye strain
______ Dry eyes
______ Watery eyes
______ Dull looking eyes
______ Headaches behind eyes
______ Mucus in eyes unpon waking
______ Styes on eyelids
______ Cataracts

______ Bumps on tongue
______ Painful tongue
______ Inflamed or swollen tongue
______ White coated tongue
______ Yellow coated tongue
______ Cherry red tongue
______ Reddish-blue tongue
______ Black colored tongue
______ Bald spots on tongue
______ Bad taste in mouth
______ Metal taste in mouth
______ Acid taste in mouth
______ Diminished or loss of taste
______ Excessive salivation
______ Itchy roof of mouth
______ White patches anywhere in mouth
______ Rough patches anywhere in mouth
______ Scalped edges on tongue
______
______

TEETH & GUMS

______ Yellow-looking teeth
______ Silver-mercury/black fillings in teeth
______ Gum problems
______ Receding gums
______ Teeth temperature sensitive
______ Dental carries
______ Toothaches
______ Soft teeth
______ Loose teeth
______ Plaque or tartar on teeth
______ Gum disease
______ Ever any teeth infections?

TEETH & GUMS

Are having any gum issues? Describe.
____
____
____
____
____
____

Gum Surgery? Describe.
____
____
____
____
____
____

How many extractions? Describe.
____
____
____
____
____
____

How many cavitations? Describe.
____
____
____
____
____
____
____

HAIR & SCALP

_____ Thinning/falling out of hair
_____ Hair won't grow
_____ Oily hair
_____ Dry hair
_____ Loss of texture of hair
_____ Dandruff
_____ Baldness
_____ Hair splitting on ends
_____ Slow growing hair
_____ Cowlicks or tufts of hair which stand on end
_____ Hair prematurely grey
_____ Itchy scalp
_____ Sores on scalp
_____ Scales on scalp
_____ Dandruff or flaking scalp
_____ Feeling of "crawling" on scalp
_____ Hair loss from the scalp, legs, arms
_____ other
_____
_____

If male, do you have a family of male pattern baldness? ( ) Yes ( ) No

NAILS

_____ Vertical lines in nails
_____ Horizontal lines in nails
_____ White spots on nails
_____ Curved nail ends (spoon shaped)
_____ Darkened nails
_____ Fungus under or around nails
_____ Splitting nails
_____ Nails break easily
_____ Slow growing nails
_____ Hangnails
_____ Cuticles tear easily
_____

FACE, NOSE & HEAD

_____ Stressed looking face
_____ Lack of eyebrow hair
_____ Ingrown hairs
_____ Acne on face
_____ Blackheads on face
_____ Red spots on face
_____ Hives on face
_____ Dark patches of skin on face
_____ Reddened face
_____ Yellowed face
_____ Boils on face or neck
_____ Freckled face
_____ Facial skin sun sensitive
_____ Face reddens when exposed to cold
_____ Tiny red blood vessels on cheeks
_____ Enlarged facial pores
_____ Oily facial skin
_____ Dry facial skin
_____ Oily facial skin in "T" zone
_____ Cholesterol and/or whitehead-like deposits on face
_____ Pale complexion
_____ Green complexion
_____ Grey complexion
_____ Premature aging of facial skin
_____ Stress lines between eyebrows
_____ Loss of hair on eyebrows
_____ Facial wrinkles
_____ Wrinkles around mouth

_____ Headaches
_____ Migraines
_____ Pain in head
_____ Pressure in head
_____ Tender spots on head
_____ Swollen or tender neck glands
_____ Tenderness in front of ears
_____ Tenderness under jawline
_____ Dry, crusty nose
_____ Nosebleeds
_____ Rough or thickening of skin on nose
_____ Tiny red blood vessels on nose
_____ Greasy scaliness on skin near nose, mouth, eyes
_____ other
_____

MUSCLES, BONES & JOINTS

_____ Problems with neck
_____ Tight muscles in neck & shoulders
_____ Problems with upper area of spine
_____ Problems with middle area of spine
_____ Problems with lower area of spine
_____ Low back pain
_____ Poor posture
_____ Rounded shoulders
_____ Growth impairment
_____ Curvature of spine
_____ Finger pain
_____ Wrist pain
_____ Elbow pain
_____ Shoulder pain
_____ Foot pain
_____ Toe pain
_____ Ankle pain
_____ Knee pain
_____ Shin pain
_____ Hip pain
_____ Buttock pain
_____ Bunions on feet
_____ Club foot
_____ Calluses on feet
_____ Calluses on hands
_____ Bone aches
_____ Sore, aching muscles
_____ Weak muscles
_____ Weak legs climbing stairs
_____ Tight or tense muscles
_____ Stiff muscles
_____ Leg cramps after exercising
_____ Atrophied muscles
_____ Muscle inflammation
_____ Muscles cramps/spasms in legs or feet
_____ Muscle cramps/spasms in other parts of body
_____ Loss of strength in muscles
_____ Legs feel tight
_____ Legs feel heavy
_____ Restricted movement of joints
_____ Foot drops
_____ Wrist drops
_____ Sore, aching joints
_____ Sprained joints
_____ Knees crack when bending
_____ Difficulty climbing stairs
_____ Restless legs in bed at night
_____ Hot feet or legs in bed at night
_____ Deep pain in bones and/or joints
_____ Growing pains

_____ Easily injure joints, muscles or tendons
_____ Wrist problems/carpel tunnel
_____ Elbow problems
_____ Bones break easily
_____ Bones thinning
_____ Bone spurs
_____ Bowlegged or knock-kneed
_____ Toes point inward when walking
_____ Poor coordination
_____ Clumbsy
_____ Difficulty walking
_____ TMJ or jaw pain
_____ Cold patches on body
_____ Bursitis
_____ Arthritis
_____ Unable to close hands into tight, fists
_____ Jerking of limbs
_____ Walking problems
_____ Hands shake
_____ Osteoporosis
_____ Arthritis
_____ Gout
_____ Athletic injuries
_____ Vertebrae problems
_____ Eye or Facial muscles twitch
_____ Other muscles twitch

Do you have chronic backache which is unresponsive to conventional medical therapy?_________

Unresponsive to alternative therapy that you have tried? __________

Have you ever had carpel tunnel syndrome? ______________
When? ______________

Do you have a history of slipped or ruptured disks? __________
When? ______________

DIGESTIVE SYSTEM

_____ Poor appetite
_____ Excessive appetite
_____ Overeating
_____ Hungry during night
_____ Weight gain
_____ Weight loss
_____ Food allergies or intolerances
_____ Intolerance to fatty foods
_____ Intolerance to protein-rich foods: meats, milk products
_____ Nausea
_____ Vomiting
_____ Vomiting of blood
_____ Mucus in throat
_____ Indigestion
_____ Heartburn
_____ Nervous stomach
_____ Spastic stomach
_____ Discomfort in "pit" of stomach
_____ Difficulty swallowing
_____ Burping after meals
_____ Burping between meals
_____ Burping during the night
_____ Burping after awakening
_____ Tenderness where rib cage meets
_____ Pain under right rib cage
_____ Pain under left rib cage
_____ Acid burning feeling in stomach
_____ Stomach pain during day time
_____ Stomach pain during night time
_____ Cravings for cold water and/or ice (chewing of ice)
_____ Lack of thirst
_____ Frequent thirst
_____ High blood sugar problems
_____ Low blood sugar problems
_____ Lightheadedness/Dizziness
_____ Hypoglycemic
_____ Liver problems
_____ Gallbladder problems
_____
_____
_____

How often do you use antacids? Daily? ___________ Weekly __________
Have you ever had a gallstone attack? ( ) Yes ( ) No When? ______________________
Have you ever had a stomach or duodenal ulcer? ( ) Yes ( ) No When? _____________
Have you ever had parasites? ____________
When? _______________
Have you ever had food poisoning? _________________________
When? ___________________

Have you ever had an Upper GI x-ray done? ____________________
When? __________________

Has your medical doctor diagnosed you with?
_____ GERD
_____ Acid Reflux
_____ Enteritis
_____ Stomach Ulcers
_____ Gallbladder Disease
_____ Celiac Disease
_____ Prolapsed Stomach
_____ Helio Pylori Bacteria

ELIMINATION SYSTEM

_____ Constipation
_____ Diarrhea
_____ Alternating constipation & diarrhea
_____ Severe, bloody diarrhea
_____ Watery diarrhea
_____ Loose bowel movements
_____ Blood in stools
_____ Abdominal bloating or distention
_____ Hard, ballooned abdomen
_____ Abdominal cramps
_____ Abdominal burning
_____ Abdominal pain left side
_____ Abdominal pain middle area
_____ Abdominal pain right side
_____ Abdominal pain lower area
_____ Rectal gas
_____ Odorous rectal gas
_____ Hemorrhoids
_____ Swollen or bleeding hemorrhoids
_____ Anal itching
_____ Anal itching during night
_____ Anal or rectal burning
_____ Intestinal parasites
_____ Body odor
_____ Foot odor
_____ Stool medium brown color
_____ Stool dark brown color
_____ Stool beige in color
_____ Mucus in stools
_____ Irritable bowel
_____ Undigested food in stools
_____ Greasy, pale or grey stools that float
_____ Narrow, thin stools
_____ Spastic colon
_____ Round or hard stools
_____ Drug laxative use
_____ Herbal laxative use
_____ Colitis
_____ Crohn's disease
_____ other
_____
_____

How often do you have a bowel movement: per day? _________ per week? _______

Do you skip days? _________

Have you ever had parasites? ___________
When? _____________________

Have you ever had a Barium Enema xray done?
____________ When?__________
Have you had a Colonoscopy? _______
When? ________________

Has your doctor ever told you that you have a spastic colon? ___________
When? __________

Do you take laxatives? __________

How often?__________________________
____
____

Which ones? ________________________
____

SKIN,LYMPH & IMMUNE SYSTEM

_____ Sensitive or tender skin
_____ Cuts heal slowly
_____ Burns heal slowly
_____ Odorous sweat
_____ Excessive perspiration
_____ Sweat even in cold weather
_____ Bruise easily
_____ Hives or welts
_____ Pale, transparent skin
_____ Loss of skin elasticity
_____ Itchy body skin
_____ Dry skin in general
_____ Dry patches of skin
_____ Leathery skin
_____ Reddened skin in general
_____ Reddened patches of skin
_____ Raised, brownish lesions on face, back, abdomen or legs
_____ Fungal skin problems
_____ Eczema
_____ Psoriasis
_____ Goose bump like lesions on back of arms
_____ Boils
_____ Feeling of "crawling" on skin
_____ Collagen problems
_____ Cellulite
_____ Acne on body
_____ Scaly skin
_____ Reddened eyelids
_____ Sweaty palms
_____ Rashes on body
_____ Tiny, red spots on skin
_____ Loss of skin pigment
_____ Darkened skin patches or blotches
_____ Whitened skin patches, vitiligo
_____ Little bumps on skin
_____ Skin sensitive to metals - darkens

______ Sunburn easily
______ Rashes from sun exposure
______ Rubbing of eyes
______ Rough skin in general
______ Stretch marks
______ Dermatitis of hands and/or face
______ Skin cracks open, especially winter
______ Skin cracks open from stress
______ Liver spots or brown age spots
______ Calcium spots in tissues
______ Fat deposit in skin
______ Yellowed skin
______ Irritated mole
______ Irritated, or reddened scar
______ Sensitivity to cold
______ Sensitivity to heat
______ Sensitivity to humidity
______ Sensitivity to drafts
______ Sensitivity to weather changes
______ Vulnerability to insect bites: fleas, mosquitoes
______ Rapidly aging skin
______ Tender spots on upper chest above breast area
______ Tender neck glands along jawline
______ Tender armpit glands against ribcage
______ Tender along side of breasts
______ Tender in groin area where legs bend
______ Low resistance to virus infections
______ Low resistance to colds
______ Hives
______ Cracks on bottom of heels
______ Warts
______ Itchy scalp
______ Itchy anus
______ Skin turns bright red

Do you use sun tanning beds? ( ) Yes ( ) No How often? ____________________

How often per year do you get colds?_________________________ Flus?______________

Do you feel that your resistance is too low?____________________

______ Genital Herpes

Would you like to know more how to prevent and reduce the length of a cold?___________

______ Low pain tolerance

NERVOUS SYSTEM

______ Nervousness
______ Jumpy
______ Agitation or irritability
______ Lack of memory or concentration
______ Loss of interest in work or play
______ Clenching of teeth or jaw
______ Daytime grinding of teeth
______ Nightime grinding of teeth
______ Dizziness
______ Faintness
______ Fainting spells
______ Convulsions or epilepsy
______ Physically weakened by stress
______ Numbness in any part of body
______ Tingling in any part of body
______ Twitching of head, face or shoulders
______ Fits, convulsions or seizures
______ Nail biting
______ Muscle tensing
______ Hot or cold spells
______ Hands shake
______ General body shakes or shakiness
______ Snoring while sleeping
______ Sleep apnea
______ Legs vibrate or restless in bed
______ Restlessness in general
______ Restlessness in bed
______ Neuralgia
______ Insomnia
______ Electricity sensitivity
______ Susceptibility to shocks
______ Repeated tapping of fingers on table
______ Repeated shaking of legs
______ Nail biting
______ Jitteriness
______ Spaciness
______ Floating sensation
______ Stuttering or stammering while stressed
______ Sleep talking
______ Sleep walking
______ Bed wetting
______ Tremors
______ Anxiety
______ Negative thought patterns
______ Sudden episodes of loss of brain function, mesmerized

______ Face palsy
______ Hyperactive
______ Attention deficit

_____ Too much stress at work
_____ Too much stress at home
Do you use a computer? (   ) Yes (   ) No
Daily _________ or Weekly _________

Do you use a cellular phone? (   ) Yes (   ) No Daily _________ or Weekly ______
Are you exposed to x-rays on a monthly basis? _________ or daily basis? __________

Do you have inadequate exposure to sun in the winter? ____________

Do you have symptoms due to a lack of sun exposure? __________
Name symptoms
____
____

GENITO-URINARY SYSTEM

(For Women)

_____ Painful menstrual periods
_____ Menstrual cramping
_____ Weakness or sickness with periods
_____ Pass blood clots during period
_____ Back pain with period
_____ Excessive or heavy flow of menses
_____ Tenseness during period
_____ Skip periods
_____ No period at all
_____ Scanty flow
_____ Premenstrual tension or sickness, PMS
_____ Headaches prior to menses
_____ Headaches during menses
_____ Swelling of face, abdomen, extremities during menses
_____ Tender breasts
_____ Swollen breasts
_____ Lumps in breasts
_____ Scaly, greasy lesions on vulva
_____ Hot flushes
_____ Night or day sweats
_____ White vaginal discharge
_____ Yellow vaginal discharge
_____ Vaginal yeast infections
_____ Itchy, irritated vagina
_____ Swellings outside vagina
_____ Uterine fibroids
_____ Ovarian fibroids
_____ Menopausal
_____ Post-menopausal
_____ Cysts in uterus
_____ Cysts in vagina
_____ Abnormal cells of cervix
_____ Hair growing around nipple area
_____ Hair growing around lip area
_____ Mood swings, worse during or before periods
_____ Dryness of vaginal membranes
_____ Presently nursing a baby
_____ Presently having problems nursing
_____
_____
_____

When was the last time you had a pap smear done? ____________________

Have you ever had abnormal cervical cells in your pap smear? ________________

When was the last time you had an internal done by your physician?
____

Have you ever had a miscarriage?
____

Have you ever had an abortion? _________
Have you ever had a sexually transmitted illness? ______________
When? ________________

(For Men)

_____ Painful genitals
_____ Prostate problems
_____ Sores on genitals
_____ Leg pains
_____ Testicle pain
_____ Skin irritation on genitals
_____ Scaly, greasy lesions on scrotum
_____ Reduced sperm count
_____ Impotence (poor erection)
_____ Delayed sexual maturity
_____ Jock itch
_____ Fungal problems
_____ Too much anger
_____ Reduced sex drive
_____ Moody
_____ Mood swings
_____ Some depression

(Both Women & Men)

_____ Painful urination
_____ Burning feeling while urinating
_____ Trouble starting to urinate
_____ Urgency to urinate
_____ Odorous urine
_____ Dark colored urine
_____ Frequent urination
_____ Urination in large volumes
_____ Infrequent urination
_____ Slow urine release
_____ Urinary tract infections
_____ Kidney stones
_____ Get up during night to urinate
_____ Loose bladder control
_____ Blood in urine
_____ Painful intercourse
_____ Diminished sex drive
_____ Genital itching
_____ Intense or frequent thirst
_____ Bedwetting
_____ Greenish tint to urine
_____ Fluid retention all over
_____ Fluid retention in hands or arms
_____ Fluid retention in feet, ankles or legs
_____ Cold sores
_____ Genital Herpes
_____

Have you ever had a kidney stone attack? _____________ When? _____________

When was the last time you had a urinary tract infection? ______________________

RESPIRATORY SYSTEM

_____ Frequent clearing of throat
_____ Sore throats
_____ Choking lump in throat
_____ Throat feels like it is closing - swelling
_____ Hot burning feeling in throat
_____ Sneezing spells
_____ Nose continually blocked
_____ Constantly running nose
_____ Nose bleeds
_____ Dry, crusty nose
_____ Severe colds
_____ Diminished smell
_____ Hay fever
_____ Itchy nose
_____ Nasal congestion
_____ Environmental allergies
_____ Chemical sensitivity
_____ Coughing spells
_____ Dry cough
_____ Loose cough
_____ Cough up blood
_____ Cough up phlegm
_____ Mucus in throat
_____ Throat swelling
_____ Night sweats
_____ Chest tightness or discomfort
_____ Stopping breathing during night
_____ Difficulty breathing
_____ Concave chest
_____ Hoarse voice
_____ Loss of voice
_____ Wheezing
_____ Frequent colds
_____ Respiratory infections
_____ Respiratory inflammations, eg. bronchitis
_____ Sinus problems
_____ Post nasal drip
_____ Sinus headaches
_____ Loss of voice, eg. laryngitis
_____ Sensitive to humid weather, saunas, hot tubs, etc.
_____ Asthma
_____ COPD
_____

Do you smoke? __________________ How much per week? _______________
Are you ready to quit smoking? __________________ Do you need some help? ____________
Are you exposed to passive smoke? ___________________ Home or work? _______________
Do you chew tobacco? ____________ Use snuff? ________________
Do you use marijuana? ____________ Daily? ________ Weekly? ______ Monthly? _______
Are you exposed to any chemicals or exhaust fumes while on the job? __________
Which ones? _______________________________________ __________________

Headaches

_____ Migraines How often? Cause?

____

______ Headache behind eyes
______ Headache elsewhere?______________________________
____

CIRCULATORY-CARDIOVASCULAR & BLOOD SYSTEM

______ High blood pressure
______ Low blood pressure
______ High cholesterol
______ High triglycerides
______ Chest pains or vague pains in chest
______ Heaviness in the chest
______ Heart palpitations
______ Rapid heartbeat

______ Excessively rapid heartbeat with mild exercise
______ Irregular heartbeat
______ Slow heartbeat
______ Difficulty breathing in general
______ Shortness of breath or out of breath easily
______ Pain down left shoulder and arm
______ Varicose veins
______ Broken capillaries in legs
______ Swollen ankles, feet, hands or arms
______ Cold hands or feet
______ Lightheadedness or Dizziness
______ Hot sweats
______ Cold sweats
______ Chills
______ Arms or legs go to sleep
______ Tingling of fingers or toes
______ Numbness of shoulders, hands, legs or feet
______ Low levels of blood proteins, eg. globulin, albumin, creatinine
______ Overweight
______ Obese
______ Blood sugar problems
______ Slow blood clotting
______ Tendency to get blood clots
______ Heaviness of arms or legs
______ Weakness of arms or legs
______ Enlarged heart
______ Mitrol valve prolapsis
______ Low body temperature
______ Require long periods to get "warmed up" after exposure to cold
______ Low iron levels, anemia
______ High iron levels
______ Shallow breathing
______ Angina
______
______

Has a doctor ever diagnosed heart trouble?
________________ When? ____________

Heart/stroke trouble in your family?
__________________Who? ______________

Have you ever had anemia?
_________________When? ______________

WOULD YOU LIKE A HEART ATTACK/STROKE PREVENTION PLAN DESIGNED FOR YOU?
YES ( ) NO ( )

WOULD YOU LIKE A CANCER PREVENTION PLAN DESIGNED FOR YOU?
YES ( ) NO ( )

FATIGUE

______ Fatigue more than normal
______ Morning fatigue, all morning
______ Morning fatigue, improving as day proceeds
______ Late afternoon fatigue
______ Fatique as a pattern for many years
______ Spells of complete exhaustion
______ Tire out from working
______ Too fatigued to work
______ Get up tired and exhausted
______ Every little effort a burden
______ Feeling sleepy only hours after arising
______ Too tired to eat
______ Nervous exhaustion
______ Weak and tired
______ Difficulty in falling asleep
______ Insomnia or difficulty sleeping
______ Wake up during the night
______ Nightmares
______ Recurrent nightmares
______ Stay up late at night
______ Thyroid problems
______ Parathyroid problems
______ Low Basal body temperature test
______
______

Nervous exhaustion in your family?

____

____

____

MIND, EMOTIONS & BEHAVIOR

______ Distracted easily
______ Tuning out
______ Mental confusion
______ Difficulty expressing yourself
______ Self-consciousness
______ Anxiety attacks
______ Crying bouts
______ Judgemental
______ Low self-esteem
______ Paranoia
______ Fearfulness
______ Lack of self-confidence
______ Bouts of anger
______ Emotional outbursts
______ Keyed up and jittery
______ Sensitive to criticism
______ Negative attitude
______ Pessimistic attitude
______ Apathy or feeling of impending doom
______ Impulsiveness
______ Compulsive behavior
______ Learning disorder
______ Attention deficit
______ Bouts of loss of memory
______ Phobias
______ Cry easily
______ Sadness
______ Temper tantrums
______ Bouts of violent behavior
______ Loss of interest in work or play
______ Depression
______ Depression worse in winter, or on overcast days
______ Suicidal thoughts
______ Emotionally unstable
______ Overstress
______ Dislike of job
______ Boredom
______ Frustration
______ Mood swings
______ Personality changes
______ Hyperactivity
______ Hallucinations
______ Bouts of hatredness
______ Bouts of jealousy
______ Non ordinary states of consciousness
______ Lack of dreams or dream recall
______ Feeling like you wished you were dead
______ Quarrelsome or argumentative
______ Dislike of self
______ Feelings of unworthiness
______ Obsessive compulsive behavior
______

Have you ever been diagnosed with mental illness? ___________________________
Is there mental illness in your family? _________________________

FREQUENCY OF ILLNESS

Answer "yes" to the following questions if they apply to you.
Leave blank otherwise.

______ Are you frequently ill?
______ Are you frequently confined to bed?
______ Are you often in poor health?
______ Are you considered sickly?
______ Do you come from a sickly family?
______ Do you worry about your health?
______ Are you often ill from being unhappy?
______ Do severe aches, pains or fatigue make it impossible to work?

How many times a year do you get colds? ____

How many times a year do you get the flu?____________________________________

Do you usually recover quickly or slowly?______________________________________ ___

Do you think you have a strong immune system? _____________________________________

DIET SYMPTOMS

______ Sugar cravings
______ Salt cravings
______ Chocolate cravings
______ Alcohol cravings
______ Tobacco cravings
______ Soft drink cravings
______ Fatty food cravings
______ Carbohydrate or starchy food cravings
______ Other cravings

FOOD & ENVIRONMENTAL INTOLERANCES

List sensitivities that you are aware of.

FOOD

____
____
____
____
____
____
____
____
____

ENVIRONMENTAL

____
____
____
____
____
____
____
____
____
____
____

WHERE HAVE YOU HAD ALLERGY TESTS DONE? WHAT KIND OF TESTS?

____
____
____
____
____
____

MEDICAL INFORMATION

Doctor's Name________________________
City_____________________

Do you have good communication with your Doctor?___________

Have you had any of the following within the past year?
Complete physical examination
Yes ( ) No ( )
Heart examination
Yes ( ) No ( )
Blood pressure check
Yes ( ) No ( )

Medical care Yes ( ) No ( )
Medical X-rays Yes ( ) No ( )
Ultra-sound Yes ( ) No ( )
MRT Medical Resonance Tests
Yes ( ) No ( )
Blood tests Yes ( ) No ( )
AIDS test Yes ( ) No ( )
EKG Electro-cardiogram
Yes ( ) No ( )

What is your blood type? ________________

ACCIDENTS & INJURIES

List all types of accidents and injuries you have had. Include year it happened or age of you at that time. Describe the injury done to your body.

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SURGERIES

List all surgeries that you have had during your life. Include year or age.

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MEDICATIONS
List all DRUG medications that you are presently taking, prescription or over-the-counter meds.
What they are for?
Include approximately how long you have been on this medication.
(Do not list any natural remedies.)

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Approximately how many times per year do you require antibiotics? _________________

Do you regularly consume over-the-counter drugs? _________________

_______acetamenophen
_______aspirin
_______antihistamins
_______ ibuprophen
_________ other

NATURAL REMEDIES

List all natural remedies that you are presently taking, i.e. vitamins, minerals, herbs, homeopathics, functional foods, etc. State what each of these remedies are for.

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CAREER / EMPLOYMENT

Describe briefly what kind of work you are presently doing.
Are there any work related physical or environmental strains on your body?
What kind of stress do you experience on your job?

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Occupation:

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HOME ENVIRONMENT

Name the people who live in your home with you and what their relationship is to you.
Is there more than average stress in your home?

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WEIGHT

Is weight a concern for you?
Are you overweight or underweight?
By how much?
Are you presently on a weight loss program?
Would you like to learn more how to manage your weight?

HOSPITALIZATION

Have you been hospitalized during the last 5 years? Indicate approximately when and for what reason.

NATURAL HEALTH PRACTITIONERS

Name the Natural Health Practitioners that you are presently seeing.

Name the Natural Health Practitioners that you have been to in the past but who you are not presently seeing.

DIET

What kind of diet are you presently on?
eg. All-Canadian diet, Diabetic diet, Weight Reduction diet, Celiac diet, Vegetarian diet, Vegan diet, Arthritic diet, Low Carb diet etc.
What major changes have you made to your diet within the last couple of months?

DIET EVALUATION

Record all the food and liquid that you have eaten for 1-2 weeks. Be honest as this is not judgemental, but a way of helping yourself. Then make an appointment for a DIET EVALUATION.

FOOD INTAKE

What is the frequency that you eat these foods?
DAILY? 1X WEEK? 2X WEEK? 4 OR 5X WEEK? HARDLY EVER? NEVER?

RED MEAT___________________________
VEGETARIAN MEAL__________________
POULTRY___________________________
ORGANIC FOODS____________________
FISH________________________________
EAT OUT____________________________
MILK or CHEESE PRODUCTS__________
FRUIT JUICE_________________________

HERBAL TEAS________________________
FRESH FRUITS_______________________
PURIFIED WATER____________________
VEGETABLES________________________
COFFEE or BLACK TEA_______________
NUTS & SEEDS_______________________
SOFT DRINKS________________________
LEGUMES (BEANS)__________________
ALCOHOL___________________________
ORANGES OR JUICE_________________

WHITE BREAD_______________________
SOYA MILK__________________________
WHEAT PRODUCTS__________________
RICE DREAM_________________________
OTHER WHOLE GRAINS______________
SALAD DRESSINGS___________
(Rye, Quinoa, Spelt, Oats, Barley, etc.)
SALADS_____________________

SUGARED PRODUCTS________________
EGGS_______________________________
ASPARTAME or NUTRISWEET__________
CHOCOLATE_________________________

How many glasses of WATER do you usually drink each day?________________

DISEASES

List all diseases or conditions that a Medical Doctor has diagnosed you with during your lifetime. Include the approximate year or your age at that time.

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FAMILY HISTORY

List all diseases that your family has a history of. Include the relationship of that person to you. (Your parents, children, grandparents, great-grandparents, sisters, brothers, aunts or uncles)

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EXERCISE

Are you doing any type of exercise program on a regular basis?
Describe below. How often?
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____

Do you ever feel ill after exercise?
____

Do you have an aversion or intolerance to exercise? __________________________

Would you like an EXERCISE PROGRAM designed specifically for your needs?______

MISCELLANEOUS

Answer with "yes" or "no".

Have you had a major trauma in the past year?
____
Loss of job? ________
Divorce or separation? ________
Loss of home? _________
Death of relative, close friend or pet?
____

Other___________________________________
____

Have you recently had a major lifestyle change?
____
Explain__________________________________
____

Do you have any addictions that you are aware of? ________
Which ones?__________________________

Do you have any obsessive behaviors?
____

Which ones?__________________________

Do you overuse alcohol? ________
How often? _____________________

CONFIDENTIAL INFO

Do you use hard drugs such as cocaine, crack or heroin, etc.? _________________

Do you use recreational drugs?
____

Do you think that you possibly could be HIV positive?____________________________

Do you suffer from a learning or reading impairment? _________________________

Are you undergoing an identity crisis or difficulty?
____

Comments________________________________
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EMOTIONAL TRAUMA

Please briefly explain any emotional trauma that you have experienced in your life and what age you were approximately.
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Do you feel that any of this trauma is blocking your healing at this time?________________________________

Comments________________________________

BOTHERSOME SYMPTOMS

List the 3 symptoms that bother you the most.

1.____________________________________

2.____________________________________

3.____________________________________

WEAKNESSES

List what you think are your 3 main weak body systems. (eg. upper digestive, elimination, nervous, eyes, ears, skin, lymph, immune, circulatory-cardiovascular, respiratory, glandular, muscular, reproductive, brain, spinal, bones, mind & emotions)

1. ___________________________________

2. ___________________________________

3. ________________________________

HEALTH CONCERNS

What health concerns do you have for yourself for the future?

HEALTH GOALS

What health goals do you have for yourself at the present time? (Short-term goals)

What health goals do you have for yourself for the future? (Long-term goals)

Signature____ **Date**_____________________

HEALTH PORTFOLIO

- Keep a copy of this assessment in a binder or file that is your own Health Portfolio. Keep a record whenever you have a fever, cold, flu, etc. along with the duration of illness. You can use this assessment with any physician or natural health practitioner to get an accurate picture of your health. Ask for copies of all tests done by your medical doctor for your Health Portfolio. It is always wise to take responsibility for your own health by taking charge.

- This **assessment** is not intended to diagnose, prescribe or treat disease, but merely to provide information for you. Consult your physician regarding any disease symptoms. It is always wise to check with an expert in the field of medicine and nutrition to determine the best remedy or therapy for your particular condition. In the event you choose to use this information without your doctor's approval, you are prescribing for yourself, which is your constitutional right, but for which this author will not assume responsibility.

- Read Disclaimer on website **www.dragonflymedicinehouse.ca**

- The information gathered in this Health Questionnaire is kept confidential in accordance to the Privacy Act.

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