Lifestyle and Symptom Survey Name: ___________________________

Please check the box next to any of the following that apply to you. Date: ___________________________

- ☐ Abdominal bloating or swelling
- ☐ **Alternating constipation and diarrhea**
- ☐ Anxious, worried, or upset during the past month
- ☐ Bad breath
- ☐ Beefy red or smooth tongue
- ☐ Belching or burping after meals
- ☐ Black or bloody bowel movements
- ☐ Bloated feeling after eating
- ☐ Body odor
- ☐ Boils or sores that take a long time to heal
- ☐ Bone fracture within the last year
- ☐ Bothered by coughing spells
- ☐ Bowel movements loose for more than a day
- ☐ Bruise easily or prolonged bleeding
- ☐ Burning or gnawing stomach pain
- ☐ Catch colds or flu easily
- ☐ Change in size or color of a mole on skin
- ☐ Chest colds more than once a month
- ☐ Chronically chapped lips
- ☐ Cloudy, red, or brownish urine
- ☐ Cold hands and feet
- ☐ Cold sores, fever blisters
- ☐ Constipated more than once a month
- ☐ Consume one or more alcoholic drinks per day
- ☐ Consume two or more cups of coffee per day
- ☐ Cough up a lot of phlegm (thick spit)
- ☐ Cough up blood
- ☐ Cracks or redness at the corners of mouth or nose
- ☐ Crave salty foods
- ☐ Crave sweets
- ☐ Crease in earlobe
- ☐ Currently taking diuretics (blood pressure medicine)
- ☐ Dark circles under eyes
- ☐ Difficulty breathing
- ☐ Difficulty either falling asleep or staying asleep
- ☐ Difficulty in digesting certain foods
- ☐ Difficulty relaxing
- ☐ Difficulty starting urine flow
- ☐ Dizziness or lightheadedness
- ☐ Dribble after urinating
- ☐ Dry eyes
- ☐ Dry mouth
- ☐ Dry skin
- ☐ Easily broken fingernails
- ☐ Easily irritated
- ☐ Enlarged veins in legs
- ☐ Entire body achy, painful to touch
- ☐ Excess saliva
- ☐ Excessively oily skin
- ☐ Exercise less than three times a week
- ☐ Exhausted or fatigued most of the time
- ☐ Family history of diabetes
- ☐ Fatty foods give indigestion
- ☐ Feel out of control
- ☐ Feeling of undigested food in stomach after eating
- ☐ Feet often painful
- ☐ Foul smelling stool or gas
- ☐ Frequent heart palpitations or fluttering
- ☐ Frequent illness
- ☐ Frequent mood swings
- ☐ Frequent nosebleeds
- ☐ Full bladder feeling, but only pass a small amount of urine
- ☐ Gain weight easily and have difficulty taking it off
- ☐ Get sleepy when sitting
- ☐ Get up at night to urinate
- ☐ Get weak and shaky if do not eat a meal on time
- ☐ Gums bleed easily upon brushing teeth
- ☐ Hair tends to get split ends or fall out
- ☐ Hard stools
- ☐ Have taken birth control pills or estrogen
- ☐ Headaches more than once a week
- ☐ Headaches relieved by eating sweets or alcohol
- ☐ Heart misses beats or has extra beats
- ☐ Heart murmur, now or in past
- ☐ Heartburn
- ☐ Heavy menstrual periods
- ☐ High stress lifestyle
- ☐ History of antibiotic use
- ☐ History of ulcer, gastritis, or antacid use
- ☐ Indigestion 1 to 3 hours after eating
- ☐ Joints swollen, red, or hot
- ☐ Known or suspected food allergies
- ☐ Lack of ear wax or hard, dark ear wax
- ☐ Lack of mental alertness
- ☐ Leak urine when cough or sneeze
- ☐ Less than one bowel movement per day
- ☐ Light colored stools
- ☐ Live in a city with air pollution
- ☐ Live or work around smokers
- ☐ Loose, floating stools
- ☐ Loss of grip strength
- ☐ Loss of height
- ☐ Loss of muscle tone
- ☐ Lower bowel gas
- ☐ Lowered resistance to disease or infection
- ☐ Monthly weight gain
- ☐ More thirsty than usual lately
- ☐ Muscle spasms or cramps
- ☐ Need 10-12 hours of sleep per day
- ☐ Need to drink coffee for an energy boost
- ☐ Nighttime leg cramps
- ☐ Nose stuffed up or running when don't have a cold
- ☐ Pain or cramping in abdomen
- ☐ Pain under the right side of rib cage
- ☐ Pain with bowel movement
- ☐ Painful urination
- ☐ Pains in legs when walking
- ☐ Pains in stomach just before or after meals
- ☐ Pains in the back or shoulder
- ☐ Pains or tightness in chest
- ☐ Pale skin complexion
- ☐ Part of body always numb
- ☐ Poor memory or concentration
- ☐ Poor night vision
- ☐ Poor sense of taste or smell
- ☐ Problems with yeast or fungus
- ☐ Rapid heartbeat after eating sweets
- ☐ Recurrent bladder or kidney infections
- ☐ Recurrent sore throats
- ☐ Recurring dandruff
- ☐ Relief of stomach pain by drinking milk or soda pop
- ☐ Ridging on fingernails
- ☐ Ringing or other noises in ears
- ☐ Rough skin at the back of arms
- ☐ Sensitive to fumes, smoke, smog, or petrochemicals
- ☐ Sensitive to hot and cold temperatures
- ☐ Short and stocky body build
- ☐ Short of breath from little effort
- ☐ Skin blushes easily
- ☐ Skin complexion problems
- ☐ Skin itches or burns
- ☐ Smoke or chew tobacco
- ☐ Sore or sensitive tongue
- ☐ Sore or swollen breasts
- ☐ Stiff all over
- ☐ Stiff in the morning
- ☐ Stiff or painful muscles or joints
- ☐ Stomach pain when emotionally upset
- ☐ Strong smelling urine
- ☐ Sweating more than usual or having night sweats
- ☐ Swollen bulging eyes
- ☐ Swollen feet or ankles
- ☐ Swollen lymph glands
- ☐ Tall and slender body build
- ☐ Tingling pain sensation in part of body
- ☐ Tired feeling 1 to 3 hours after eating
- ☐ Trouble remembering dreams
- ☐ Trouble waking up in the morning

- ☐ Twisting neck quickly is painful
- ☐ Unexplained swelling or lump that persists
- ☐ Urinate more than five or six times a day
- ☐ Usually feel lonely or depressed
- ☐ Wake up at night short of breath
- ☐ Water retention
- ☐ White spots on fingernails

Personal Health History Weight: _____ lbs. Would you like to lose weight? Yes ☐ No ☐ How Much? ____ Lbs.

Check the box next to any of the following problems you have, or have had. If this is a significant problem for you please circle the condition. If known, write the year the problem began next to the item.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Trouble
- ☐ Bone or Joint Problems
- ☐ Bowel Polyps
- ☐ Bronchitis
- ☐ Bursitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever Blisters
- ☐ Gall Bladder Disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Hives or Rashes
- ☐ Hot Flashes
- ☐ Hyperactive Personality
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Kidney Trouble
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus (SLE)
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis (MS)
- ☐ Nephritis
- ☐ Nervous Breakdown
- ☐ Neuritis or Neuralgia
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Pleurisy
- ☐ PMS-premenstrual syndrome
- ☐ Pneumonia
- ☐ Prostate Trouble
- ☐ Psoriasis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sciatica
- ☐ Seborrheic Dermatitis
- ☐ Seizures
- ☐ Stomach/Duodenal Ulcer
- ☐ Stroke
- ☐ Tension/anxiety
- ☐ Thyroid Disease
- ☐ Tooth or Gum Disease
- ☐ Tuberculosis
- ☐ Unexplained Weight Loss
- ☐ Varicose Veins

Please list any other health concerns you may have: ____
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Please list any drugs, either over the counter or prescription, that you are currently taking, and the frequency:
____
____
____

Surgeries – Please check the box next to any of the following surgeries you have had, or surgeries that have been recommended to you. If the surgery was actually performed, write the year it was done next to the box.

- ☐ Adrenal
- ☐ Appendix
- ☐ Back (disk)
- ☐ Bone
- ☐ Bowel
- ☐ Brain
- ☐ Breast
- ☐ Carpal Tunnel
- ☐ Cataract
- ☐ Duodenum
- ☐ Gallbladder
- ☐ Heart
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Kidney
- ☐ Liver
- ☐ Lung
- ☐ Lymph nodes
- ☐ Ovaries (or tubal ligation)
- ☐ Pancreas
- ☐ Pituitary
- ☐ Prostate
- ☐ Skin
- ☐ Spleen
- ☐ Stomach
- ☐ Testicle (or vasectomy)
- ☐ Thymus
- ☐ Thyroid
- ☐ Tonsils
- ☐ Uterus
- ☐ Other ___________________