

Lozier Natural Health Center

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Today's Date: _____ Age _____ Sex _____
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: ____/____/____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone :(____) _____
Email Address _____
Your Occupation _____ Your Employer: _____
Social Security #: _____
Marital Status: Married Single Divorced Separated Other _____
Name of Spouse or Nearest Relative: _____ Phone :(____) _____
Referred to this Office by: _____

Have you been treated by a physician for any health condition in the last year? Yes No
If yes by whom _____
Describe Condition _____ Date of Last Physical Exam _____

Surgical History:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS: Rate pain (1-10, 0-no pain to 10 worst pain)

	#
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Have you received Chiropractic care before? YES NO
Are you currently receiving chiropractic care? YES NO

What medications are you currently taking?

What nutritional supplements are you currently taking?

Are you pregnant? Yes No Date of last menstrual period _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

Lozier Natural Health Center

What do you know about our approach?

What *three* expectations do you have from *this* visit?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 1 2 3 4 5 6 7 8 9 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

SURVEY OF YOUR OVERALL HEALTH OF YOUR BODY'S SYSTEMS

Patient Name _____ Date _____

For your 1st visit-checkmark any symptom you have experienced in the last month. **For Re-exams**-checkmark symptoms you are currently experiencing.

HEADACHES

___ Base of Skull (back)

___ Side of head (Temples)

___ Frontal (above eyes)

___ Top of head

___ Entire Head

___ Migraines

___ TMJ

___ Cluster

___ Other _____

CHEST

___ Tension

___ Tight

___ Pressure

___ Heaviness

___ Anxiety

___ Congestion

___ Chest Pain

___ Sternal Pain

___ Sharp Heart Pain

___ Palpitations-Heart Skip/Flutter

___ Mitral Valve Prolapse

___ Tachycardia/Heart Racing

___ Bradycardia/Heart Slowing down

___ Murmur

___ Arm Pain

___ Other _____

For Men Only: PROSTATE

___ History

___ Current

___ Burn

___ Achyness

___ Pain

___ Restriction

___ Dribbling

___ Emission

___ Swelling

___ Other _____

CRAMPS/ ACHES/ RESTLESS

___ Cramps (legs/feet/arms/hands)

___ Aches (legs/feet/arms/hands)

___ Restless (legs/feet/arms/hands)

ENERGY

___ Low

___ Variable

___ Normal

___ High

___ Slow to start in the morning

___ Energy Crash _____ am/pm

___ Low Energy after meals

___ Other _____

EARS

___ Noise (Ring/Hiss/Pound)

___ Plugged

___ Popping

___ Ear Ache

___ Ear Infections

___ Draining

___ Itchy

___ Hearing Loss

___ Dizziness/ Vertigo

___ Excessive Ear Wax

___ Other _____

SHORTNESS OF BREATH

___ Constant

___ Upon Exertion

___ Asthma

___ Wheezing

___ Air Hunger/ Frequent Sighs

___ Yawning

___ Emphysema

___ Other _____

VAGINA (women only)

___ Burn

___ Itch

___ Dry

___ Pain

___ Pain with intercourse

___ Blood

___ Discharge

___ - Clear

___ - White

___ - Yellow

___ - Green

___ - Brown

___ - Odor

___ Other _____

SKIN/ HAIR/ NAILS

___ Skin Rash

___ Acne

___ Dry Skin

___ Itchy Skin

___ Fungus

___ Patches skin look different

___ Cellulite

___ Nails (weak/ spots/ lines)

___ Hair loss

___ Limp Hair

___ Cherry Hemangiomas

___ Slow Healing

___ Bruise Easily

___ Other _____

EXERCISE

___ Cardiovascular _____ times/ week

___ Weight Train _____ times/per week

MEMORY

___ Short Term Loss

___ Long Term Loss

___ Forget Names

___ Forget Numbers

___ Forget Words

___ Forget Actions

___ Difficulty Concentrating

___ Other _____

EYES

___ Burn

___ Tear

___ Ache

___ Red

___ Dry

___ Eye Film

___ Crust in morning

___ Itchy Eyes

___ Bouts of Blurriness

___ Floaters

___ Spots

___ Tired

___ Puffy

___ Styte

___ Twitching around eyes

___ Dark Circles

___ Light Bothers Eyes

___ Nearsighted

___ Farsighted

___ Other _____

STOMACH

___ Heartburn

___ Indigestion

___ Stomach Aches

___ Stomach Cramps

___ Nausea/ Queasy

___ Bloat after Eat

___ Gas/ Flatulence

___ Belching

___ Ulcer

___ Hiatal Hernia

___ Other _____

MENSES (women only)

___ Last Menstrual Period _____

___ Length of Menses _____

___ Regular

___ Irregular

___ Early (less than 28 days)

___ Late (more than 28 days)

___ Skip

___ Birth Control Pill

___ Flow (heavy/ moderate/ light)

___ Cramps (mild/ mod/ severe)

___ Low Abdominal Puffiness

___ Fluid Retention Face

___ Fluid Retention Hands

___ Fluid Retention Feet

___ Fluid Retention Body

___ Breast Tender around cycle

___ Acne (pre/mid/post)

___ Clotting

___ Spotting

___ PMS

___ Mood Swings

___ Irritable

___ Depression

___ Tired during period

___ Pain during Ovulation

___ Cysts/PCOS

___ Discharge with Ovulation

___ Regular Ovulation

___ Irregular Ovulation

___ Fibroids

___ Facial Hair

___ Hair growing up towards belly button

___ Dark Nipple Hair

___ Other _____

URINATION

___ _____ times per day-frequency

___ Urinate at night _____ per night

___ Frequency

___ Urgency

___ Burning

___ Pain

___ Odor

___ Spasm

___ Leakage

___ Urinary Tract Infection

___ Kidney Troubles

___ Other _____

LIBIDO/ SEXUALITY

___ Flat

___ Low

___ Normal

___ Erectile Dysfunction (men)

___ Orgasm Quality (poor/ good/ great)

___ Other _____

SINUS

___ Dry

___ Drain

___ Stuffy/ plugged up

___ Post nasal drip...circle color:
___ white/yellow/green/gray
___ brown/blood/blood/clear

___ Excessive Sneezing

___ Loss of Smell

___ Loss of Taste

___ Thirsty

___ Not Thirsty

___ Unquenchable thirst

___ Other _____

BOWELS

___ Bowel Movements _____ Per day

___ Regular

___ Incomplete

___ Skip days _____ per (week/month)

___ Sluggish bowels every _____ days

___ Cramps in Abdomen

___ Taking Laxatives

___ Using Suppositories

___ Enemas

___ Colonics

___ Take Herbal Laxatives/Supplements

___ Bulky

___ Pain with Bowel Movements

___ Irritable Bowel Syndrome

___ Chrons

___ Colitis

___ Other _____

BREASTS (women only)

___ Breast Feeding

___ Fibrosis

___ Lump

___ Discharge

___ Prosthesis

___ Augmentation Surgery

___ Reduction Surgery

___ Pathology

___ Breast Tender constant

___ Other _____

SLEEP

___ Quality (poor/fair/good/great)

___ _____ Hours in bed

___ _____ Hours asleep

___ Difficulty falling asleep

___ Difficulty staying asleep

___ Interrupted _____ per night

___ Crave Sleep during day

___ Awaken Suddenly (Jolt)

___ Don't Remember Dreams

___ Nightmares

___ Night sweats

___ Restlessness

___ Sleep Apnea

___ Other _____

**PAIN/ STIFFNESS/ SWELLING
NUMBNESS/ TINGLING**

___ Facial

___ Neck

___ Trapezius

___ Upper Back

___ Shoulders

___ Arms

___ Elbows

___ Wrist

___ Hand

___ Mid Back

___ Low Back

___ Sacral Iliac

___ Hips

___ Buttocks

___ Legs

___ Sciatica

___ Knees

___ Ankles

___ Feet

MOUTH/ THROAT/ IMMUNE

___ Sore Throat

___ Hoarseness

___ Cough (dry/productive)

___ Allergies

___ Upper Respiratory Infection

___ Teeth Health Problems

___ Fever

___ Chills

___ Bad Breath

___ Canker Sores

___ Blisters

___ Frequent Colds/ Flu

___ Neck Stiffness

___ Shoulder Tension

___ Cracks at lip corners/ Chielosis

___ Dry Mouth

___ Cold sweaty hands & feet

___ Bleeding gums

___ Receding gums

___ Teeth Health Problems

FECAL CONSISTENCY

___ Color feces light or dark _____

___ Soft/Unformed

___ Ribbon-like

___ Mucous

___ Normal/ Banana Shaped

___ Hard

___ Pebbles

___ Dry

___ Painful

___ Diarrhea

___ Constipation

___ Broken

___ Other _____

BREASTS (women only)

___ Breast Feeding

___ Fibrosis

___ Lump

___ Discharge

___ Prosthesis

___ Augmentation Surgery

___ Reduction Surgery

___ Pathology

___ Breast Tender constant

___ Other _____

EMOTIONS

___ Stressed

___ Sad

___ Grief

___ Depression

___ Moodiness

___ Irritable

___ Worrisome

___ Angry

___ Nervous

___ Frustrated

___ Anxiety

___ Panic

___ Cry

___ Fear

___ Shame

**List Your Primary Concerns
in order of importance to you:**

1) _____

2) _____

3) _____

4) _____

HEMORRHOIDS

___ History

___ Current

___ Swollen

___ Burn

___ Blood

___ Distended

MENOPAUSE (women only)

___ Natural

___ Surgical (partial/complete)

___ Hormones

___ Patch

APPETITE/ DIET

___ Low Appetite

___ Normal Appetite

___ High Appetite

___ Starch (pasta/bread/potatoes/rice)

___ Sweets

___ Chocolate

___ Coffee _____ cups/ day

___ Caffeinated Tea _____ cups/day

___ Beer _____ per week

___ Wine _____ per week

___ Juice _____ per week

___ Soda _____ per week

___ Artificial Sweeteners

For Doctor's Use

___ Frenular Cyst

___ Cracks in Tongue

___ Allergy Patches Tongue

___ Geographic Tongue

___ Red Spots Tongue

___ Swollen Tongue

___ Color Tongue _____

___ Dark Veins Tongue

___ Coated Tongue (mild/mod/severe)

___ Ear Creases (R/ L) mild/mod/severe

___ Weight _____ (+/- lbs) overall (+/-) _____

___ Height _____

___ Pulse _____ BP: (____/____)

___ saliva pH _____ Urine pH _____

___ Allergies _____

___ Current Meds: _____

AUTO ACCIDENT QUESTIONNAIRE

Dear patient:

We need this confidential information answered completely to help us access your need for care. If we do not sincerely believe your condition will respond to chiropractic care, we will not access you as a patient. Thank you.

NAME: _____ DATE OF BIRTH _____ SS# _____

NATURE OF AUTO ACCIDENT- Please explain in detail how your accident happened:

1. What was the time and date of your present injury? Date: _____ Time: _____ AM/PM

2. Please explain in detail how your accident happened. (Please include location and conditions.)

You were heading: North South East West on _____ (street or highway)

Other vehicle was headed: North South East West on _____ (Street or Highway)

Were police notified? Yes No - You were struck from Behind Front Left side Right side

You were: Driver Passenger Front seat Back seat Using seat belt Not using seatbelt

3. Did you come in contact with any objects? Yes No

If yes, what objects (Door, Steering wheel, etc)? _____

4. What parts of your body came in contact with the above object(s)? _____

5. Where did you feel pain or unusual feeling immediately after the accident? _____

6. Were you unconscious as a result of the injury? _____ If yes, how long? _____

7. Were you bleeding as a result of the accident? _____ Where? _____

8. Were you taken to the hospital after your accident? Yes No By ambulance? Yes No

If so, where? _____

Treating Doctor's name: _____ DC _____ MD _____ DO _____ DDS

9. Describe the doctor's diagnosis: _____

10. What treatment did you receive? _____

11. Are you still under a doctor's care? Yes No

If yes, please explain. _____

Past History:

1. Have you ever injured this area before? Yes No If yes, when? _____

2. If injured before did you lose time from work? Yes No

3. Have you been involved in any previous accidents of any kind? Yes No

If yes, please explain dates and details. _____

4. Have you been treated previously by a chiropractor? Yes No

If yes, please explain _____

PRESENT INFORMATION DISABILITY:

1. Did you lose any time from work? Yes No If yes, date of lost time _____

2. Have you returned to work? Yes No If yes, date returned to work _____

3. Job description: _____

4. Are your work activities restricted as a result of the accident? _____

5. Do you have to favor any part of your body in your work? _____

6. Since this injury, are your symptoms: Improving Getting worse Same

Please explain _____

7. Do any diseases or accidents affect your employment? _____

INSURANCE INFORMATION:

1. Name of driver of vehicle in which you were injured: _____

Driver's Insurance Co.: _____ Agent's name: _____ Phone: _____

POLICY # _____ CLAIM # _____

OTHER CARS INSURANCE:

2. NAME OF DRIVER OF VEHICLE (IF ANY): _____

Insurance Co.: _____ Policy Holder: _____ Policy # _____

CLAIM # _____ ADJUSTER: _____

LEGAL REPRESENTATION:

1. Have you retained an attorney? Yes No

If yes, name and address? _____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's signature

Date

Doctors Signature (Upon review)

Date

Lozier Natural Health Center, PC

Headache Disability Index

Name: _____ Date: _____ Age: _____ Scores Total: _____ E _____ F _____

Instructions: Please Circle the Correct response:

1. I have headaches: (1) 1 per month (2) more than 1 but less than 4 per month (3) more than one a week
 2. My headache is: (1) mild (2) moderate (3) severe

Instructions: PLEASE READ CAREFULLY: The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off “YES”, “SOMETIMES”, or “NO” to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped			
F2. Because of my headaches I feel restricted in performing my routine daily activities			
E3. No one understands the effect my headaches have on my life			
F4. I restrict my recreational activities because of my headaches.			
E5. My headaches make me angry.			
E6. Sometimes I feel that I am going to lose control because of my headaches.			
F7. Because of my headaches I am less likely to socialize			
E8. My spouse/ significant other, family and friends have no idea what I am going through because of my headaches			
E9. My headaches are so bad that I feel I am going insane.			
E10. My outlook on the world is affected by my headaches			
E11. I am afraid to go outside when I feel a headache starting			
E12. I feel desperate because of my headaches.			
F13. I am concerned that I am paying penalties at work or at home because of			
E14. My headaches place stress on my relationships with family or friends			
F15. I avoid being around people when I have a headache			
F16. I believe my headaches are making it difficult for me to achieve my goals.			
F17. I am unable to think clearly because of my headaches.			
F18. I get tense (e.g. muscle tension) because of my headaches			
F19. I do not enjoy social gatherings because of my headaches.			
E20. I feel irritated because of my headaches			
F21. I avoid traveling because of my headaches			
E22. My headaches make me feel confused			
E23. My headaches make me feel frustrated.			
F24. I find it difficult to read because of my headaches			
F25. I find it difficult to focus my attention away from my headaches and on other things			

Lozier Natural Health Center, PC

Neck Pain Disability Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1—Pain Intensity

- A I have no pain at the moment
- B The pain is very mild at the moment
- C The pain is moderate at the moment
- D The pain is fairly severe at the moment
- E The pain is very severe at the moment
- F The pain is the worst imaginable at the moment

SECTION 2—Personal Care

- A I can look at myself normally without causing extra pain
- B I can look at myself normally, but it causes extra pain
- C It is painful to look at myself and I am slow and careful
- D I need some help, but manage most of my personal care
- E I need help every day in most aspects of self care
- F I do not get dressed; I wash with difficulty and stay in bed

SECTION 3 – Lifting

- A I can lift heavy weights without extra pain.
- B I can lift heavy weights, but it causes extra pain.
- C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are positioned, on a table.
- D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- E I can lift very light weights
- F I cannot lift or carry anything at all

SECTION 4 – Reading

- A I can read as much as I want to with no pain in my neck
- B I can read as much as I want to with slight pain in my neck
- C I can read as much as I want to with moderate pain in my neck
- D I cannot read as much as I want to because of moderate pain in my neck
- E I cannot read as much as I want to because of severe pain in my neck
- F I cannot read at all

SECTION 5 – Headaches

- A I have no headaches at all
- B I have slight headaches which come infrequently
- C I have moderate headaches which come infrequently
- D I have moderate headaches which come frequently
- E I have severe headaches which come frequently
- F I have headaches almost all the time

SECTION 6—Concentration

- A I can concentrate fully when I want to with no difficulty
- B I can concentrate fully when I want to with slight difficulty
- C I have a fair degree of difficulty in concentrating when I try to
- D I have a lot of difficulty in concentrating when I want to.
- E I have a great deal of difficulty in concentrating when I want to
- F I cannot concentrate at all

SECTION 7—Work

- A I can do as much work as I want to
- B I can only do my usual work, but no more
- C I can do most of my usual work, but no more
- D I cannot do my usual work
- E I can hardly do any work at all
- F I cannot do any work at all

SECTION 8—Driving

- A I can drive my car without any neck pain
- B I can drive my car as long as I want with slight neck pain
- C I can drive my car as long as I want with moderate neck pain
- D I cannot drive my car as long as I want because of moderate neck pain
- E I can hardly drive at all because of severe neck pain
- F I cannot drive my car at all

SECTION 9—Sleeping

- A I have no trouble sleeping
- B My sleep is slightly disturbed (less than 1 hour sleepless)
- C My sleep is mildly disturbed (1-2 hours sleepless)
- D My sleep is moderately disturbed (2-3 hours sleepless)
- E My sleep is greatly disturbed (3-5 hours sleepless)
- F My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10 – Recreation

- A I am able to engage in all my recreational activities with no neck pain at all
- B I am able to engage in all my recreational activities with some neck pain at all
- C I am able to engage in most, but not all of recreational activities because of pain in my neck
- D I am able to engage in few of my recreational activities because of pain in my neck
- E I can hardly do any recreational activities because of pain in my neck
- F I cannot do any recreational activities at all

Patient Signature: _____ Date: _____

Comment: _____

NECK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): _____ DATE _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION _____

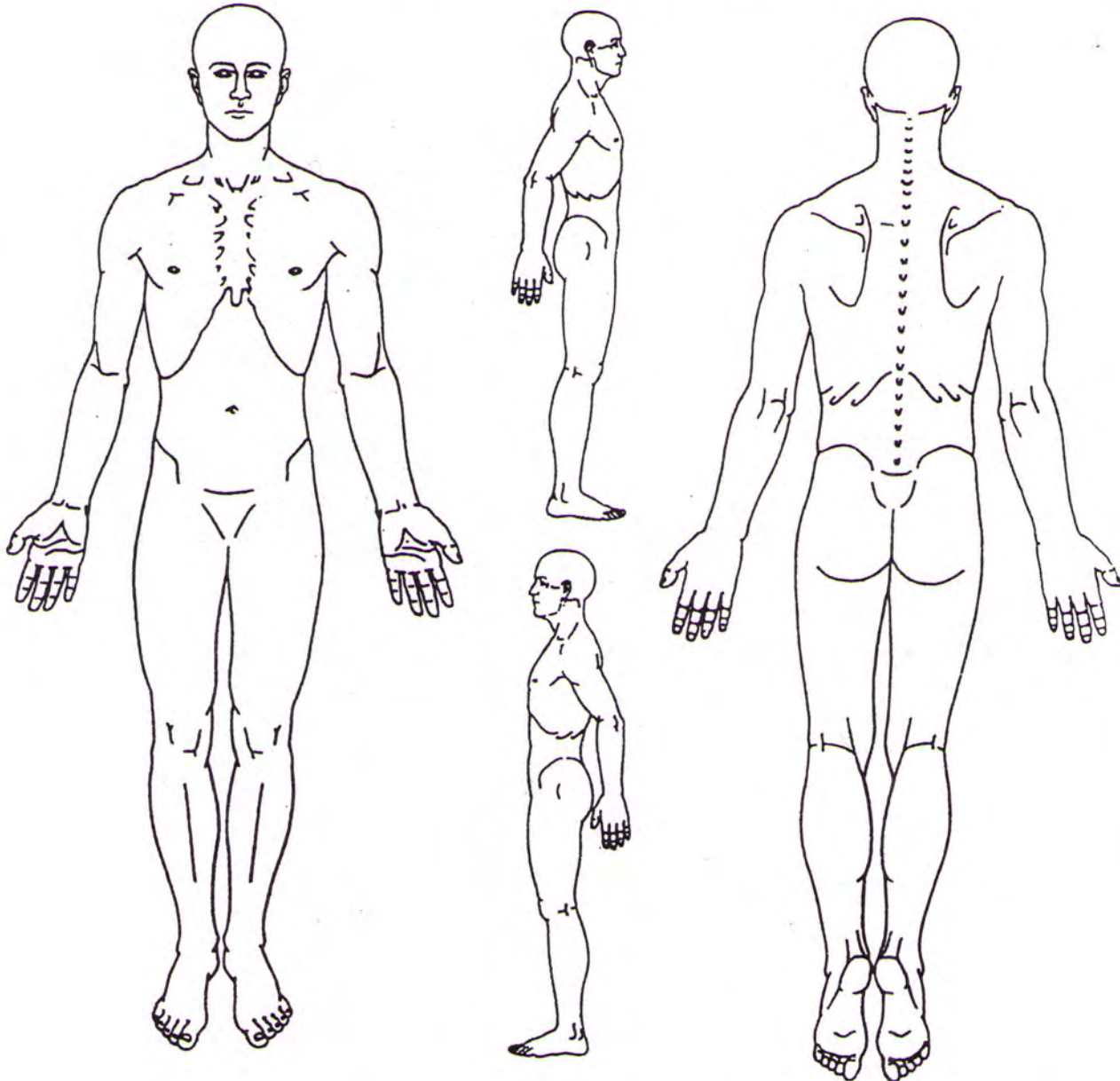
HOW LONG HAVE YOU HAD BACK PAIN? _____ YEARS _____ MONTHS _____ WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? _____ YES _____ NO

**USE THE LETTER BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SENSATIONS RIGHT NOW**

(Please remember to complete both sides of this form)

KEY: A=ACHE B=BURNING N=NUMBNESS
 P=PINS AND NEDLES S= STABBING O=OTHER



Lozier Natural Health Center, PC

Revised Oswesrty Low Back Disability Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1—Pain Intensity

- A The pain comes and goes and is very mild.
- B The pain is mild and does not vary much.
- C The pain comes and goes and is moderate
- D The pain is moderate and does not vary much.
- E The pain comes and goes and is severe.
- F The pain is severe and does not vary much.

SECTION 2—Personal Care

- A I would not have to change my way of washing or dressing in order to avoid pain.
- B I do not normally change my way of washing or dressing even though it causes some pain.
- C Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E Because of the pain, I am unable to do some washing and dressing without help.
- F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

- A I can lift heavy weights without extra pain.
- B I can lift heavy weights, but it causes extra pain.
- C Pain prevents me from lifting heavy weights off the floor
- D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are positioned, on a table.
- E Pain prevents me from lifting heavy weights, but I can manage to lift light to medium weights if they are conveniently positioned.
- F I can only lift light weights at the most

SECTION 4 – Walking

- A Pain does not prevent me from walking any distance
- B Pain prevents me from walking more than one mile
- C Pain prevents me from walking more than ½ mile.
- D Pain prevents me from walking more than ¼ mile
- E I can only walk while using a cane or on crutches
- F I am in bed most of the time and have to crawl to the bathroom

SECTION 5 – Sitting

- A I can sit in any chair as long as I like without any pain.
- B I can only sit in my favorite chair as long as I like
- C Pain prevents me from sitting more than one hour
- D Pain prevents me sitting more than a half hour
- E Pain prevents me from sitting more than ten minutes
- F Pain prevents me from sitting at all

SECTION 6—Standing

- A I can stand as long as I want without pain.
- B I have some pain while standing, but it does not increase with time.
- C I cannot stand for longer than one hour without increasing pain.
- D I cannot stand for longer than ½ hour without increasing pain
- E I cannot stand for longer than ten minutes without increasing pain.
- F I avoid standing, because it increases the pain straight away

SECTION 7—Sleeping

- A I get no pain in bed.
- B I get pain in bed, but it does not prevent me from sleeping well.
- C Because of pain, my normal nights sleep is reduced by less than one quarter.
- D Because of pain my normal nights sleep is reduced by less than a half hour.
- E Because of pain, my normal nights sleep is reduced by less than three- quarters.
- F Pain prevents me from sleeping at all.

SECTION 8—Social Life

- A My social life is normal and gives me no pain
- B My social life is normal, but increases the degree of my pain.
- C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc
- D Pain has restricted my social life and I do not go out often.
- E Pain has restricted my social life to my home.
- F I have hardly any social life because of my pain

SECTION 9—Traveling

- A I get no pain while traveling
- B I get some pain while traveling, but none of my usual forms of travel make it any worse
- C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel
- D I get extra pain while traveling which compels me to seek alternative forms of travel.
- E Pain restricts all form of travel.
- F Pain prevents all forms of travel except while done lying down

SECTION 10 – Changing degree of pain

- A My pain is rapidly getting better
- B My pain fluctuates, but over all is definitely getting better.
- C My pain seems to be getting better, but improvement is slow at present
- D My pain in neither getting better or worse
- E My pain is gradually worsening.
- F My pain is rapidly worsening.

Patient Signature: _____ Date: _____

Comment: _____

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): _____ DATE _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION _____

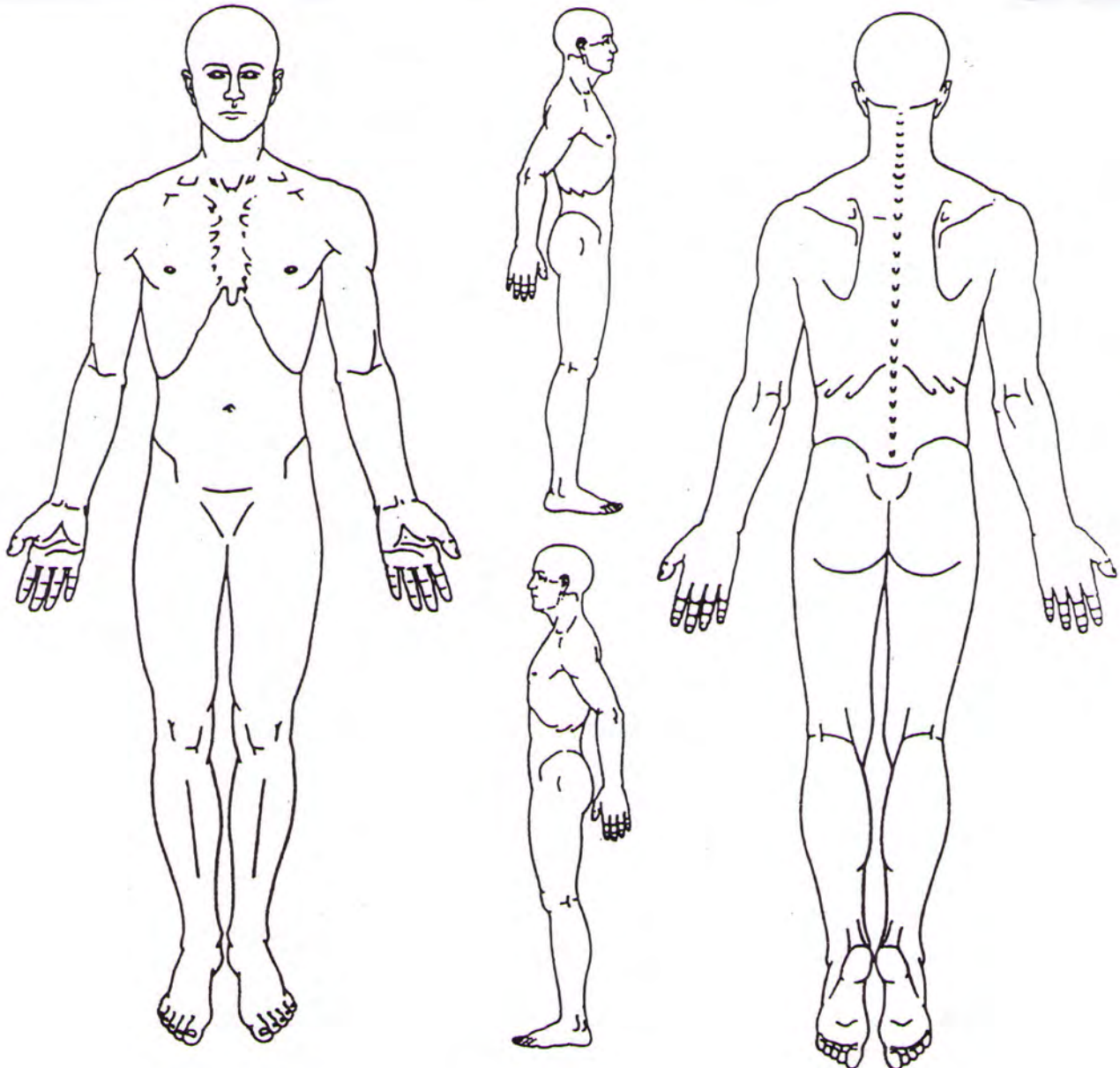
HOW LONG HAVE YOU HAD BACK PAIN? _____ YEARS _____ MONTHS _____ WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? _____ YES _____ NO

USE THE LETTER BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form)

KEY: A=ACHE B=BURNING N=NUMBNESS
 P=PINS AND NEDLES S= STABBING O=OTHER



Name: _____

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a Clinical Purification™ program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloating feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4
Total:	_____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4
Total:	_____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4
Total:	_____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4
Total:	_____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4
Total:	_____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4
Total:	_____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4
Total:	_____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4
Total:	_____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4
Total:	_____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4
Total:	_____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4
Total:	_____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4
Total:	_____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Rheumatoid arthritis	0 1 2 3 4
c. Osteoarthritis	0 1 2 3 4
d. Stiffness or limited movement	0 1 2 3 4
e. Pain or aches in muscles	0 1 2 3 4
f. Recurrent back aches	0 1 2 3 4
g. Feeling of weakness or tiredness	0 1 2 3 4
Total:	_____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4
Total:	_____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4
Total:	_____

Section I Total: _____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily
---	-------	---	--------	---	---------	---	--------	---	-------

- a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4
- b. How often are pesticides used in your home? 0 1 2 3 4
- c. How often do you have your home treated for insects? 0 1 2 3 4
- d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?
0 1 2 3 4
- e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4
- f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change
---	----	---	-------------	---	-----------------	---	----------------

- a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3
- b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

- | | No | Yes |
|---|----|-----|
| a. Do you have a water purification system in your home? | 2 | 0 |
| b. Do you have any indoor pets? | 0 | 2 |
| c. Do you have an air purification system in your home? | 2 | 0 |
| d. Are you a dentist, painter, farm worker, or construction worker? | 0 | 2 |

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a Clinical Purification™ program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.

SYMPTOM SURVEY FORM
(Restricted to Professional Use)

PATIENT _____ DOCTOR _____ DATE _____

AGE _____ PHONE (_____) _____ VEGETARIAN ____ Yes ____ No

INSTRUCTIONS: Circle the number that applies to you. **If symptom doesn't apply, leave blank.** Use (1) for **MILD** symptoms (occurs once or twice a month), (2) for **MODERATE** symptoms (occurs several times a month), and (3) for **SEVERE** symptoms (you are aware of it almost constantly).

GROUP ONE

- | | | |
|--|---|--|
| 1 - 1 2 3 Acid foods upset | 8 - 1 2 3 Gag easily | 15 - 1 2 3 Appetite reduced |
| 2 - 1 2 3 Get chilled, often | 9 - 1 2 3 Unable to relax; startles easily | 16 - 1 2 3 Cold sweats often |
| 3 - 1 2 3 "Lump" in throat | 10 - 1 2 3 Extremities cold, clammy | 17 - 1 2 3 Fever easily raised |
| 4 - 1 2 3 Dry mouth-eyes-nose | 11 - 1 2 3 Strong light irritates | 18 - 1 2 3 Neuralgia-like pains |
| 5 - 1 2 3 Pulse speeds after meal | 12 - 1 2 3 Urine amount reduced | 19 - 1 2 3 Staring, blinks little |
| 6 - 1 2 3 Keyed up – fail to calm | 13 - 1 2 3 Heart pounds after retiring | 20 - 1 2 3 Sour stomach frequent |
| 7 - 1 2 3 Cuts heal slowly | 14 - 1 2 3 "Nervous" stomach | |

GROUP TWO

- | | | |
|--|--|--|
| 21 - 1 2 3 Joint stiffness after arising | 29 - 1 2 3 Digestion rapid | 37 - 1 2 3 "Slow starter" |
| 22 - 1 2 3 Muscle-leg-toe cramps at night | 30 - 1 2 3 Vomiting frequent | 38 - 1 2 3 Get "chilled" infrequently |
| 23 - 1 2 3 "Butterfly" stomach, cramps | 31 - 1 2 3 Hoarseness frequent | 39 - 1 2 3 Perspire easily |
| 24 - 1 2 3 Eyes or nose watery | 32 - 1 2 3 Breathing irregular | 40 - 1 2 3 Circulation poor, sensitive to cold |
| 25 - 1 2 3 Eyes blink often | 33 - 1 2 3 Pulse slow; feels "irregular" | 41 - 1 2 3 Subject to colds, asthma, bronchitis |
| 26 - 1 2 3 Eyelids swollen, puffy | 34 - 1 2 3 Gagging reflex slow | |
| 27 - 1 2 3 Indigestion soon after meals | 35 - 1 2 3 Difficulty swallowing | |
| 28 - 1 2 3 Always seems hungry; feels "lightheaded" often | 36 - 1 2 3 Constipation, diarrhea alternating | |

GROUP THREE

- | | | |
|--|--|---|
| 42 - 1 2 3 Eat when nervous | 49 - 1 2 3 Heart palpitates if meals missed or delayed | 53 - 1 2 3 Crave candy or coffee in afternoons |
| 43 - 1 2 3 Excessive appetite | 50 - 1 2 3 Afternoon headaches | 54 - 1 2 3 Moods of depression – "blues" or melancholy |
| 44 - 1 2 3 Hungry between meals | 51 - 1 2 3 Overeating sweets upsets | 55 - 1 2 3 Abnormal craving for sweets or snacks |
| 45 - 1 2 3 Irritable before meals | 52 - 1 2 3 Awaken after few hours sleep – hard to get back to sleep | |
| 46 - 1 2 3 Get "shaky" if hungry | | |
| 47 - 1 2 3 Fatigue, eating relieves | | |
| 48 - 1 2 3 "Lightheaded" if meals delayed | | |

GROUP FOUR

- | | | |
|---|---|---|
| 56 - 1 2 3 Hands and feet go to sleep easily, numbness | 63 - 1 2 3 Get "drowsy" often | 68 - 1 2 3 Bruise easily, "black and blue" spots |
| 57 - 1 2 3 Sigh frequently, "air hunger" | 64 - 1 2 3 Swollen ankles worse at night | 69 - 1 2 3 Tendency to anemia |
| 58 - 1 2 3 Aware of "breathing heavily" | 65 - 1 2 3 Muscle cramps, worse during exercise; get "charley horses" | 70 - 1 2 3 "Nose bleeds" frequent |
| 59 - 1 2 3 High altitude discomfort | 66 - 1 2 3 Shortness of breath on exertion | 71 - 1 2 3 Noises in head, or "ringing in ears" |
| 60 - 1 2 3 Opens windows in closed room | 67 - 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion. | 72 - 1 2 3 Tension under the breastbone, or feeling of "tightness" worse on exertion |
| 61 - 1 2 3 Susceptible to colds and fevers | | |
| 62 - 1 2 3 Afternoon "yawner" | | |

GROUP FIVE

- | | | |
|--|---|---|
| 73 - 1 2 3 Dizziness | 82 - 1 2 3 Worrier, feels insecure | 90 - 1 2 3 History of gallbladder attacks or gallstones |
| 74 - 1 2 3 Dry Skin | 83 - 1 2 3 Feeling queasy; headache over eyes | 91 - 1 2 3 Sneezing attacks |
| 75 - 1 2 3 Burning feet | 84 - 1 2 3 Greasy foods upset | 92 - 1 2 3 Dreaming, nightmare type bad dreams |
| 76 - 1 2 3 Blurred vision | 85 - 1 2 3 Stools light-colored | 93 - 1 2 3 Bad breath (halitosis) |
| 77 - 1 2 3 Itching skin and feet | 86 - 1 2 3 Skin peels on foot soles | 94 - 1 2 3 Milk products cause distress |
| 78 - 1 2 3 Excessive falling hair | 87 - 1 2 3 Pain between shoulder blades | 95 - 1 2 3 Sensitive to hot weather |
| 79 - 1 2 3 Frequent skin rashes | 88 - 1 2 3 Use laxatives | 96 - 1 2 3 Burning or itching anus |
| 80 - 1 2 3 Bitter, metallic taste in mouth in mornings | 89 - 1 2 3 Stools alternate from soft to watery | 97 - 1 2 3 Crave sweets |
| 81 - 1 2 3 Bowel movements painful or difficult | | |

GROUP SIX

- | | | |
|---|---|---|
| 98 - 1 2 3 Loss of taste for meat | 101 - 1 2 3 Coated tongue | 104 - 1 2 3 Mucous colitis or “irritable bowel” |
| 99 - 1 2 3 Lower bowel gas several hours after eating | 102 - 1 2 3 Pass large amounts of foul-smelling gas | 105 - 1 2 3 Gas shortly after eating |
| 100 - 1 2 3 Burning stomach sensations, eating relieves | 103 - 1 2 3 Indigestion ½- 1 hour after eating; may be up to 3 – 4 hrs. | 106 - 1 2 3 Stomach “bloating” after eating |

GROUP SEVEN

- | | | |
|--|---|--|
| (A) | | (E) |
| 107 - 1 2 3 Insomnia | | 150 - 1 2 3 Dizziness |
| 108 - 1 2 3 Nervousness | | 151 - 1 2 3 Headaches |
| 109 - 1 2 3 Can't gain weight | | 152 - 1 2 3 Hot flashes |
| 110 - 1 2 3 Intolerance to heat | | 153 - 1 2 3 Increased blood pressure |
| 111 - 1 2 3 Highly emotional | | 154 - 1 2 3 Hair growth on face or body (female) |
| 112 - 1 2 3 Flush easily | | 155 - 1 2 3 Sugar in urine (not diabetes) |
| 113 - 1 2 3 Night sweats | (C) | 156 - 1 2 3 Masculine tendencies (female) |
| 114 - 1 2 3 Thin, moist skin | 137 - 1 2 3 Failing memory | |
| 115 - 1 2 3 Inward trembling | 138 - 1 2 3 Low blood pressure | (F) |
| 116 - 1 2 3 Heart palpitates | 139 - 1 2 3 Increased sex drive | 157 - 1 2 3 Weakness, dizziness |
| 117 - 1 2 3 Increased appetite without weight gain | 140 - 1 2 3 Headaches, “splitting or rending” type | 158 - 1 2 3 Chronic fatigue |
| 118 - 1 2 3 Pulse fast at rest | 141 - 1 2 3 Decreased sugar tolerance | 159 - 1 2 3 Low blood pressure |
| 119 - 1 2 3 Eyelids and face twitch | | 160 - 1 2 3 Nails weak, ridged |
| 120 - 1 2 3 Irritable and restless | (D) | 161 - 1 2 3 Tendency to hives |
| 121 - 1 2 3 Can't work under pressure | 142 - 1 2 3 Abnormal thirst | 162 - 1 2 3 Arthritic tendencies |
| | 143 - 1 2 3 Bloating of abdomen | 163 - 1 2 3 Perspiration increase |
| (B) | 144 - 1 2 3 Weight gain around hips or waist | 164 - 1 2 3 Bowel disorders |
| 122 - 1 2 3 Increase in weight | 145 - 1 2 3 Sex drive reduced or lacking | 165 - 1 2 3 Poor circulation |
| 123 - 1 2 3 Decrease in appetite | 146 - 1 2 3 Tendency to ulcers, colitis | 166 - 1 2 3 Swollen ankles |
| 124 - 1 2 3 Fatigue easily | 147 - 1 2 3 Increased sugar tolerance | 167 - 1 2 3 Crave salt |
| 125 - 1 2 3 Ringing in ears | 148 - 1 2 3 Women: menstrual disorders | 168 - 1 2 3 Brown spots or bronzing of skin |
| 126 - 1 2 3 Sleepy during day | 149 - 1 2 3 Young girls: lack of menstrual function | 169 - 1 2 3 Allergies – tendency to asthma |
| 127 - 1 2 3 Sensitive to cold | | 170 - 1 2 3 Weakness after colds, influenza |
| 128 - 1 2 3 Dry or scaly skin | | 171 - 1 2 3 Exhaustion – muscular and nervous |
| 129 - 1 2 3 Constipation | | 172 - 1 2 3 Respiratory disorders |
| 130 - 1 2 3 Mental sluggishness | | |
| 131 - 1 2 3 Hair coarse, falls out | | |
| 132 - 1 2 3 Headaches upon arising wear off during day | | |
| 133 - 1 2 3 Slow pulse, below 65 | | |
| 134 - 1 2 3 Frequency of urination | | |
| 135 - 1 2 3 Impaired hearing | | |
| 136 - 1 2 3 Reduced initiative | | |

GROUP EIGHT	FEMALE ONLY	MALE ONLY
173 - 1 2 3 Apprehension	200 - 1 2 3 Very easily fatigued	213 - 1 2 3 Prostate trouble
174 - 1 2 3 Irritability	201 - 1 2 3 Premenstrual tension	214 - 1 2 3 Urination difficult or dribbling
175 - 1 2 3 Morbid fears	202 - 1 2 3 Painful menses	215 - 1 2 3 Night urination frequent
176 - 1 2 3 Never seems to get well	203 - 1 2 3 Depressed feelings	216 - 1 2 3 Depression
177 - 1 2 3 Forgetfulness	204 - 1 2 3 Menstruation excessive and prolonged	217 - 1 2 3 Pain on inside of legs or heels
178 - 1 2 3 Indigestion	205 - 1 2 3 Painful breasts	218 - 1 2 3 Feeling of incomplete bowel evacuation
179 - 1 2 3 Poor appetite	206 - 1 2 3 Menstruate too frequently	219 - 1 2 3 Lack of energy
180 - 1 2 3 Craving for sweets	207 - 1 2 3 Vaginal discharge	220 - 1 2 3 Migrating aches and pains
181 - 1 2 3 Muscular soreness	208 - 1 2 3 Hysterectomy/ovaries removed	221 - 1 2 3 Tire too easily
182 - 1 2 3 Depression; feelings of dread	209 - 1 2 3 Menopausal hot flashes	222 - 1 2 3 Avoids activity
183 - 1 2 3 Noise sensitivity	210 - 1 2 3 Menses scanty or missed	223 - 1 2 3 Leg nervousness at night
184 - 1 2 3 Acoustic hallucinations	211 - 1 2 3 Acne, worse at menses	224 - 1 2 3 Diminished sex drive
185 - 1 2 3 Tendency to cry without reason	212 - 1 2 3 Depression of long standing	
186 - 1 2 3 Hair is coarse and/or thinning		
187 - 1 2 3 Weakness		
188 - 1 2 3 Fatigue		
189 - 1 2 3 Skin sensitive to touch		
190 - 1 2 3 Tendency toward hives		
191 - 1 2 3 Nervousness		
192 - 1 2 3 Headache		
193 - 1 2 3 Insomnia		
194 - 1 2 3 Anxiety		
195 - 1 2 3 Anorexia		
196 - 1 2 3 Inability to concentrate; confusion		
197 - 1 2 3 Frequent stuffy nose; sinus infections		
198 - 1 2 3 Allergy to some foods		
199 - 1 2 3 Loose joints		

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent _____ Standing _____ Pulse _____

Hema-Combistix Urine readings: pH _____ Albumin per cent _____ Glucose per cent _____

Occult Blood _____ pH of Saliva _____ pH of Stool specimen _____ Weight _____

Hemoglobin _____ Blood Clotting Time _____

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES

Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES

The 2nd and 3rd day of flow OR any 5 days in a row.

MALES

Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

Date: _____ Temperature: _____

BP SIT _____

PULSE SIT _____

SALIVA PH _____

BP STAND _____

PULSE STAND _____

BLOOD TYPE _____