# 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_____________________

<u>For your 1st visit-</u>checkmark any symptom you have experienced in the last month. <u>For Re-exams-</u>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_____________________

### EARS
___ Noise (Ring/Hiss/Pound)
___ Plugged
___ Popping
___ Ear Ache
___ Ear Infections
___ Draining
___ Itchy
___ Hearing Loss
___ Dizziness/ Vertigo
___ Excessive Ear Wax
___ Other_____________________

### EYES
___ Burn
___ Tear
___ Ache
___ Red
___ Dry
___ Eye Film
___ Crust in morning
___ Itchy Eyes
___ Bouts of Blurriness
___ Floaters
___ Spots
___ Tired
___ Puffy
___ Stye
___ Twitching around eyes
___ Dark Circles
___ Light Bothers Eyes
___ Nearsighted
___ Farsighted
___ 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
___ Unquechable thirst
___ Other_____________________

### 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
___ Receeding gums
___ Teeth Health Problems

### 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_____________________

### SHORTNESS OF BREATH
___ Constant
___ Upon Exertion
___ Asthma
___ Wheezing
___ Air Hunger/ Frequent Sighs
___ Yawning
___ Emphysema
___ Other_____________________

### STOMACH
___ Heartburn
___ Indigestion
___ Stomach Aches
___ Stomach Cramps
___ Nausea/ Queasy
___ Bloat after Eat
___ Gas/ Flatulence
___ Belching
___ Ulcer
___ Hiatal Hernia
___ 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_____________________

### FECAL CONSISTENCY
___ Color feces light or dark _______
___ Soft/Unformed
___ Ribbon-like
___ Mucous
___ Normal/ Banana Shaped
___ Hard
___ Pebbles
___ Dry
___ Painful
___ Diarrhea
___ Constipation
___ Broken
___ Other

### HEMORRHOIDS
___ History
___ Current
___ Swollen
___ Burn
___ Blood
___ Distended

### For Men Only: PROSTATE
___ History
___ Current
___ Burn
___ Achyness
___ Pain
___ Restriction
___ Dribbling
___ Emission
___ Swelling
___ Other_____________________

### VAGINA (women only)
___ Burn
___ Itch
___ Dry
___ Pain
___ Pain with intercourse
___ Blood
___ Discharge
___ - Clear
___ - White
___ - Yellow
___ - Green
___ - Brown
___ - Odor
___ 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_____________________

### BREASTS (women only)
___ Breast Feeding
___ Fibrosis
___ Lump
___ Discharge
___ Prosthesis
___ Augmentation Surgery
___ Reduction Surgery
___ Pathology
___ Breast Tender constant
___ Other

### MENOPAUSE (women only)
___ Natural
___ Surgical (partial/complete)
___ Hormones
___ Patch

### CRAMPS/ ACHES/ RESTLESS
___ Cramps (legs/feet/arms/hands)
___ Aches (legs/feet/arms/hands)
___ Restless (legs/feet/arms/hands)

### 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

### URINATION
___ _____times per day-frequency
___ Urinate at night ____ per night
___ Frequency
___ Urgency
___ Burning
___ Pain
___ Odor
___ Spasm
___ Leakage
___ Urinary Tract Infection
___ Kidney Troubles
___ 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_____________________

### EMOTIONS
___ Stressed
___ Sad
___ Grief
___ Depression
___ Moodiness
___ Irritable
___ Worrisome
___ Angry
___ Nervous
___ Frustrated
___ Anxiety
___ Panic
___ Cry
___ Fear
___ Shame

### 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

### ENERGY
___ Low
___ Variable
___ Normal
___ High
___ Slow to start in the morning
___ Energy Crash_______am/pm
___ Low Energy after meals
___ 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_____________________

### LIBIDO/ SEXUALITY
___ Flat
___ Low
___ Normal
___ Erectile Dysfunction (men)
___ Orgasm Quality (poor/ good/ great)
___ 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

### List Your Primary Concerns in order of importance to you:
1) _____________________
_____________________
2) _____________________
_____________________
3) _____________________
_____________________
4) _____________________
_____________________

### 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 (Rt/ Lt) mild/mod/severe)
Weight ____(+/-___lbs) overall(+/-___)
Height______
Pulse______BP:(_____/_____)
saliva pH_______ Urine pH_______
Allergies___________________
Current Meds:__________________

# FEMALE HEALTH HISTORY QUESTIONNAIRE

Name ______________________________________________ Age: _______ Today's date: ______________

Birth Date: _____________ Weight: _______ Height: _________ Occupation: ______________________________

What is the reason for this visit?

______________________________________________________________________________

______________________________________________________________________________

List medications you are currently taking:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Any known drug allergies? ______________________________________________________________

List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

List your history of GYN procedures or surgeries (ovaries, hysterectomy, tubal ligation, breast, etc.)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

List significant non-GYN health issues (diabetes, surgeries, etc.):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Date of last pelvic/gynecological exam: __________ Last Pap Test: __________ Last mammogram: __________

Last thermography? _____________ Unusual results? ________________________________________________

Are you currently under another physician's care? ________________________________________________

Do you eat sugar/refined carbs? Yes No How much/how often? _____________________________________

Do you drink alcohol? Yes No How much/how often? _________________________________________

Do you smoke? Yes No How much/how often? _______________________________________________

How often do you exercise? never rarely sometimes regularly competitively



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| Signs & Symptoms | Ongoing | Just w/ period | Mild | Moderate | Severe | More Information |
|---|---|---|---|---|---|---|
| Mood swings | | | | | | |
| Anxiety/Nervousness | | | | | | |
| Overly Reactive/Short fuse | | | | | | |
| Irritability | | | | | | |
| Depression | | | | | | |
| Lowered self-esteem/self-image | | | | | | |
| Caretake others before yourself | | | | | | |
| Sadness/Crying | | | | | | |
| Foggy thinking | | | | | | |
| Memory difficulties | | | | | | |
| Fatigue | | | | | | |
| Constant hunger | | | | | | |
| Sweet cravings (carbs/chocolate) | | | | | | |
| Hypoglycemia | | | | | | |
| Hyperglycemia (diabetes) | | | | | | |
| Weight gain | | | | | | |
| Weight loss | | | | | | |
| Water Retention | | | | | | |
| Bloating | | | | | | |
| Irritable Bowel | | | | | | |
| Constipation | | | | | | |
| Light colored stool | | | | | | |
| Loose stool/Diarrhea | | | | | | |
| Nausea/vomiting | | | | | | |
| Headaches/Migraines | | | | | | |
| Body/Joint Aches | | | | | | |
| Back Ache | | | | | | |
| Acne | | | | | | |
| Excessive facial hair | | | | | | |
| Body/Head hair loss | | | | | | |
| Dry skin/Brown spots | | | | | | |
| Lowered Libido | | | | | | |
| Heightened Libido | | | | | | |
| Hot flashes | | | | | | |
| Night sweats | | | | | | |
| Breast tenderness/swelling | | | | | | |
| Nipple discharge | | | | | | |
| Vaginal infections | | | | | | |
| Urinary frequency | | | | | | |
| Incontinence | | | | | | |
| Vaginal dryness | | | | | | |
| Painful intercourse | | | | | | |

**Any other symptoms?** ____________________________________________

____________________________________________



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**REPRODUCTIVE HEALTH HISTORY** *(please fill in or circle the appropriate answer)*

Age at onset of menarche (first period): ________ Approximate date of onset: ______________

Are you currently using a method of birth control? Yes No

If yes, what method? ______________________________________________

Are you, or have you used *(please circle)* oral, injected, patch, or ring hormone contraceptives? Yes No

When and for how long? ______________________________________________

Have you ever used Emergency Contraception (aka "the day after pill")? Yes No Year: ____________

Any unusual reactions? ______________________________________________

Are you, or have you used an IUD? Yes No If yes, when and for how long? ________________

What type of IUD did you use? copper hormone other ______________________

Please describe problems that you may have experienced associated with the use of any and all birth control methods (such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue depression, palpitations, etc.)

______________________________________________

______________________________________________

______________________________________________

Have you used, or are you currently using fertility or treatment? Yes No

If yes, please explain. ______________________________________________

Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? Yes No If yes, please explain: ______________________

______________________________________________

Have you been pregnant before? Yes No

Number of pregnancies? ________ Details/ Complications: ______________________________

Number of live births: __________ ______________________________

Miscarriages: __________ ______________________________

Premature births: ________ ______________________________

Cesarean births: ________ ______________________________

Stillbirths: ____________ ______________________________

Abortions: ____________ ______________________________

Ectopic pregnancies ______ ______________________________

If you have had a miscarriage, how many weeks pregnant were you? ____________________________

______________________________________________

Did you breastfeed? Yes No How long? ______________________________

Have you had an abnormal Pap Test? Yes No Diagnosis/Reason: ______________________

Treatment and/or Medication: ______________________________________________

Have you had a vaginal infection? Yes No If yes, what? ______________________________

Treatment and/or Medication: ______________________________________________

Any history of… Ovarian cysts? Yes No Uterine fibroids? Yes No

Fibrocystic Breasts? Yes No Endometriosis? Yes No

Polycystic Ovarian Syndrome (PCOS)? Yes No


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**FOR CYCLING-AGE WOMEN** *(please fill in or circle the appropriate answer)*

First day of last menstrual period (LMP): ____________

Has there been any recent change in your cycle or symptoms associated with your cycle? Yes No

If yes, please give details. ________________________________________________

________________________________________________

________________________________________________

________________________________________________

How many days is your current cycle? (Counted from the first day of your period to the first day of your next period)

<20 _______ 20-30 _________ 30-40 _________ 40-50 ________ >50 ________

How many days does menstruation typically last? ________

Is your cycle regular? Yes No Not Always Details: ________________________

Typical menstrual flow: Light Medium Heavy Details: ________________________

How many *pads* and/or *tampons* (circle) are used on heavy days? _________

Do you pass clots? Yes No How often? ________________________

Do you spot? Yes No At what point in your cycle? ________________________

Do you experience cramping? None Mild Moderate Severe

At what point in your cycle? ________________________

Do you experience abnormal vaginal discharge? Yes No If yes, when? ________________

Do you experience vaginal itching and/or odor? Yes No If yes, when? ________________

Do you experience breast tenderness? None Mild Moderate Severe

At what point in your cycle? ________________ Change in breast size? Yes No

Do experience nipple discharge? Yes No If yes, when? ________________________

What color? ________________________________________________

**FOR MENOPAUSAL WOMEN** *(please fill in or circle the appropriate answer)*

Your age at the onset of menopause: _______ Year of onset: _______________

Have you had a hysterectomy? complete *(ovaries AND uterus)* partial *(uterus only)*

Date of hysterectomy: _______________ Reason for hysterectomy: ________________________

________________________________________________

________________________________________________

Describe your experience transitioning into menopause *(symptoms, strong emotions, thoughts, unusual stressors, etc.)*

________________________________________________

________________________________________________

________________________________________________

________________________________________________

________________________________________________



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**MENOPAUSAL WOMEN, CONT'D**

Have you used, or are you currently using, conventional hormone replacement therapy (HRT)? Yes No

If yes, what were you prescribed? ____________________

What dosage? ____________________ For how long? ____________________

Have you used, or are you currently using, bioidentical hormone creams/gels/sublingual, troche, oral, other? Yes No

If yes, what? ____________________

What dosage? ____________________ For how long? ____________________

Have you utilized any alternative, complementary, or natural remedies in your management of menopause? Yes No

If yes, what? ____________________

What dosage? ____________________ For how long? ____________________

Have you had, or do you have any vaginal spotting or bleeding since menopause? Yes No

If yes, when? ____________________ Were you evaluate and/or treated by a GYN? Yes No

Treatment: ____________________

***PLEASE DESCRIBE YOUR CYCLE HISTORY.***

How would you have described your menstruation?

Easy Uncomfortable Difficult Debilitating

What was your typical menstrual flow? Light Medium Heavy

When you were cycling would you consider your cycle regular? Yes No

If no, explain. ____________________

Please describe any 'treatment' you ever received for cycle issues. ____________________

____________________

____________________

**<u>SLEEP HABITS</u>**

How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

How long has this been happening? ____________________

How many hours do you sleep a night on average? ___________

Do night sweats wake you up? Yes No How often? ____________________

Do you wake up tired? Yes No How long has this been happening? ____________________

Is your room completely dark when you sleep at night? *(no night light, street lamp, TV, etc.)* Yes No

Do you get at least 30 minutes of outside daylight time, several days each week? Yes No



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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. Bloated 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 questions16a-16f below.

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

| Question | Rating |
|---|---|
| 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 |
|---|---|---|---|---|---|---|---|

| Question | Rating |
|---|---|
| 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.

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

## GROUP TWO

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

## GROUP THREE

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

## GROUP FOUR

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

## GROUP FIVE

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

## GROUP SIX

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

## GROUP SEVEN

**(A)**

107 - 1 2 3 Insomnia
108 - 1 2 3 Nervousness
109 - 1 2 3 Can't gain weight
110 - 1 2 3 Intolerance to heat
111 - 1 2 3 Highly emotional
112 - 1 2 3 Flush easily
113 - 1 2 3 Night sweats
114 - 1 2 3 Thin, moist skin
115 - 1 2 3 Inward trembling
116 - 1 2 3 Heart palpitates
117 - 1 2 3 Increased appetite without weight gain
118 - 1 2 3 Pulse fast at rest
119 - 1 2 3 Eyelids and face twitch
120 - 1 2 3 Irritable and restless
121 - 1 2 3 Can't work under pressure

**(B)**

122 - 1 2 3 Increase in weight
123 - 1 2 3 Decrease in appetite
124 - 1 2 3 Fatigue easily
125 - 1 2 3 Ringing in ears
126 - 1 2 3 Sleepy during day
127 - 1 2 3 Sensitive to cold
128 - 1 2 3 Dry or scaly skin
129 - 1 2 3 Constipation
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

**(C)**

137 - 1 2 3 Failing memory
138 - 1 2 3 Low blood pressure
139 - 1 2 3 Increased sex drive
140 - 1 2 3 Headaches, "splitting or rending" type
141 - 1 2 3 Decreased sugar tolerance

**(D)**

142 - 1 2 3 Abnormal thirst
143 - 1 2 3 Bloating of abdomen
144 - 1 2 3 Weight gain around hips or waist
145 - 1 2 3 Sex drive reduced or lacking
146 - 1 2 3 Tendency to ulcers, colitis
147 - 1 2 3 Increased sugar tolerance
148 - 1 2 3 Women: menstrual disorders
149 - 1 2 3 Young girls: lack of menstrual function

**(E)**

150 - 1 2 3 Dizziness
151 - 1 2 3 Headaches
152 - 1 2 3 Hot flashes
153 - 1 2 3 Increased blood pressure
154 - 1 2 3 Hair growth on face or body (female)
155 - 1 2 3 Sugar in urine (not diabetes)
156 - 1 2 3 Masculine tendencies (female)

**(F)**

157 - 1 2 3 Weakness, dizziness
158 - 1 2 3 Chronic fatigue
159 - 1 2 3 Low blood pressure
160 - 1 2 3 Nails weak, ridged
161 - 1 2 3 Tendency to hives
162 - 1 2 3 Arthritic tendencies
163 - 1 2 3 Perspiration increase
164 - 1 2 3 Bowel disorders
165 - 1 2 3 Poor circulation
166 - 1 2 3 Swollen ankles
167 - 1 2 3 Crave salt
168 - 1 2 3 Brown spots or bronzing of skin
169 - 1 2 3 Allergies – tendency to asthma
170 - 1 2 3 Weakness after colds, influenza
171 - 1 2 3 Exhaustion – muscular and nervous
172 - 1 2 3 Respiratory disorders

## GROUP EIGHT

173 - 1 2 3 Apprehension
174 - 1 2 3 Irritability
175 - 1 2 3 Morbid fears
176 - 1 2 3 Never seems to get well
177 - 1 2 3 Forgetfulness
178 - 1 2 3 Indigestion
179 - 1 2 3 Poor appetite
180 - 1 2 3 Craving for sweets
181 - 1 2 3 Muscular soreness
182 - 1 2 3 Depression; feelings of dread
183 - 1 2 3 Noise sensitivity
184 - 1 2 3 Acoustic hallucinations
185 - 1 2 3 Tendency to cry without reason
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

## FEMALE ONLY

200 - 1 2 3 Very easily fatigued
201 - 1 2 3 Premenstrual tension
202 - 1 2 3 Painful menses
203 - 1 2 3 Depressed feelings
204 - 1 2 3 Menstruation excessive and prolonged
205 - 1 2 3 Painful breasts
206 - 1 2 3 Menstruate too frequently
207 - 1 2 3 Vaginal discharge
208 - 1 2 3 Hysterectomy/ovaries removed
209 - 1 2 3 Menopausal hot flashes
210 - 1 2 3 Menses scanty or missed
211 - 1 2 3 Acne, worse at menses
212 - 1 2 3 Depression of long standing

## MALE ONLY

213 - 1 2 3 Prostate trouble
214 - 1 2 3 Urination difficult or dribbling
215 - 1 2 3 Night urination frequent
216 - 1 2 3 Depression
217 - 1 2 3 Pain on inside of legs or heels
218 - 1 2 3 Feeling of incomplete bowel evacuation
219 - 1 2 3 Lack of energy
220 - 1 2 3 Migrating aches and pains
221 - 1 2 3 Tire too easily
222 - 1 2 3 Avoids activity
223 - 1 2 3 Leg nervousness at night
224 - 1 2 3 Diminished sex drive

## 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__________ BP STAND__________
PULSE SIT__________ PULSE STAND__________
SALIVA PH__________ BLOOD TYPE__________