FOLLOW UP ASSESSMENT

Name: ______________________________ Date: ___________________________

Please take your time and be thorough in completing this application.

List your five major health complaints in order of importance.
RATE THEM USING THE POINT SCALE BELOW

	Please circle one
1. ______________________________	0 1 2 3 4
2. ______________________________	0 1 2 3 4
3. ______________________________	0 1 2 3 4
4. ______________________________	0 1 2 3 4
5. ______________________________	0 1 2 3 4

Please rate each of the following symptoms based upon your typical health profile for the last week.

Point scale: 0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occastionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

General Symptoms

____ Poor Appetite
____ Heavy Appetite
____ Strong thirst
____ Lack of thirst
____ Poor Sleep
____ Heavy Sleep
____ Sleepy after meals
____ Bitter taste in mouth
____ Anxiety
____ Anger
____ Depression
____ Grief
____ Addictive nature
____ Fatigue
____ Lack of strength
____ Nose bleeds easily or tend to bruise easily

____ Dream disturbed sleep
____ Cold Hands or Feet
____ Poor Circulation
____ Lack of interest
____ Crave chocolate
____ Difficulty swallowing
____ Difficulty falling asleep
____ Vertigo or Dizziness
____ Bleed Easily
____ Bruise Easily
____ Difficulty losing weight
____ Feel warm
____ Feel Cold
____ Night Sweats
____ Bodily Heaviness
____ Muscle cramping, with or with out exertion

____ Food allergies/sensitivity
____ Crave bread or noodles
____ Poor tolerance to sugar
____ Crave sweets
____ Clench or grind teeth
____ Fear of impending doom
____ Worrier, apprehensive
____ Restless leg syndrome
____ Sleepy in the afternoon
____ Seasonal allergies
____ Shortness of Breath
____ Sweat Easily
____ Muscle Cramps
____ Lack of motivation, initiative
____ Slow starter in the morning
____ Crave coffee or sugar in the afternoon to maintain energy

____ Pain between shoulder blades
____ Sensitive to chemicals or fumes
____ Chronic fatigue or fibromyalgia
____ Eat dessert or sugary snacks
____ Cuts heal slowly or scar easily
____ Specific foods cause bloating & fatigue
____ Awaken after a few hours of sleep
____ Difficulty focusing or general brain fog
____ Shaky or irritable if meals are delayed
____ Binge or uncontrolled eating
____ Strong light irritates eyes
____ Calm on the outside, troubled inside
____ Difficulty gaining weight, even with normal appetite
____ Peculiar taste in mouth
Describe: ______________________
____

Women:

____ Breast tenderness
____ Painful intercourse
____ Vaginal dryness
____ Vaginal itchiness
____ Excess facial or body hair

Men:

____ Night sweats
____ Prostate Problems
____ Impotence
____ Premature ejaculation
____ Nocturnal Emission

Head, Eyes, East, Nose, Throat

____ Eye strain
____ Eye Pain
____ Red Eyes
____ Itchy Eyes
____ Dry Eyes
____ Spots in Eyes
____ Poor Vision
____ Blurred Vision
____ Night blindness

____ Glaucoma
____ Cataracts
____ Teeth Problems
____ Grinding Teeth
____ TMJ
____ Facial Pain
____ Gum Problems
____ Sores on lips
____ Sores on tongue

____ Dry Mouth
____ Excessive Saliva
____ Sinus Problems
____ Excessive Phlegm
(Color of Phlegm) ________
____ Recurrent Sore Throat
____ Swollen Glands
____ Lumps in Throat
____ Enlarged Thyroid

____ Nose Bleeds
____ Ringing in Ears
____ Poor Hearing
____ Earaches
____ Headaches
____ Migraines
____ Concusions
____ Other Head/Neck Problems

Respiratory

____ Difficulty Breathing when lying on back
____ Shortness of Breath
____ Tight Chest
____ Asthma /wheezing

____ Cough
Wet or Dry? ________
Thick or Thin? ________
(Color of Phlegm) ________

____ Pneumonia
____ Coughing Blood

Cardiovascular

____ High Blood Pressure
____ Blood Clots
____ Low Blood Pressure

____ Fainting
____ Chest Pain
____ Difficulty Breathing

____ Rapid heart rate
____ Heart Palpitations
____ Phlebitis

____ Irregular Heart beat

Other: ______________

Gastrointestinal

____ Nausea
____ Vomiting
____ Acid Reflux
____ Gas
____ Hiccup
____ Bloating
____ Diarrhea

____ Constipation
____ Laxative Use
____ Black stools
____ Bloods stools
____ Mucous in stools
____ Intestinal Pain
____ Intestinal Cramping

____ Itchy anus
____ Burning anus
____ Rectal Pain
____ Hemorrhoid
____ Anal Fissures
____ Bad breath

Bowel Movements:
____ Light or clay colored stools
Color ________________
Odor ________________
Frequency ______________
Texture ______________
Form ________________

Musculoskeletal

____ Neck/Shoulder
____ Muscle Pain

____ Low Back Pain
____ Upper Back Pain

____ Joint Pain
____ Rib Pain

____ Limited Range of motion
____ Limited Use

Skin and Hair

____ Rashes
____ Hives
____ Ulcerations

____ Brittle or weak nails
____ Eczema
____ Psoriasis

____ Acne
____ Dandruff
____ Itching

____ Change in Hair/skin texture
____ Fungal Infections
____ Dryness

Neuropsychological

____ Seizures
____ Ticks

____ Numbness

____ Brain Fog

____ Poor Memory

Genito - Urinary

____ Darkly Colored Urine
____ Cloudy Urine
____ Incomplete Urination

____
____ Unable to Hold Urine
____ Urgency to Urinate
____ Increased frequency

____ Wake to urinate
____ Bedwetting
____ Kidney stone

____ Increased libido
____ Decreased libido

Other: *Please list symptoms and rate the severity using the point scale on previous page.*

Please circle one

____ 0 1 2 3 4
____ 0 1 2 3 4
____ 0 1 2 3 4
____ 0 1 2 3 4