

Symptoms:

Please check all that apply to you.

C = Current or P = past

Headache

Migraine ___

Tension ___

Sinus ___

Ophthalmic

Eye pain / Itchy eye ___

Tearing ___

Puffy lids ___

Red, "bloodshot" eyes ___

Otology

Fluid in the ears ___

Ringing in ears ___

Vertigo / Dizziness ___

Respiratory

Asthma / Difficulty Breathing ___

Postnasal discharge ___

Laryngitis ___

Cough ___

Bronchitis ___

Snoring ___

Blocked sinuses/ Sinusitis

Cardiovascular

Irr. heart beat / Palpitation

Varicose veins ___

Fainting ___

Pericarditis ___

Flushing ___

Hot flashes / Night sweats

Blood pressure

(high or low) ___

Chest pain ___

Cold feet/hands ___

Blood clots ___

Gastrointestinal

Belching ___

Nausea/Vomiting ___

Hrtburn / Indigestion ___

Gassiness/Passing gas ___

Abdominal pain ___

Abdominal cramps ___

Diarrhea ___

Constipation ___

IBS ___

Bloating ___

Food allergies or

intolerances ___

Urological

Painful urination ___

Frequent urination at night ___

Poor bladder control ___

Muscular

Muscle spasm/cramps ___

Muscle pain or weakness ___

Backache ___

Sciatica ___

Bursitis ___

TMJ syndrome / Jaw pain ___

Skeletal

Scoliosis ___

Arthritis: Osteo or Rheum. ___

Joint swelling ___

Joint stiffness ___

Pain ___

Bone spurs ___

Nervous System/Cerebral

Herpes / Shingles ___

Numbness / Tingling ___

Insomnia / Sleep disorders ___

Anxiety / Hyperactivity ___

Tremors ___

Depression ___

Fatigue / Sluggishness ___

Uncontrolled anger ___

Restless leg ___

Autoimmune Disorders

Lupus ___

Multiple Sclerosis ___

Fibromyalgia /CFS ___

Other disorders

Other

Anemia ___

Cancer / Tumors ___

Diabetes ___

Eating Disorders ___

Drug / alcohol addiction ___

Nicotine/caffeine addiction ___

Reproductive

Pregnant: Yes or No

PMS

Medications

Date: _____

Signature: _____

