Remedies LLC

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NAME: _____ DATE: _____

YOUR HEALTH HISTORY: *Circle all that are applicable*

ADD	Cataracts	Hepatitis	Multiple Sclerosis	Spinal Meningitis
ADHD	Celiac	Hernia	Mumps	Stroke
AIDS/HIV	Chem. Dependency	Herniated Disc	Muscular Dystrophy	Suicide Attempt
Alcoholism	Chicken Pox	Herpes	Osteoporosis	Thyroid Problems
Allergy Shots	Crohn's	High Blood Pressure	Pacemaker	Tonsillitis
ALS	COPD	High Cholesterol	Parkinson's Disease	Tuberculosis
Anemia	Depression	Hyper-Glycemia	Pinched Nerve	Tumors, Growths
Anorexia	Diabetes	Hypo-Glycemia	Pneumonia	Typhoid Fever
Appendicitis	Emphysema	Kidney Issues	Polio	Ulcers
Arthritis	Epilepsy	Liver Disease	Prostate Problems	Vasculitis- all forms
Asthma	Fibromyalgia	Low Blood Pressure	Prosthesis	Vaginal Infections
Bipolar	Fractures	Lupus	Psoriasis	Venereal Disease
Bleeding Disorders	Glaucoma	Lyme's	Psychiatric Care	Whooping Cough
Breast Lump	Goiter	Measles	Rheumatic Fever	Other_____
Bronchitis	Gonorrhea	Migraines	Rheumatoid Arthritis	_____
Bulimia	Gout	Miscarriage	Scarlet Fever	_____
Cancer	Heart Disease	Mononucleosis	Shingles	_____

Surgeries:_____
_____
_____

Women: Are you pregnant? _____ Nursing? _____ Menopause? _____

Do you have any amalgam (silver/metal) dental fillings? _____

PLEASE LIST BELOW YOUR MAIN HEALTH CONCERNS IN ORDER OF IMPORTANCE:

1. _____

2. _____

3. _____

4. _____

List all Medications, Supplements, Herbs or Homeopathics
PLEASE BRING THESE ALONG WITH YOU

Do you smoke? Yes No
If so, what brand?_____
Frequency_____

Do you drink alcoholic or caffeinated beverages? Yes No
If so, what
type_____Frequency_____

HEALTH GOALS: _____

_____

HEALTH EVALUTION

Mark (1) for MILD, (2) for MODERATE, (3) for SEVERE –Leave blank for no symptom

GROUP ONE

___ "Nervous" Stomach
___ Not mentally alert, quick
___ Cold sweats often
___ Dry Mouth, eyes, nose
___ Extremities cold, clammy
___ Fever easily raised
___ Pulse speeds after meal
___ Heart pounds after retiring
___ Neuralgia-like pains
___ Keyed up; fail to calm
___ Acid foods upset
___ Symptoms made worse by emotional stress?
TOTAL _____

GROUP TWO

___ Perspire easily
___ Digestion rapid
___ Joint stiffness after rising
___ Muscle/leg/toe cramps
___ Vomiting frequent
___ Poor circulation/sensitive to cold
___ Eyelids swollen, puffy
___ Difficulty swallowing
___ Subject to colds/asthma/ Bronchitis
___ Indigestion soon after meals
___ Constipation, diarrhea
___ Symptoms made worse by physical stress?
TOTAL _____

GROUP THREE

___ Afternoon headaches
___ Heart palpitates if meals missed or delayed
___ Crave candy or coffee in afternoons
___ Faintness if meals missed or delayed
___ Awaken after few hours' can't get back to sleep
___ Abnormal craving for sweets or snacks
___ Get "shaky" if hungry
TOTAL _____

GROUP FOUR

___ Bruise easily
___ Swollen ankles
___ Hands & feet go to sleep easily, numbness
___ Sigh frequently
___ Muscle cramps
___ Breath heavily
___ Shortness of breath
___ Tendency to anemia
___ Susceptible to colds/fevers
___ Opens window in rooms
___ Dull pain in chest or radiating into left arm
___ Tightness under breastbone
TOTAL _____

GROUP FIVE

___ Dry skin

___ Skin rashes frequent

___Gallbladder attacks/stones

___ Bitter metallic taste in mouth in mornings

___ Constipation, headaches

___ Greasy foods upset

___ Pain between shoulder blades

___ Bowel movements painful or difficult

___ Laxatives used often

___ Stools light colored

___ Sneezing attacks

TOTAL _____

GROUP SIX

___ Lower bowel gas after eating

___ Coated tongue

___ Stomach "bloating" after eating

___ Gas shortly after eating

___ Burning stomach sensations, eating relieves

___ Indigestion after eating; may continue for 3 or 4hrs

TOTAL _____

GROUP SEVEN

(A)

___ Pulse fast at rest

___ Nervousness

___ Can't gain weight

___ Intolerance to heat

___ Highly emotional

___ Flush easily

___ Night sweats

___ Inward trembling

___ Heart palpitates

___ Insomnia

TOTAL _____

(B)

___ Impaired hearing

___ Decrease in appetite

___ Increase in weight

___ Ringing in ears

___ Constipation

___ Mental sluggishness

___ Headaches upon arising wear off during the day

___ Slow pulse, below 65

TOTAL _____

(C)

___ Low blood pressure

___ Failing memory

___Increased sex desire

___ Headaches

___Decreased sugar tolerance

TOTAL _____

(D)	(E)	(F)
___ Bloating of intestines	___ Hot flashes	___ Chronic fatigue
___Abnormal thirst	___Headaches	___Low blood pressure
___Weight gain around hips or waist	___Dizziness	___Weakness, dizziness
___Sex desire reduced or lacking	___Increased blood pressure	___Tendency to hives
___Tendency to ulcers, colitis	___Sugar in urine (not Diabetes)	___Arthritic tendencies
___Increased sugar tolerance	___Masculine tendencies-female	___Perspiration increases
___Menstrual disorders		___Crave salt
___Delayed Menstruation		___Brown spots on skin
		___Allergies-Asthma
		___Exhaustion muscular/nerves
		___Respiratory disorders
TOTAL_____	TOTAL_____	TOTAL_____

GROUP EIGHT

(Female Only)

___ Painful menses	___ Menstruation excessive	___Vaginal discharge
___ Premenstrual tension	___Menopause, hot flashes	___Menses scanty
___ Very easily fatigued	___ Painful breasts	___Acne, worse at menses
___ Depressed before menses	___ Menstruate too frequently	TOTAL_____

(Male Only)

___ Tire too easily	___ Pain on inside of legs or heel	___ Prostate trouble
___ Urination difficult at night	___ Feeling of incomplete bowel evacuation	___ Leg nervousness
___ Night urination frequent	___ Diminished sex desire	TOTAL _____

GROUP NINE

___ Chronic cough
___ Pain around ribs
___ Shortness of breath
___ Chest pain
___ Difficulty breathing
___ Coughing up phlegm
___ Coughing up blood
___ Sensitive to smog
___ Bronchitis (frequent)
___ Infections settle in lungs

TOTAL _____

GROUP TEN

___ Frequent urination
___ Rose colored (bloody)
___ Dripping after urination
___ Difficulty passing urine
___ Cloudy urine
___ Rarely need to urinate
___ Strong smelling urine
___ Frequent bladder infections
___Painful/burning when passing urine
___ Urination when you cough or sneeze

TOTAL _____

GROUP ELEVEN

___ Throat infections
___ Poor wound healing
___ Slow to recover from colds or flu
___ Chronic lung congestion
___ Post nasal drip
___ Gets boils or styes
___ Swollen lymph glands
___ Catch colds or flu easily
___ Breathe through mouth
___ Swollen tongue
___ Bumpy skin on back of arms
___ Inflamed/bleeding gums
___ Hyperactivity
___ Food sensitivity or allergies

TOTAL _____