Body Symmetry

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PLEASE PRINT LEGIBLY All information for office use only.

Date _____ DOB_____ Age____ Gender _____

Name _____ Phone _____

Full Address _____

Email (for newsletters and special offers) _____

Occupation _____ How did you hear about us? _____

Emergency contact info _____

Personal goals relating to services _____

Military (past or present) or immediate family member _____

Colonic clients: Is this your first colonic? ___Y ___ N If not, when and where was the last one? _____

GENERAL HEALTH

Have you been hospitalized? _____ When? _____ Why? _____
Have you been diagnosed with a major illness/disease? _____ When? _____ What? _____
_____
_____
Please explain any kind of medical treatments you are currently receiving. _____
_____
Please list any medications you are taking any why. _____
_____
_____
Please list any supplements you are taking and why. _____
_____
_____
Please list any kind of 'program' you are on. Ex: fasting, weight loss, nutrition, etc. _____
_____
_____
_____
Please list all allergies. _____

Are you currently pregnant? ☐ yes ☐ no How many pregnancies?___ full term___ miscarriage___ abortion___.
Did you gain additional weight with each pregnancy? ☐ yes ☐ no Did you lose your pregnancy weight with each child? ☐ yes ☐ no

How often are your bowel movements? _____ Constipation? ☐ yes ☐ no

Do you have any metal surgical parts in your body? ☐ yes ☐ no

Do you currently have, or have you had in the past, any of the following: **C** for Current, **P** for Past

___ abdominal gas/**pain**
___ **abdominal hernia**
___ acid reflux
___ AIDS/HIV
___ anal bleeding
___ anal discomfort/itching
___ anxiety
___ anemia
___ **aneurysm**
___ anorexia
___ appendicitis
___ arthritis
___ asthma
___ Atonic colon
___ auto immune disorder
___ bad breath
___ belching
___ bloating, general
___ bloating, after eating
___ blood pressure high/low
___ blood sugar high/low
___ Bulimia
___ **Cancer**: type _____
___ Candida
___ Celiac disease
___ cholesterol high/low
___ chronic fatigue
___ chronic pain
___ **cirrhosis**
___ **colitis**
___ **congestive heart failure**
___ **contagious disease**
___ constipation
___ cramping
___ **Crohn's disease**
___ depression
___ Diabetes
___ dialysis
___ diarrhea
___ Diverticulosis
___ **Diverticulitis**
___ dizziness
___ eczema
___ edema
___ environmental allergies
___ **Epilepsy**
___ Epstein-Bar Virus
___ extreme weight gain/loss
___ fainting
___ fatigue after eating
___ fever/chills
___ Fibromyalgia
___ fibroid cysts
___ **fissure/fistula**
___ gallstones
___ headaches/migraines
___ ulcer
___ **heart condition**
___ **hemorrhoids**
___ IBS
___ indigestion
___ **intestinal perforation**
___ irregular period
___ kidney disorder
___ kidney stones
___ liver disorder
___ loss of sleep
___ low libido
___ lung disorder
___ Lupus
___ Lyme disease
___ metal toxicity
___ menopause
___ mental disorder
___ nausea
___ Osteopenia
___ Osteoporosis
___ pace maker
___ parasites
___ PMS
___ polyp
___ prolapsed colon
___ prostate disorder
___ **recent surgery**
___ **rectal bleeding**
___ **renal insufficiencies**
___ **seizures**
___ sinus condition
___ skin condition
___ spastic colon
___ sweats
___ thyroid disorder
___ ulcer
___ urinary tract infection
___ vomiting
___ other

DIETARY

Are you: Vegan? _____ Vegetarian? _____ Omnivorous?(eat animal protein) _____

Do you want to change? _____ To which group? _____ Why? _____

Usual breakfast _____

Usual lunch _____

Usual dinner _____

Usual snack _____

List any cravings you have on a regular basis _____

Do you have sensitivities to any of the following? _____Lactose _____casein _____wheat _____gluten

_____night shade foods _____ additives _____ dyes _____ MSG _____ preservatives _____ latex

Have you had any significant physical and/or emotional trauma? _____ If yes, please explain. _____

_____

If you have an exercise routine, please explain. _____

Indicate your consumption accordingly.
H-Heavy(5-7 times per week) **M-Moderate**(2-4 times per week) **L-Light**(1 time or less per week) **N-**Never

____ fresh fruit
____ fresh vegetable juice
____ fresh fruit juice
____ smoothies
____ nuts/seeds
____ beans
____ meats: chicken___ beef___ pork___ fish ___ lamb ___ shellfish ___ turkey ___
____ eggs
____ salad
____ raw vegetables
____ water
____ salt
____ organic foods

____ candy
____ alcohol
____ cooked vegetables
____ caffeine (coffee/tea)
____ soda
____ dairy: milk, cheese, yogurt, ice cream
____ night shade family: eggplant___ peppers___ potatoes___ tomatoes___
____ processed foods
____ flour products
____ fast foods
____ sugar
____ Tobacco
____ antacids

OTHER:
How much water do you drink per day? What is the source? _____
Do you drive a Hybrid? ☐ yes ☐ no
Do you live near radio towers, high power lines, sub-station, etc.? ☐ yes ☐ no
What electrical appliances are in your bedroom?_____
Where is your cell phone while you sleep? _____
Ever have Lyme disease? ☐ yes ☐ no What was the treatment? _____
Ever been exposed to mold? ☐ yes ☐ no Explain. _____

All information provided above is true and complete. I have no expectation of a diagnosis, prescription or cure and service/consultation is NOT a substitute for medical exam, treatment or diagnosis.

I understand the required 24 hour cancellation notice for all reschedules and cancellations with the only exception being a medical emergency for myself or my immediate family. I agree to pay the $30 fee for missed appointments if I fail to provide the required notice.

Signature _____ Date _____

Initial Symptom Survey

Date:	Patient Name:	Practitioner:

INSTRUCTIONS: Score every symptom based on your experience **OVER THE PAST MONTH**. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score to the left of EVERY symptom listed. Write the "Grand Total" at the top. Also note the number of missed work days you have had in the last month due to illness.

SCALE OF SYMPTOM POINTS

IF you did not suffer from the symptom ever or almost never, leave it blank.

1 = **OCCASIONALLY** (less than 2 times per week) and symptom **was MILD**
2 = **FREQUENTLY** (2 or more times per week) and symptom **was MILD**
3 = **OCCASIONALLY** (less than 2 times per week) and symptom **was SEVERE**
4 = **FREQUENTLY** (2 or more times per week) and symptom **was SEVERE**

Grand Total:	**# Missed Work Days**

CONSTITUTIONAL		**NASAL/SINUS**		**MUSCULOSKELETAL**	
	Fatigue (sluggish, tired)		Post nasal drip		Joint pains
	Hyperactive (nervous energy)		Sinus pain		Stiff joints
	Restless (can't relax/sit still)		Runny nose		Muscle aches
	Daytime sleepiness		Stuffy nose		Stiff muscles
	Insomnia at night		Sneezing		Tics (facial or otherwise)
	Malaise (feeling lousy)		TOTAL (0-20)		Muscle spasms
	Seizures	**MOUTH/THROAT**			Muscle cramps
	TOTAL (0-28)		Sore throat		TOTAL (0-28)
EMOTIONAL/MENTAL			Swollen throat	**CARDIOVASCULAR**	
	Depression		Swelling/burning lips/tongue		Irregular heartbeat
	Anxiety (fears, uneasiness)		Gagging/throat clearing		High blood pressure
	Mood swings (rapid changes)		Canker sores		TOTAL (0-8)
	Irritability		Difficulty swallowing	**DIGESTIVE**	
	Forgetfulness		TOTAL (0-24)		Heartburn/reflux
	Lack of concentration/Brain fog	**LUNGS**			Stomach pains/cramps
	Low sex drive		Wheezing		Intestinal pains/cramps
	TOTAL (0-28)		Chest congestion		Constipation
HEAD/EARS			Dry cough		Diarrhea
	Headache (not migraine)		Wet cough		Bloating sensation
	Migraine		Shortness of breath		Gas (of any kind)
	Earache		TOTAL (0-20)		Nausea
	Ear infection	**EYES**			Vomiting
	Ringing in ears		Red or swollen eyes		Painful elimination
	Itchy ears		Watery eyes		TOTAL (0-40)
	Discharge from ears		Itchy eyes	**WEIGHT MANAGEMENT**	
	Sensitivity to sound		Dark circles or "bags"	Current weight:	
	TOTAL (0-32)		Sensitivity to light		Fluctuating weight
SKIN			Aura		Food cravings
	Blemishes, acne		TOTAL (0-24)		Water retention
	Rashes or hives	**GENITOURINARY**			Binge eating or drinking
	Eczema or psoriasis		Increased urinary frequency		Purging (all methods)
	"Rosy" cheeks		Painful urination		TOTAL (0-20)
	Flushing		Bladder pain	**LIST OTHER SYMPTOMS:**	
	Itchy skin		Bedwetting		
	TOTAL (0-24)		TOTAL (0-16)		