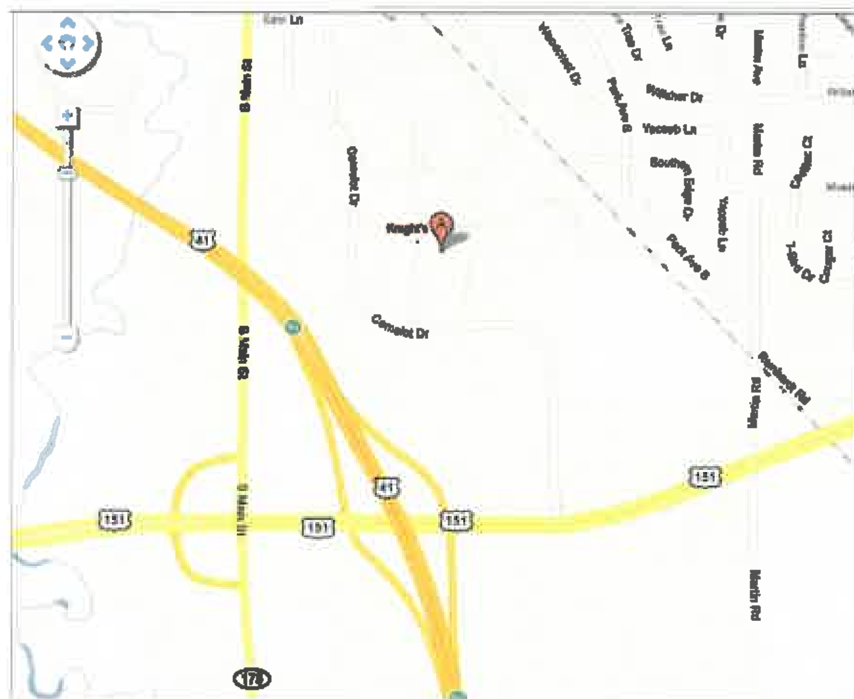
Fox Valley Wellness Center/Midwest Hyperbarics is located at

180 Knights Way
Fond du Lac, WI 54935



For people coming from the north: Take Hwy 41 south to the south side of Fond du Lac. Exit 151 North (also known as the bypass or exit 95). Turn left at the end of the off ramp. Follow 151 North for about ¼ mile and turn left on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.

For people coming from the east and northeast: Take the 151 bypass around the east and south portions of Fond du Lac to Camelot Drive. Turn right on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.

For people coming from the south (up Hwy 41): Exit at US 151 North (bypass/ exit 95). Turn right off the exit ramp. Go about ¼ mile and turn on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.

For people coming from the west: Take Hwy 151 North (going east) connecting with Hwy 41 (southbound). Follow 151 North for about ¼ mile past Hwy 41 and turn left on Camelot Drive. Follow Camelot to Knights Way and turn right. We are located at 180 Knights Way.

Instructions for Saliva Sampling

In order for you to provide us with the most accurate saliva sample, it is preferable that you fast a minimum of 2 hours prior to your appointment. We ask that you do not consume food or drink (including water) during this time. In addition, you should not brush your teeth or use breath mints, chewing gum, lip balms or lipstick during that time period. When you arrive, you will be asked to provide saliva for us in a small cup.

Instructions for Collecting a First Morning Urine Sample

First morning implies anything after 4:30 a.m. and prior to eating or drinking anything. Your urine sample can be brought to us in any glass or plastic container that has been washed thoroughly, has a seal-tight lid and does not need to be returned. You may also stop at our clinic or purchase a urine specimen cup from your local pharmacy. With sterile container in hand, follow the instructions for females or males below.

FEMALES

1. Wash hands with soap and rinse **thoroughly** with warm water.
2. Spread the labia (folds of skin) apart with one hand and wipe with a damp (no soap) washcloth. Wipe from front to back.
3. Continue holding the labia apart. As you start to urinate, allow a small amount of urine to fall into the toilet bowl. (This clears the urethra of contaminants). Do not touch the inside of the cup.
4. After the urine stream is well established, urinate into the cup. Once an adequate amount of urine fills the cup, remove the cup from the urine stream.
5. Pass the remaining urine into the toilet.
6. Screw the lid onto the cup tightly (do not touch the inside of the cup or lid). Place in a plastic bag and refrigerate until you leave for your appointment.

MALES

1. Wash hands with soap and rinse **thoroughly** with warm water.
2. Wipe the end of the penis with a damp (no soap) washcloth. If uncircumcised, retract foreskin first.
3. As you start to urinate, allow a small amount of urine to fall into the toilet bowl. (This clears the urethra of contaminants). Do not touch the inside of the cup.
4. After the urine stream is well established, urinate into the cup. Once an adequate amount of urine fills the cup, remove the cup from the urine stream.
5. Pass the remaining urine into the toilet.
6. Screw the lid onto the cup tightly (do not touch the inside of the cup or lid). Place in a plastic bag and refrigerate until you leave for you appointment.

****PLEASE FEEL FREE TO BRING FOOD TO EAT AT YOUR APPOINTMENT AFTER THE TESTING IS COMPLETED****

MEDICAL MICROSCOPY – THE IDEAL BIOLOGICAL PROBE FOR ASSESSING HEALTH & DISEASE

PERIPHERAL BLOOD ASSESSMENT
(HLB_{TM} AND $HRBM_{TM}$ CORRELATIONS)

Peripheral Blood Assessment (PBA_{TM}) is a cost effective way to assess the amount and general location of oxidative processes within the body, as well as hormones, enzymes and other by-products of biological stress. The generation of toxic oxygen products affects the body's basic cellular structures and biochemical pathways. This leads to further and accelerated degeneration and specific diseases. These disease processes will usually be in a chronic, progressive pattern such as cancer, cardiovascular diseases, diabetes, the collagen diseases and the progressive neurological diseases.

Peripheral Blood Assessment can determine cellular nutritional status. Nutritional status is essential to aid in curbing and reversing the free radical cascade of destructive, deteriorating cell structures. The interaction of the toxins given off by these cell structures with normal body cells produces major systemic effects of metabolic dysfunctions and challenges.

This unique assessment of peripheral blood can reveal a good prospectus of the immune system. By observing the morphology of the white blood cells and their activity in contrast to the extent of active foreign antigens and microbes within the serum and red blood cells, the strength of the immune system can be judged. Weakness and dysfunction in any one of these three major components can influence the strength and function of the other two. This can be indicative of a progressive disease process.

The Peripheral Blood Assessment, through the use of the BVPM variable projection microscope, cannot be depended upon for specific diagnoses or pinpointing of specific organs involved; however, good judgment can be made as to general location of pathological activity. Thus, this can direct the attending physician toward organ complexes.

This unique analysis technique has the capability of offering the doctor a quick and simple way to determine the extent of a disease process. It helps determine whether it is functional or organic, acute or chronic, mild or severe, and give a general idea as to what physiological pathway of the body requires the greatest support. This can include oxidative control, nutritional and enzyme correction and supplementation or immune support.

The utilization of the variable projection microscope in analyzing the serial drops of blood, air dried and coagulated (HLB_{TM}) and conjunction with High Resolution Blood Morphology ($HRBM_{TM}$), is a simple, proven way to triage the new patient, saving money and time as well as pain and suffering. It is an intelligent way to direct further laboratory studies and physiological or psychological examinations in determining a more accurate diagnosis. Treatment can be directed toward normalizing physiological functions by supporting known immune and nutritional deficiencies and allopathic support. Allopathic as well as integrative modalities may be employed in eliminating foreign invaders and/or removing tumofactions which might have had the opportunity to become organized, walled off and protected from the body's natural immune modalities.

The peripheral blood assessment lends itself readily to monitoring physiological and morphological changes during treatment. This enables the physician to fine tune the supportive therapies and know when further allopathic support is not needed. This monitoring tells the physician when the body's basic cellular structures and biochemical pathways have regained their integrity and the organ reserve has again been re-established. This, indeed, is truly demonstrating "state-of-the-art" integrative medicine.

A Journey to Health

Donna Abfall and her brother grew up eating in restaurants and supper clubs. Donna was plagued with migraines by the age of 9 which increased in frequency throughout her childhood. In 5th grade Donna was told she needed to have her tonsils and adenoids out. During the procedure she was injected with a contaminated needle. This resulted in an illness in which she lost 1/3 of her body weight and suffered from severe aching, extreme fatigue, fainting, nausea, and constant vomiting. She was admitted to Children's Hospital in Madison, but none of the fifteen doctors that saw her were able to come up with a diagnosis. She was sent home and told her immune system would either win or it wouldn't. It took a strong will and a lot of perseverance, but after 2 ½ years of fighting Donna was able to attend school again full-time.

Donna's parents had a violent relationship which ended in divorce. This did not help her physical health. She remembers suffering from constant fatigue, frequent migraines, and food cravings. After graduating high school, Donna attended WWTI in La Crosse and received her degree as an Operating Room Technician. She continued on to UW La Crosse to pursue a degree in teaching. She knew her passion was in nursing however and returned to the O.R. and switched her major to nursing.

At age 20, Donna and her husband Roger were hit from behind by a truck traveling 60mph. Donna had severe whiplash which caused her migraines to intensify. Unable to sit for long periods of time, she was forced to take a two year leave from nursing school. She sought medical help from various healthcare professionals with very little relief.

Donna graduated as an RN at 26 years of age and began working in Milwaukee. In October 1990, the month Donna turned 30, she became ill with a lung infection. She was put on two different antibiotics which helped clear up the infection, but triggered more frequent and more severe migraines. They were so debilitating that she was virtually bed-ridden for six months. She was considering going to a pain clinic when a friend from church gave her the book, "Yeast Connection." After reading it, she went on a yeast and sugar-free diet which helped control the migraines. This was the first real education she received on diet and how it directly impacts health.

In 1991 and 1993 Donna gave birth to her third and fourth children. After these final two pregnancies, Donna's thyroid had enlarged, her migraines increased, chronic fatigue worsened, memory issues ensued, and her body ached all over. She was unable to work during this time but attempted to home school her children from the confines of her bed or couch. Every day was a struggle as crawling was the only way Donna was able to get around and vomiting became a normal occurrence. She was medicated in an attempt to lessen the headaches, body aches and extreme nausea, but the medication only heightened the vomiting and it did nothing to relieve the pain or migraines. Eventually, Donna would be diagnosed with Chronic Fatigue Syndrome and Fibromyalgia, but nobody had any remedies for her. Months spent suffering in bed with four young children to care for turned into years.

In March of 1998, Donna would learn of a naturopathic doctor in Madison, Dr. Renee Welhouse, via another friend from her church. Her friend also suffered from incapacitating pain and migraines making it impossible for him to work. He was unable to support his family and experiencing such despair and exhaustion for so many years led him to commit suicide. Before his death however, he told Donna she should go see Dr. Welhouse. Donna knew nothing about natural medicine and initially chose not to pursue this route. After her friend's death however, she knew she needed to continue to search for answers. Through fervent prayer for direction she changed her mind about talking to the naturopath in Madison. Donna had no idea that her life was about to change forever.

Dr. Renee Welhouse took one look at Donna and told her she was a "toxic, hormonal mess." Some naturopathic doctors use the practice of Iridology to determine information about a person's systemic health. Just by looking at the state of Donna's irises, Dr. Welhouse knew her body was toxic. The next step was to analyze Donna's blood under the microscope. Through blood microscopy, Dr. Welhouse could see that Donna's red blood cells were stacked like poker chips. It was no wonder why Donna had been feeling so awful. Donna quickly realized that Dr. Welhouse was someone who could quite possibly help her and so began her journey to health and an interest in natural medicine.

Learning that she had the power to change the health of her blood, Donna began to have hope again. She saw what the results of a poor diet did to the state of her blood and she knew that if she wanted to live, she had to make some drastic changes to her lifestyle. Dr. Welhouse shared her own amazing story of survival. With her guidance and direction, Donna began to change her diet, supplement, detox and educate herself in the field of Natural Medicine. It was a very long, arduous battle; most days a piece of fruit, a glass of water, and a bag of organic spinach was all she could eat. Other days it was eggs and tea in bed and perhaps a crawl to the bathroom to do a colonic and back to bed again. Gradually, Donna started regaining some strength. Realizing that Dr. Welhouse's natural approach to medicine was working, Donna set out on a course of study to become an ND herself and help others who struggled as she did all those years. She interned with Dr. Welhouse in Madison, taking courses in Blood Microscopy and Cranio-sacral Therapy. Thanks to drastic changes in lifestyle and cranio-sacral therapy, Donna finally got a handle on her enervating migraines.

With a drastic reduction in migraines and improvements in general health, Donna opened up a Welhouse Clinic in West Bend, WI determined to spread her knowledge and experience to as many people as she could. She still battled fatigue, making each day a struggle, but she was so grateful for how far she had come and now, in her mid-40's, Donna finally felt among the living again.

Life still presented Donna and her family with struggles and tragedy. In 2005, Donna's mom was diagnosed with a brain tumor and a second tumor in her left lung. She was admitted to hospice where she died just weeks later. Her mom drank and smoked the majority of her life. She was just 65. Then in March of 2007, Donna's friend, teacher, and mentor, Dr. Renee Welhouse died in a tragic auto accident. Donna was asked to come work at the Welhouse clinic in Madison. She felt compelled to close her clinic in West Bend and fulfill the request of Renee's family and staff.

Unfortunately, Donna was experiencing persistent health issues that left her feeling chronically weak. She had her doctor run some tests and they discovered a cantaloupe-size fibroid tumor in her uterus. Fifteen years of being bed-ridden was likely the culprit. With a hemoglobin level of just 3.6 and only 4 pints of blood flowing through her, Donna was in dire need of blood transfusions. She was put on Lupron for a year but after stopping the medication she hemorrhaged and required a hysterectomy. Thanks to the changes she had made in her lifestyle her body healed and she started to feel better. She returned to West Bend in 2008 and started the Inochi clinic, named after her Japanese business partner. In May of 2009, her father, a smoker and drinker, died of lung and kidney cancer.

With decades of pain and poor health behind her, Donna was back to practicing natural medicine in West Bend and in 2011 joined the staff at Fox Valley Wellness Center in Fond du Lac, WI. Now, almost 60, she reports feeling the best she's felt in her entire life and opened up her own clinic, Wellness for Life in West Bend. With a combination of Western and Naturopathic medicine, the love of her family, and the goodness of God, she has been healed and given the chance to educate individuals on how to prevent and overcome disease through healthy lifestyle choices.

Fox Valley Wellness Center | 180 Knights Way Fond du Lac, WI 54935 | ph: 877-676-LIFE (5433) or 920-922-LIFE (5433)

Patient Demographics 2019

Patient Name: ______________________________ **DOB:** ____/____/______

Address: ____
Street **City** **State** **Zip Code**

Marital Status: S / M / D **Sex: Male / Female** **Last 4 digits of SS #** ____________ **Cell #** ______________

Daytime Phone # ________________ **Email Address:** ______________________________

Responsible Party for Medical Expenses

____**Parent** ____**Spouse** ____**Self *(if self, go to insurance section)*** **Phone #** ______________________

Parent or Spouse's Name: ______________________ **DOB:** ___/___/____ **Last 4 digits of SS#** ________

Address: ______________________________ **Employer:** ______________________

Medical Insurance Company

Primary Insurance: ______________________ **Group#** ____________ **ID#** ____________

Subscriber Name: ______________________ **DOB:** ___/___/____ **Effective Date:** ___/___/____

Secondary Insurance: ______________________ **Group#** ____________ **ID#** ____________

Subscriber Name: ______________________ **DOB:** ___/___/____ **Effective Date:** ___/___/____

Emergency Contact

Name: ______________________ **Relationship:** ____________ **Ph #** ____________

Address: ____
Street **City** **State** **Zip Code**

Authorization for Release of Information

Authorization is hereby granted to release to the above named Insurance Company. Such information may be necessary for the completion of my clinic claims. I understand I am financially responsible for charges not covered by insurance and assign any insurance benefits to above said clinic.

Signature: ______________________________ **Date:** ________________

Who do we thank for referring you to us today? ______________________________

Name:

Day 1 - Date:					
FOOD GROUPS	**BREAKFAST** Time:	**LUNCH** Time:		**DINNER** Time:	
Meat & Dairy					
Vegetables & Fruits					
Breads, Cereals & Grains					
Fats (butter, margarine, oils, etc.)					
Candy, Sweets & Junk Food					
Water Intake (fl. oz.)					
Other Drinks					
	MID-MORNING SNACK Time:	**MID-DAY SNACK** Time:		**NIGHTTIME SNACK** Time:	
Snack					
Bowel Movements (# and consistency):		**Hours of Sleep:**		**Quality of Sleep:** (good) 1 2 3 4 5 (poor)	
Day 1 - Notes:					

Day 2 - Date:					
FOOD GROUPS	**BREAKFAST** Time:	**LUNCH** Time:		**DINNER** Time:	
Meat & Dairy					
Vegetables & Fruits					
Breads, Cereals & Grains					
Fats (butter, margarine, oils, etc.)					
Candy, Sweets & Junk Food					
Water Intake (fl. oz.)					
Other Drinks					
	MID-MORNING SNACK Time:	**MID-DAY SNACK** Time:		**NIGHTTIME SNACK** Time:	
Snack					
Bowel Movements (# and consistency):		**Hours of Sleep:**		**Quality of Sleep:** (good) 1 2 3 4 5 (poor)	
Day 2 - Notes:					

Day 3 - Date:

FOOD GROUPS	**BREAKFAST** Time:	**LUNCH** Time:	**DINNER** Time:
Meat & Dairy			
Vegetables & Fruits			
Breads, Cereals & Grains			
Fats (butter, margarine, oils, etc.)			
Candy, Sweets & Junk Food			
Water Intake (fl. oz.)			
Other Drinks			
	MID-MORNING SNACK Time:	**MID-DAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack			
Bowel Movements (# and consistency):		**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)
Day 3 - Notes:			

Day 4 - Date:

FOOD GROUPS	**BREAKFAST** Time:	**LUNCH** Time:	**DINNER** Time:
Meat & Dairy			
Vegetables & Fruits			
Breads, Cereals & Grains			
Fats (butter, margarine, oils, etc.)			
Candy, Sweets & Junk Food			
Water Intake (fl. oz.)			
Other Drinks			
	MID-MORNING SNACK Time:	**MID-DAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack			
Bowel Movements (# and consistency):		**Hours of Sleep:**	**Quality of Sleep:** (good) 1 2 3 4 5 (poor)
Day 4 - Notes:			

Day 5 - Date:					
FOOD GROUPS	**BREAKFAST** Time:	**LUNCH** Time:		**DINNER** Time:	
Meat & Dairy					
Vegetables & Fruits					
Breads, Cereals & Grains					
Fats (butter, margarine, oils, etc.)					
Candy, Sweets & Junk Food					
Water Intake (fl. oz.)					
Other Drinks					
	MID-MORNING SNACK Time:	**MID-DAY SNACK** Time:		**NIGHTTIME SNACK** Time:	
Snack					
Bowel Movements (# and consistency):		**Hours of Sleep:**		**Quality of Sleep:** (good) 1 2 3 4 5 (poor)	
Day 5 - Notes:					

Day 6 - Date:					
FOOD GROUPS	**BREAKFAST** Time:	**LUNCH** Time:		**DINNER** Time:	
Meat & Dairy					
Vegetables & Fruits					
Breads, Cereals & Grains					
Fats (butter, margarine, oils, etc.)					
Candy, Sweets & Junk Food					
Water Intake (fl. oz.)					
Other Drinks					
	MID-MORNING SNACK Time:	**MID-DAY SNACK** Time:		**NIGHTTIME SNACK** Time:	
Snack					
Bowel Movements (# and consistency):		**Hours of Sleep:**		**Quality of Sleep:** (good) 1 2 3 4 5 (poor)	
Day 6 - Notes:					

Day 7 - Date:

FOOD GROUPS	BREAKFAST Time:	LUNCH Time:		DINNER Time:	
Meat & Dairy					
Vegetables & Fruits					
Breads, Cereals & Grains					
Fats (butter, margarine, oils, etc.)					
Candy, Sweets & Junk Food					
Water Intake (fl. oz.)					
Other Drinks					
	MID-MORNING SNACK Time:	MID-DAY SNACK Time:		NIGHTTIME SNACK Time:	
Snack					
Bowel Movements (# and consistency):		Hours of Sleep:		Quality of Sleep: (good) 1 2 3 4 5 (poor)	
Day 7 - Notes:					

New Client Intake Form

Please fill this out entirely and bring it with you to your appointment. Also bring copies of any lab or radiology reports that you feel are relevant to your primary health concerns. Thank you!

Name ______________________ Date ________ Date of Birth ___________
Address ____
Home Phone _________________________ Cell Phone ___________________
Email Address ____
How were you referred to us? ____

Inochi or individual health care providers will call patients at times, and we wish to ensure your privacy regarding treatment at our clinic. In the event that we are unable to reach you by phone, please indicate where it is appropriate to leave messages for you:

☐ Home message machine ☐ With family members ☐ At work ☐ Never leave messages

What are your primary health concerns? List as many as you can, in the order of their importance to you.

1) ____
2) ____
3) ____
4) ____
5) ____

What are the primary expectations you have for your visit today to our clinic?

1) ____
2) ____

Is this your first visit to a Naturopathic Physician? ____________ Chiropractor? ____________

Have you ever had a colonic? _______ Yes ______ No _________ Open? ________ Closed?

Have you ever had a massage? _____________________ When was your last? __________

General Information:

Height _______ Weight _______ Weight 1 yr ago _______ Maximum weight _______ When _______

When during the day is your energy and alertness best? _______ Worst? _______ Blood type _______

What surgeries if any have you had (include dental)? ___________________________

____

____

Patient History: Do you have a history of any of the following diseases or conditions? Check all that apply.

☐ Anemia	☐ Cancer	☐ Heart Disease	☐Mental Illness	☐Alzheimer's
☐Arthritis	☐ Diabetes	☐ Hypertension	☐ Multiple Sclerosis	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Parkinson's	☐ Other (list below)

Family History: Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.

☐ Anemia	☐ Cancer	☐ Heart Disease	☐Mental Illness	☐Alzheimer's
☐Arthritis	☐ Diabetes	☐ Hypertension	☐ Multiple Sclerosis	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Parkinson's	☐ Other (list below)

Please list other significant family medical history not listed above:

____

____

____

Are you currently under the care of a health care practitioner? If yes, please list the doctors name and the clinic where care was received. When was the last time you received medical care and why?

____

____

____

Which of the following childhood illnesses have you had?

☐ Diphtheria	☐ Measles	☐ Scarlet Fever	☐ German measles
☐ Mumps	☐ Rheumatic Fever	☐ Chickenpox	☐ Other: __________

Which immunizations have you had? If you don't know if you've had one, place a question mark beside it.

☐ Diphtheria ☐Measles/Mumps/Rubella ☐ Meningitis ☐ Polio ☐ Tetanus
☐Chickenpox ☐ Hepatitis A/B/C ☐ Pertusis ☐ Flu ☐Other: ____________

Which diagnostic studies have you had in the past year?

☐ Electrocardiogram (EKG) ☐ X-Ray ☐ Bone Density Scan (DEXA) ☐ CT Scan
☐ Electroencephalogram (EEG) ☐ Mammogram ☐MRI ☐ Other: ____________

Are you aware of having allergies to any of the following? If so, describe your reaction to each one:

Drugs:

____

Foods:

____

Chemicals/Perfumes:

____

Animals:

____

Which medications, either by prescription or over-the-counter, are you taking or have you taken in the past 6 months?

☐ Laxatives ☐ Pain Relievers ☐ H2 Blockers/Ulcer Medication ☐ Antacids
☐ Cortisone/Prednisone ☐ Appetite Suppressants ☐ Anti-depressants ☐ Antibiotics
☐ Tranquilizers ☐ Thyroid medication ☐ Cholesterol-lowering medication
☐ Sleeping medication
☐ Other: ______________________________

Please list, by name, any prescription medications you currently take, over-the-counter medications, and all vitamins/supplements/herbs you take regularly at this time. Include dosage, if known. ***If you need additional space, please use the back of this page.***

1) ____

2) ____

3) ____

4) ____

5) ____

Assessing the Areas of Your Life

In assessing your health, it is helpful to have some sense of the degree of satisfaction you feel in various areas of your life. Using the scales below, please rate yourself in terms of satisfaction and dissatisfaction. Number 1 means you are very dissatisfied or stressed. Number 10 means you are very satisfied or comfortable.

Friends & Family
0 1 2 3 4 5 6 7 8 9 10

Physical Environment
0 1 2 3 4 5 6 7 8 9 10

Health
0 1 2 3 4 5 6 7 8 9 10

Career
0 1 2 3 4 5 6 7 8 9 10

Relationships/Romance
0 1 2 3 4 5 6 7 8 9 10

Recreation
0 1 2 3 4 5 6 7 8 9 10

Money
0 1 2 3 4 5 6 7 8 9 10

Personal Growth/Spirituality
0 1 2 3 4 5 6 7 8 9 10

Primary interests and hobbies ______________________________

____

Primary form of exercise, if any

____

____

How often______________________________

Check the appropriate box:

	Yes	No
Get 6-8 hours of sleep nightly?		
Sleep Well		
Awaken Rested		
In a supportive relationship		
History of abuse		
Suffered recent (past 3 years) major life trauma		
Use recreational drugs		
Treated for drug/alcohol dependence		
Drink alcohol?		
Use tobacco? If so, how many packs daily: ___ How many years: ____		
Enjoy your work?		

	Yes	No
Take vacations?		
Spend time outside?		
Watch TV? Hours daily ____		
Read? Hours daily ____		
Eat 3 meals daily?		
Eat out more than 3 times weekly?		
Go on diets more than twice yearly?		
Drink tea?		
Drink coffee?		
Drink soda/cola?		
Use products with Nutrasweet or Splenda?		
Add sugar/salt to food?		

Review of Systems

In this section, check the box if you have the symptom currently or if you have experienced it in the past 6 months. Some questions are yes/no; please write the answer in the box.

Mental/Emotional	
Treated for depression	
Mood swings	
Considered/Attempted suicide	
Poor concentration	
Depression	
Anxiety or nervousness	
Tension	
Memory problems	

Endocrine	
Hair loss	
Brittle nails	
Excessive thirst	
General fatigue	
Fatigue after meals	
Heat intolerance	
Cold intolerance	
Excessive hunger	
Seasonal depression	

Head	
Headaches	
Migraines	
Head injury	
Jaw pain/TMJ	

Immune	
Chronic fatigue symdrome	
Swollen glands	
Reaction to vaccines	
Ongoing infections	
Slow wound healing	
Colds/flu more than once yearly	

Neurological	
Seizures	
Muscle weakness	
Loss of memory	
Vertigo/dizziness	
Paralysis	
Numbness or tingling	
Easily stressed	
Involuntary shaking or unsteadiness in hands	

Ears	
Impaired hearing	
Earaches	
Ringing	
Itching inside or outside	
Frequent popping	

Nose and Sinuses	
Frequent head colds	
Stuffiness	
Sinus pain	
Nose bleeds	
Hay fever	
Loss of smell	

Eyes	
Spots in vision	
Blurriness	
Color blindness	
Double vision	
Cataracts	
Eye pain/strain	
Uncomfortable tearing or dryness	
Glaucoma	

Mouth and Throat	
Frequent sore throat	
Teeth grinding	
Gum bleeding/pain/disease	
Dental cavities	
Copious saliva	
Sore tongue/lips	
Hoarseness	
Jaw clicks	

Neck	
Lumps	
Goiter/enlargement in front of throat	
Pain or stiffness	

Skin	
Rashes	
Acne, boils	
Color changes	
Lumps	
Eczema	
Hives	
Generalized itching	
Night sweats	

Urinary	
Pain with urination	
Frequency at night; If so, how often do you wake to urinate each night ___	
Frequent infections	
Unable to hold urine	
Kidney stones	
Splitting of stream	

Respiratory	
Cough	
Spitting of blood	
Asthma	
Pneumonia	
Emphysema	
Pain on breathing	
Shortness of breath at night	
Shortness of breath daily	
Shortness of breath lying down	
Lung congestion/sputum	
Wheezing	
Bronchitis	
Pleurisy	
Difficulty breathing	
Difficult taking a full deep breath	

Cardiovascular	
Heart disease	
High blood pressure	
Low blood pressure	
Blood clots	
Phlebitis	
Rheumatic fever	
Ankle swelling	
Angina/chest pain	
Heart murmurs	
Fainting	
Heart palpitations/fluttering	

Intestinal	
Trouble swallowing	
Change in thirst	
Change in appetite	
Nausea/vomiting	
Burning pain in stomach	
Jaundice	
Gallbladder disease	
Liver disease	
Hemorrhoids	
Heartburn	
Abdominal pain or cramps	
Excessive belching or excess gas	
Constipation	
Diarrhea	
Black stools	
Blood in stools	
Bowel movement (BM) daily How often are BMs: ______	

Musculoskeletal	
Joint pain or stiffness	
Broken bones	
Muscle spasms or cramps	
Arthritis	
Weakness	
Sciatica	

Blood/Peripheral Vascular	
Easy bleeding/bruising	
Deep leg pain	
Varicose veins	
Anemia	
Cold hands	
Cold feet	

Male Reproduction (questions apply to lifetime, not just last 6 months)	
Hernias	
Prostate disease	
Are you sexually active?	
Impotence	
Premature ejaculation	
Use condoms	
Testicular masses or pain	
Discharge or sores on penis	
Chlamydia	
Gonorrhea	
Condyloma/genital warts	
Genital herpes	
Syphilis	

Female Reproduction/Breasts (questions apply to lifetime, not just last 6 months)	
Age at first menses (first period) ____	
Age of last menses (if menopausal) ____	
Usual length of cycle (blood flow to next blood flow): ______	
Duration of menstruation (days of bleeding) ____	
Irregular cycles	
Painful menses	
Heavy flow	
Light flow	
Bleeding/spotting between periods	
Clotting	
Discharge	
PMS	
Menopausal symptoms	
Endometriosis	
Ovarian cysts	
Date of last annual exam/Pap ______	

Sexually active	
Pain during intercourse	
Use of birth control; if so, what type ______________________	
Difficulty conceiving	
Cervical dysplasia	
Sexual difficulties	
Gonorrhea	
Genital herpes	
Chlamydia	
Condyloma/genital warts	
Syphilis	
Regular self breast exams	
Breast pain/tenderness	
Breast lumps	
Nipple discharge	
Number of pregnancies ______ Number of live births ______ Number of miscarriages ______	

Are there any other health concerns that you have which have not been covered in this questionnaire?

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Signature Date