Wellness Revolution Clinic

Name: _____Date of Birth: _____ Age: _____Date: _____

Circle: 1 = Never, 2 = Rarely, 3 = Occasionally, 4 = Frequently, 5= Constantly

Ears/Eyes/Nose/Throat/Resp.

Asthma	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Hay Fever	1 2 3 4 5
Drainage	1 2 3 4 5
Ear Infections	1 2 3 4 5
Seasonal Allergies	1 2 3 4 5
Chronic Allergies	1 2 3 4 5

Musculo /Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5

Cardiovascular

HTN	1 2 3 4 5
Low BP	1 2 3 4 5
Racing Heart	1 2 3 4 5
SOB with activity	1 2 3 4 5
SOB Lying down	1 2 3 4 5

Gastrointestinal

Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Reflux or Heartburn	1 2 3 4 5
Bloating	1 2 3 4 5
Gas	1 2 3 4 5
Nausea/Vomiting	1 2 3 4 5
Crohn's	1 2 3 4 5
IBS	1 2 3 4 5
Dark circle under the eyes	1 2 3 4 5

Urinary

Frequency	1 2 3 4 5
Urgency	1 2 3 4 5
Burning or Pain	1 2 3 4 5
Blood in Urine	1 2 3 4 5
Incontinence	1 2 3 4 5
Hesitancy	
Blood in Urine	

Skin

Rashes	1 2 3 4 5
Eczema	1 2 3 4 5
Itching	1 2 3 4 5
Dryness	1 2 3 4 5
Loss of Hair	1 2 3 4 5
Excessive Sweating	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5

Endocrine/ Hormone

Chronic Fatigue	1 2 3 4 5
Weight loss or Gain	1 2 3 4 5
Hypo/Hyperthyroid	1 2 3 4 5
Cold Hands/Feet	1 2 3 4 5
Dry Skin	1 2 3 4 5
Dry Brittle Hair	1 2 3 4 5
Forgetfulness	1 2 3 4 5
Depression	1 2 3 4 5
Outer Third of Eyebrow thinning	1 2 3 4 5
Inhalant allergies	1 2 3 4 5
Sensitivity to fumes	1 2 3 4 5
Insomnia and awakening in the night	1 2 3 4 5
Low BP	1 2 3 4 5
Dizziness upon standing	1 2 3 4 5
Puffy under eyes	1 2 3 4 5
Night sweats	1 2 3 4 5
Hot Flashes	1 2 3 4 5
Puffy: water retention	1 2 3 4 5

Hypoglycemia

HA with missed meal	1 2 3 4 5
Sweets Craving	1 2 3 4 5
Heart Palpitations when Craving sweets	1 2 3 4 5
Mood Swings	1 2 3 4 5
Poor Concentration	1 2 3 4 5
Restless Sleep	1 2 3 4 5

For Men Only

Latest PSA_____	
Erectile Dysfunction	1 2 3 4 5
Low Sex Drive	1 2 3 4 5

Women Only

Hot Flashes	1 2 3 4 5
Night Sweats	1 2 3 4 5
Erratic period	1 2 3 4 5
Pain during sex	1 2 3 4 5
Insomnia	1 2 3 4 5
Bone Pain	1 2 3 4 5
Low sex drive	1 2 3 4 5
Fibrocystic breasts	1 2 3 4 5
Breast tenderness	1 2 3 4 5
Intense PMS	1 2 3 4 5
Irregular periods	1 2 3 4 5
Anxiety with Period	1 2 3 4 5
Recurrent Vaginitis	1 2 3 4 5
BCP/IUD Yes_____ NO_____	

Mental/Emotional

Anxiety	1 2 3 4 5
Stress	1 2 3 4 5
Depression	1 2 3 4 5
Poor Concentration	1 2 3 4 5
Foggy Thinking	1 2 3 4 5
Forgetfulness	1 2 3 4 5
Mood Swings	1 2 3 4 5
Irritability	1 2 3 4 5
Hyperactivity	1 2 3 4 5

Other

Fever/Chills	1 2 3 4 5
Weakness	1 2 3 4 5
Widespread use of Antibiotics	1 2 3 4 5

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1. Which conditions and symptoms bother you the most?

2. How long have these symptoms bothered you?

3. Describe how it feels when your symptoms are at their worst.

4. What are your goals for ongoing health?