

Health Survey

Name: _____

Birth Date _____

Constitution _____

Circle the answer that best reflects the intensity of each symptom at this time

0 = never 1 = seldom 2 = occasional 3 = often

Unit I: DIGESTION

Part A: LOW ACIDITY

1. Indigestion	0	1	2	3
2. Abdominal bloating	0	1	2	3
3. Feel too full after eating	0	1	2	3
4. Constipation	0	1	2	3
5. Belching / Burping	0	1	2	3
6. Diminished appetite	0	1	2	3
7. Stomach growls / gurgles	0	1	2	3
8. Any known food allergies?		N	Y	

Part B: HIGH ACIDITY

1. Stomach pains just before or after meals	0	1	2	3
2. Stomach pains with no apparent reason	0	1	2	3
3. Stomach pain relieved by carbonated drinks	0	1	2	3
4. Stomach pain relieved by milk / cream	0	1	2	3
5. Emotional upset causes stomach pain	0	1	2	3
6. Heartburn immediately after meals	0	1	2	3
7. Constant need for antacids	0	1	2	3
8. "Butterfly feeling" in stomach	0	1	2	3
9. Family history of ulcer / gastritis?		N	Y	
10. Ulcer in the past year?		N	Y	
11. Current ulcer?		N	Y	
12. Very dark or black stool?		N	Y	
13. Hot / spicy food cause stomach irritation?		N	Y	

Unit II: ASSIMILATION

Part A: SMALL INTESTINE

	0	1	2	3
1. Stomach cramps	0	1	2	3
2. Indigestion immediately after eating	0	1	2	3
3. Feel tired after meals	0	1	2	3
4. Flatulence (gas)	0	1	2	3
5. Constipation / diarrhea (alternating)	0	1	2	3
6. Fiber rich diet won't stop constipation	0	1	2	3
7. Loose stool	0	1	2	3
8. Presence of mucus in stool	0	1	2	3
9. Stool poorly formed	0	1	2	3
10. Four or more large stools daily	0	1	2	3
11. Stools have foul odor	0	1	2	3
12. Pain in left side of abdomen	0	1	2	3
13. History of pimples, skin eruptions?		N	Y	
14. Any known food allergies?		N	Y	

Part B: LARGE INTESTINE (COLON)

1. Diarrhea	0	1	2	3
2. Recurrent infections / colds	0	1	2	3
3. History of kidney and / or bladder infection	0	1	2	3
4. Yeast infection (including vaginal)	0	1	2	3

5. Frequent abdominal cramps	0	1	2	3
6. Fingernail and/or toenail fungus	0	1	2	3
7. Diarrhea and constipation (alternating)	0	1	2	3
8. Chronic constipation	0	1	2	3
9. Use of antibiotics in the past year?		N	Y	
10. Meat eater?		N	Y	
11. Vision deteriorating rapidly?		N	Y	

Unit III: PANCREAS

Part A: LOW BLOOD SUGAR (HYPOGLYCEMIA)

1. Decreased resistance to infection	0	1	2	3
2. Strong desire / craving for sweets	0	1	2	3
3. Sweets / alcohol promptly relieve headaches	0	1	2	3
4. Irritable if a meal is delayed or missed	0	1	2	3
5. Hungry most of the time	0	1	2	3
6. Constantly anxious, nervous, worrisome	0	1	2	3
7. Frequently drowsy, impatient, moody	0	1	2	3
8. Need for caffeine to get going.	0	1	2	3

Unit III, Part A (Cont.)

9. Rapid heart beat after eating sweets	0	1	2	3
10. Hungry 1-3 hours after eating	0	1	2	3
11. Restless, poor concentration	0	1	2	3
12. Forgetful; poor memory	0	1	2	3
13. Feel shaky; weak or fatigued	0	1	2	3
14. Feel better / calmer after eating?		N	Y	
15. Low protein / high carbohydrate diet?		N	Y	

SECTION B: HIGH BLOOD SUGAR (DIABETES)

1. Decreased resistance to infection	0	1	2	3
2. Slow healing cuts, wounds, etc.	0	1	2	3
3. Night sweats	0	1	2	3
4. Heightened thirst	0	1	2	3
5. Increased appetite	0	1	2	3
6. Eating sweets does not alleviate cravings	0	1	2	3
7. Fatigue, mental confusion	0	1	2	3
8. Poor, deteriorating eyesight	0	1	2	3
9. Itchy skin, boils and / or leg sores	0	1	2	3
10. History of diabetes in family?		N	Y	
11. Sugar (glucose) detected in urine?		N	Y	
12. Low protein / high carbohydrate diet?		N	Y	
13. Overweight?		N	Y	

Unit IV: LIVER

Part A: LIVER AND GALLBLADDER

1. Abdominal pain after eating fatty foods	0	1	2	3
2. Pain in the side under right rib cage	0	1	2	3
3. Painful or tender big toe	0	1	2	3
4. Hard / dry stool (painful to pass)	0	1	2	3
5. Stool color is grayish (light in color)	0	1	2	3
6. Stool has foul odor	0	1	2	3
7. Less than one daily bowel movement	0	1	2	3
8. History of constipation	0	1	2	3
9. Headaches following meals	0	1	2	3
10. Recurring sour, bitter taste in mouth	0	1	2	3
11. Gray colored skin	0	1	2	3
12. Yellow sclera (white of the eyes)	0	1	2	3
13. Bad breath or body odor	0	1	2	3
14. Tired / sleepy after meals	0	1	2	3
15. Dandruff	0	1	2	3
16. Retain water	0	1	2	3
17. Dry skin and/or hair	0	1	2	3
18. Eat at fast food restaurants	0	1	2	3
19. Impatient, impulsive, easy to anger	0	1	2	3
20. Vision problems / red or dry eyes?		N	Y	
21. Red blood in stool?		N	Y	
22. Have had jaundice or hepatitis?		N	Y	
23. High blood cholesterol and / or low HDL cholesterol?		N	Y	

Unit V: URINARY SYSTEM

Part A: KIDNEY / BLADDER

1. Constant feeling of a full bladder	0	1	2	3
2. Loss of control holding urine	0	1	2	3
3. Drip / Dribble after urination	0	1	2	3
4. Blood or pus in urine (in any amount)	0	1	2	3
5. Hazy or cloudy urine	0	1	2	3
6. Urine has odor / strong smell	0	1	2	3
7. Long intervals between urination	0	1	2	3
8. Straining to urinate with scant passage	0	1	2	3
9. Awaken in middle of night to urinate	0	1	2	3

10. Feeling of fear / insecurity	0	1	2	3
11. Dark circles under eyes	0	1	2	3
12. Pain or pressure in middle of back	0	1	2	3
13. Intermittent pain in urethra	0	1	2	3
14. History of bladder infection / cystitis?	N	Y		
15. Recent use of antibiotics for kidney / bladder infections?	N	Y		
16. Recent bladder surgery (including A& P repair)	N	Y		

Unit VI: THYROID

Part A: THYROID

1. Sensitivity to cold / wet weather	0	1	2	3
2. Hands and feet are cold	0	1	2	3
3. Constantly tired / fatigued	0	1	2	3
4. Lack of stamina for daily chores	0	1	2	3
5. Diagnosis of attention deficit disorder (ADD)	0	1	2	3
6. Eyes appear bulging or swollen	0	1	2	3
7. Skin is dry (lacks moisture)	0	1	2	3
8. Difficulty waking up in the morning	0	1	2	3
9. Depressed, apathetic, lethargic	0	1	2	3
10. Lack of or diminished sex drive	0	1	2	3
11. Irritability / mood swings from eating sweets	0	1	2	3
12. Constipation	0	1	2	3
13. Gain weight easily?		N	Y	
14. Basal (armpit) temperature less than normal?		N	Y	
15. Slow reflexes /reaction time?		N	Y	
16. Infertility / impotency?		N	Y	

For women:

17. Heavy / profuse menstrual bleeding	0	1	2	3
18. Premenstrual tension / distress	0	1	2	3

Unit VII: ADRENAL

Part A: ADRENAL

1. Unable to tolerate much exercise	0	1	2	3
2. Catch colds or get sick easily	0	1	2	3
3. Sensitive to air pollutants, chemicals, smoke	0	1	2	3
4. Breathing is labored / difficult	0	1	2	3
5. Feelings of weakness / shakiness	0	1	2	3
6. Moments of depression	0	1	2	3
7. Rapid mood swings	0	1	2	3
8. Energy lag in morning to mid-afternoon	0	1	2	3
9. Need for caffeine to get going	0	1	2	3
10. Intermittent constipation	0	1	2	3
11. Dark circles beneath the eyes	0	1	2	3
12. Dizzy / light headed upon standing	0	1	2	3
13. Lack of mental alertness (mental fog)	0	1	2	3
14. Retain water	0	1	2	3
15. Insomnia	0	1	2	3
16. Eyes sensitive to bright / direct light	0	1	2	3
17. use cortisone, prednisone, steroids		N	Y	

Unit VIII: FEMALE

Part A: SYMPTOMS DURING MENSTRUATION

1. Monthly weight gain	0	1	2	3
2. Feelings of depression / anxiety	0	1	2	3
3. Moodiness / irritability / anger	0	1	2	3
4. Bloating / swelling	0	1	2	3
5. Nausea / vomiting	0	1	2	3
6. Leg cramps / tenderness	0	1	2	3
7. Headaches	0	1	2	3
8. Easily distracted	0	1	2	3
9. Tenderness in breast area	0	1	2	3
10. Lower back ache	0	1	2	3
11. Asthma / bronchitis attacks?	0	1	2	3
12. Suicidal feelings?		N	Y	

Part B: AMENORRHEA (ABSENCE OF MENSTRUATION)

1. Vaginal itching / discharge	0	1	2	3
2. Missed periods	0	1	2	3

3. Crave sweets or additional food	0	1	2	3
4. More than 1 cycle per month	0	1	2	3
5. Low or no desire for sex?		N	Y	
6. Pain during intercourse?		N	Y	
7. Menstruation started after age 15?		N	Y	
8. Unable to get pregnant?		N	Y	
9. Number of miscarriages (if any)	0	1	2	3+
10. Number of abortions (if any)	0	1	2	3+

Part C: DYSMENORRHEA (PAINFUL MENSTRUATION)

1. Anxiety about arrival of menstrual cycle	0	1	2	3
2. Low abdominal pain	0	1	2	3
3. Dull pain radiating to lower back or legs	0	1	2	3
4. Menstrual pain	0	1	2	3
5. Menstrual pain becoming progressively worse	0	1	2	3
6. Pain and cramps without blood flow	0	1	2	3
7. Light, sparse blood flow	0	1	2	3
8. Heavy menstrual bleeding	0	1	2	3
9. Nausea / vomiting prior to or during periods	0	1	2	3
10. Need to lie down first 1 or 2 days of period	0	1	2	3
11. Increased urinary frequency	0	1	2	3
12. Pelvic soreness	0	1	2	3
13. Diarrhea associated with menstruation?		N	Y	
14. Headache during periods	0	1	2	3
15. Abdominal bloating	0	1	2	3
16. Craving for sweets (especially chocolate)	0	1	2	3

Part D: FIBROUS TISSUE AND CYSTS

1. Irregularities / soreness / lumps in vaginal area	0	1	2	3
2. Pain in ovaries	0	1	2	3
3. Retain water	0	1	2	3
4. Swollen feeling	0	1	2	3
5. Premenstrual breast pain or discomfort	0	1	2	3
6. Breast lumps?		N	Y	
7. Recent abnormal pap smear?		N	Y	
8. Family history of breast cancer?		N	Y	
9. Ovarian / uterine cyst?		N	Y	
10. Recent use of hormones?		N	Y	
11. Recent use of birth control device / medication?		N	Y	

Part E: CHANGE OF LIFE (AGE 35 AND OVER)

1. Sweating throughout the day	0	1	2	3
2. Night sweats	0	1	2	3
3. Hot flashes	0	1	2	3
4. Mood swings	0	1	2	3
5. Insomnia / light sleeper	0	1	2	3
6. Craving for sweets (especially chocolate)	0	1	2	3
7. Heavy bleeding two weeks at a time	0	1	2	3
8. Dryness of pubic hair and vaginal area	0	1	2	3
9. Vaginal pain / itching	0	1	2	3
10. Painful intercourse	0	1	2	3
11. Hysterectomy?		N	Y	
12. Osteoporosis?		N	Y	

Unit IX: MALE

Part A: PROSTATE

1. Weakened urinary flow	0	1	2	3
2. Burning / painful urination	0	1	2	3
3. Bladder feels full	0	1	2	3
4. Blood / pus in urine (any amount)	0	1	2	3
5. Awakening to urinate during the night	0	1	2	3
6. Drip / Dribble after urination	0	1	2	3
7. Fatigue in legs or lower back	0	1	2	3
8. Decreased libido / sex drive	0	1	2	3
9. Pain or discomfort upon ejaculation	0	1	2	3

Part B: MALE REPRODUCTION

1. Coldness / pain in genital area	0	1	2	3
2. Difficulty in maintaining an erection	0	1	2	3

3. Fear / anxiety about sexual intimacy	0	1	2	3
4. Premature ejaculation	0	1	2	3
5. Weak knees / lower back	0	1	2	3
6. Infertility?		N	Y	
7. Varicose veins on scrotum?		N	Y	
8. Sperm count low?		N	Y	
9. Lack of / diminished sex drive?		N	Y	

Part C: GENITAL INFECTION

1. Genitals swollen and/or tender	0	1	2	3
2. Groin area swollen / inflamed	0	1	2	3
3. Multiple sexual partners	0	1	2	3
4. Discharge from penis?		N	Y	
5. Rash on penis / pubic area?		N	Y	
6. Current venereal disease?		N	Y	
7. Venereal disease in the past?		N	Y	

Unit X: CARDIOVASCULAR SYSTEM

Part A: HEART

1. Nervous / jittery for no apparent reason	0	1	2	3
2. Calf muscles cramp when walking	0	1	2	3
3. Arrhythmia / chest pain when walking	0	1	2	3
4. Shortness of breath during minor activity	0	1	2	3
5. Rapid heart beat during minor activity	0	1	2	3
6. Palpitations / erratic heart beat	0	1	2	3
7. Numbness / pain in left arm	0	1	2	3
8. Heaviness in legs	0	1	2	3
9. Edema/swelling of feet and ankles	1	2	3	
10. Regular exercise?	0	1	2	3
11. Frequent aerobic exercise?		N	Y	
12. Red, swollen nose?		N	Y	
13. Usual heart beat	Slow	Normal	Fast	

Part B: CIRCULATION

1. Get angry / excited easily	0	1	2	3
2. Headaches / migraines for no apparent reason	0	1	2	3
3. Poor concentration / foggy brain	0	1	2	3
4. Ringing in ears	0	1	2	3
5. Cold extremities (hands / feet)	0	1	2	3
6. Numbness in extremities (hands / feet)	0	1	2	3
7. Blushing for no apparent reason	0	1	2	3
8. Speech slurred / sloppy	0	1	2	3
9. Calf muscles cramp when walking	0	1	2	3
10. Poor circulation	0	1	2	3
11. Systolic and diastolic pressures widely separated?		N	Y	
12. Lower ear lobe has vertical crease?		N	Y	
13. Heart attack?		N	Y	
14. History of stroke?		N	Y	
15. Resting blood pressure	Low	Normal	High	

Part C: HIGH BLOOD PRESSURE

1. Pain in back of head upon arising in the AM	0	1	2	3
2. Dizziness / Lightheadedness / vertigo	0	1	2	3
3. Rapid pulse / shortness of breath	0	1	2	3
4. Easily tired with minor exertion	0	1	2	3
5. Visual disturbance	0	1	2	3
6. Exercise regularly?		N	Y	
7. Blood pressure higher than it should be?		N	Y	
8. Systolic and diastolic pressures close to each other?		N	Y	

Part D: LYMPHATIC

1. Need to clear throat, particularly in AM	0	1	2	3
2. Swelling in throat/neck area	0	1	2	3
3. Skin irritation / rash	0	1	2	3
4. Pressure/congestion in or behind ears	0	1	2	3
5. Do you exercise regularly?		N	Y	

For women:

6. Nodules or tenderness in breasts	0	1	2	3
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7. Swelling in feet/ankles upon waking in A.M.	0	1	2	3
8. Puffiness beneath eyes in the morning	0	1	2	3

Unit XI: RESPIRATORY SYSTEM

Part A: RESPIRATORY SYSTEM

1. Shortness of breath / labored breathing	0	1	2	3
2. Chest tightness / pain	0	1	2	3
3. Recurring / chronic cough	0	1	2	3
4. Coughing up phlegm or blood	0	1	2	3
5. Chest colds	0	1	2	3

Unit XI, Part A (Cont.)

6. Sensitive to smog / perfumes, etc	0	1	2	3
7. Live / work with people who smoke	0	1	2	3
8. Smoker -- currently or in past 3 years?		N	Y	
9. Chronic lung infections?		N	Y	
10. Exposure to chemicals, pesticides or radiation?		N	Y	

Unit XII: IMMUNE SYSTEM

Part A: LOW-FUNCTION (HYPO IMMUNITY)

1. Bleeding or sensitive gums	0	1	2	3
2. Runny / sniffy nose	0	1	2	3
3. Nose bleeds for no apparent cause	0	1	2	3
4. Loss of sense of smell or taste	0	1	2	3
5. Chest and throat infections	0	1	2	3
6. Fever blisters, cold sores	0	1	2	3
7. Wounds heal slowly	0	1	2	3
8. Hair thinning / falling out / slow growing	0	1	2	3
9. Ear infection / congestion	0	1	2	3
10. Slow recovery from cold or flu	0	1	2	3
11. Catch colds / flu easily, despite precautions	0	1	2	3
12. Skin on back of arms is rough / bumpy	0	1	2	3
13. Lymph glands swell?		N	Y	

Part B: EXCESSIVE FUNCTION (HYPER IMMUNITY)

1. Known food sensitivity / allergy	0	1	2	3
2. Some foods cause illness, anxiety or depression	0	1	2	3
3. Stomach pain / G.I. tract discomfort	0	1	2	3
4. Swallowing tablets is difficult	0	1	2	3
5. Mucus in throat / chest	0	1	2	3
6. Low grade fever from time to time	0	1	2	3
7. Swollen / inflamed joints, body aches	0	1	2	3
8. Swollen or sore tongue	0	1	2	3
9. Ear stuffy / congested	0	1	2	3
10. Sinus infection	0	1	2	3
11. Runny nose / post nasal drip	0	1	2	3
12. Alternating diarrhea and constipation	0	1	2	3
13. Bed wetting?		N	Y	
14. Attention deficit / hyperactivity?		N	Y	
15. Use aspirin, tylenol, ibuprofen?		N	Y	
16. Use Cortisone, prednisone, steroids?		N	Y	
17. Mouth breather?		N	Y	
18. Skin disorder / rashes?		N	Y	
19. Bronchitis / asthma / chronic lung problems?		N	Y	
20. Recurring migraine headaches?		N	Y	
21. Eye itch / puffiness / discharge?		N	Y	

Unit XIII: BONES

Part A: BONE INTEGRITY

1. Cavities / dental weaknesses	0	1	2	3
2. Bones sore / painful	0	1	2	3
3. Pain in joints / extremities	0	1	2	3
4. Eat meat with most meals?		N	Y	
5. 3+ cups/day of carbonated beverages?		N	Y	
6. Gingivitis / gum sensitivity?		N	Y	
7. Use antacids at least once a day?		N	Y	
8. Presently wear dentures?		N	Y	
9. Any known bone deformities?		N	Y	
10. Diagnosed with arthritis / rheumatism?		N	Y	
12. Recent bone fracture (past 2 years)?		N	Y	

For women:

13. Post menopausal?

N Y

Unit XIV: SOFT TISSUE

Part A: MUSCLE

1. Muscle cramps	0	1	2	3
2. Muscle spasms	0	1	2	3
3. Tension in shoulder muscles	0	1	2	3
4. Pain in neck (fibronalgia)	0	1	2	3
5. Unable to sit for long periods	0	1	2	3
6. Stiff upon awakening	0	1	2	3
7. Pain / cramps in arms, legs, hands and feet	0	1	2	3
8. Fibromyalgia?	N	Y		

Part B: CONNECTIVE TISSUE

1. Injured tendons / ligaments	0	1	2	3
2. Double jointed	0	1	2	3
3. Aching joints	0	1	2	3
4. Back pain	0	1	2	3
5. Tendonitis	0	1	2	3
6. Knees / elbows swollen	0	1	2	3
7. Bursitis	0	1	2	3
8. Slipped / herniated disc?		N	Y	
9. Height loss?		N	Y	
10. Bruise / injure easily?		N	Y	

Unit XV: NERVOUS SYSTEM

Part A: NERVOUS SYSTEM

1. Tingling sensation under the skin	0	1	2	3
2. Noises / ringing in ears	0	1	2	3
3. Loss of balance / vertigo	0	1	2	3
4. Abnormally exhausted	0	1	2	3
5. Light headedness / dizziness	0	1	2	3
6. Nervousness / restlessness	0	1	2	3
7. Grip strength weaker than usual	0	1	2	3
8. Arms and legs feel heavy	0	1	2	3
9. Numbness in hands and feet	0	1	2	3
10. Heavy headed feeling	0	1	2	3
11. Tremor in hands	0	1	2	3
12. Clumsiness / bad coordination	0	1	2	3
13. Convulsions / seizures?		N	Y	
14. Have shingles / herpes?		N	Y	
15. Accident prone?		N	Y	
16. Need for 10 or more hours of sleep?		N	Y	
17. Noticeable loss of muscle mass?		N	Y	

Unit XVI: SLEEP

Part A: SLEEP PATTERNS

1. Nightmares / intense dreams	0	1	2	3
2. Insomnia	0	1	2	3
3. "Toss and turn" sleeper	0	1	2	3
4. Restless legs when laying down	0	1	2	3
5. Currently using a sleep aid?		N	Y	
6. Wake up frequently during the night?		N	Y	
7. Wake early, can't fall back to sleep?		N	Y	
8. Sleep walk / talks in sleep?		N	Y	