

**HEALTH PROFILE QUESTIONAIRE**

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| **Name:**  |  | **Date:** |  |

**Please place a check mark next to any symptoms you are CURRENTLY experiencing:**

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| --- | --- | --- |
| **HEAD** | [ ]  Headaches[ ]  Faintness[ ]  Dizziness | [ ]  Difficulty falling asleep[ ]  Difficulty staying asleep  |
| **EYES** | [ ]  Watery, dry or itchy[ ]  Swollen, reddenedor sticky eyelids  | [ ]  Bags or dark circles[ ]  Blurred or tunnel vision |
| **EARS** | [ ]  Itchy[ ]  Drainage from ear[ ]  Earaches | [ ]  Ear infections [ ]  Ringing in ears[ ]  Hearing loss  |
| **NOSE** | [ ]  Itchy nose[ ]  Stuffy nose[ ]  Sneezing attacks | [ ]  Sinus problems[ ]  Hay fever/ allergies[ ]  Excessive mucus |
| **MOUTH/** **THROAT** | [ ]  Sore throat[ ]  Hoarseness[ ]  Loss of voice[ ]  Chronic coughing[ ]  Bleeding gums[ ]  Chapped lips[ ]  Bad breath  | [ ]  Mouth sores, ulcers[ ]  Excessive mucus[ ]  Swollen or discolored tongue, gums, lips[ ]  Frequent throat clearing[ ]  Teeth grinding/clenching[ ]  Cracks in mouth corners |
| **HEART** | [ ]  Heart palpitations[ ]  Chest pain | [ ]  Tight feeling in chest[ ]  Rapid/pounding heartbeat |
| **LUNGS** | [ ]  Asthma[ ]  Bronchitis[ ]  Chest congestion | [ ]  Smoker[ ]  Difficulty breathing[ ]  Shortness of breath |
| **DIGESTIVe****TRACT** | [ ]  Nausea[ ]  Vomiting[ ]  Bloated feeling[ ]  Belching[ ]  Passing gas[ ]  Diarrhea | [ ]  Constipation[ ]  Irritable bowel [ ]  Heartburn[ ]  Acid reflux[ ]  Intestinal pain[ ]  Stomach pain |
| **SKIN,****HAIR,****AND****HAIR**  | [ ]  Acne[ ]  Hives[ ]  Rashes[ ]  Hair loss  | [ ]  Dry skin[ ]  Eczema[ ]  Psoriasis[ ]  Hot flashes | [ ]  Excessive sweating[ ]  Thin, peeling nails [ ]  Ridges on nails[ ]  White spots on nails |
| **EMOTION** | [ ]  Anger[ ]  Anxiety[ ]  PMS | [ ]  Panic[ ]  OCD[ ]  Fear | [ ]  Irritability/Aggression[ ]  Mood swings[ ]  Depression |
| **JOINTS/** **MUSCLE** | [ ]  Stiffness[ ]  Arthritis[ ]  Muscle weakness[ ]  Muscle pain/aches | [ ]  Joint pain or aches[ ]  Limitation of movement[ ]  Overall feeling of weakness or tiredness  |
| **WEIGHT** | [ ]  Excessive weight[ ]  Underweight[ ]  Emotional eating/drinking[ ]  Binge eating/drinking [ ]  Water retention | Craving certain foods: [ ]  Sugar [ ]  Caffeine [ ]  Salt [ ]  Alcohol [ ]  Chocolate |
| **ENERGY/** **ACTIVITY** | [ ]  Interrupted sleep[ ]  Insomnia[ ]  Hyperactivity[ ]  Restlessness | [ ]  Apathy, lethargy[ ]  Fatigue, sluggishness[ ]  Frequent illness |
| **MIND** | [ ]  Poor memory[ ]  Confusion[ ]  Poor comprehension [ ]  Stuttering/stammering | [ ]  Difficulty with focus or concentration[ ]  Trouble making decisions[ ]  Poor physical coordination  |
| **URO-GENITAL SYSTEM** | [ ]  Vaginal dryness[ ]  Erectile dysfunction[ ]  Disinterest in sex[ ]  Frequent urination | [ ]  Urgent urination [ ]  Genital itch[ ]  Genital discharge[ ]  Bed wetting  |
|  |  |  |  |
| **Additional information:** |
| **Please describe any recent illness (e.g., flu, cold, infection) or injury**. **List all prescription medicines you are CURRENTLY taking.** **List any food (e.g., shellfish, citrus…) or drug allergies you have:****List recent vaccinations, type and date received.** |