Zionsville Holistic Chiropractic and Wellness Center

Confidential Health History

Name: _____ Date:____/____/____

Home Address: _____City: _____State: _____

Zip: _____ Home Phone: ____/_____/_____ Cell Phone: ____/_____/_____ Work phone: ____/_____/_____

Date of Birth: ____/____/_____ Age: _____ Marital Status: S M D W #of Children:_____

In case of Emergency call:_____ Email: _____

Permission for the office to communicate with you by email? YES NO

Your Occupation: _____ Employer Name: _____

Referred By: _____ Previous Chiropractic care? Yes No When? _____Who_____

Is your condition due to an auto accident? ___ or work related? ___ Date of Injury_____Claim#_____

PRESENT COMPLAINTS

1._____Date Started: ____/____/____ Caused by: _____

Circle all that apply: Sharp Dull Constant Intermittent Radiating Numbness Tingling Weakness Spasm

What makes it better? _____Worse? _____ What times of day is it worse or better? _____

Does it interfere with certain activities like: Daily Routine Sleep Work Recreation Other_____

Please rate the level of pain on a scale of 1 to 10 (10 is high) 1 2 3 4 5 6 7 8 9 10

Have you seen other doctors for this condition? _____Who?_____

Other Treatment? _____

Please list any tests and their dates. (MRI, CT, X-Ray, Lab, Ultrasound, etc.)

1.____/____/_____ 2.____/____/_____

3.____/____/_____ 4. ____/____/_____

Other Complaints

2._____ Date Started: ____/____/____ Caused by: _____

Circle all that apply: Sharp Dull Constant Intermittent Radiating Numbness Tingling Weakness Spasm

What makes it better? _____Worse?_____ What times of day is it worse or better? _____

Does it interfere with certain activities like: Daily Routine Sleep Work Recreation Other: _____

Please rate the level of pain on a scale of 1 to 10 (10 is high) 1 2 3 4 5 6 7 8 9 10

Have you seen other doctors for this condition? _____Who?_____

Other Treatment? _____

Please list any tests and their dates. (MRI, CT, X-Ray, Lab, Ultrasound, etc.)

1.____/____/_____ 2.____/____/_____

PAST HEALTH HISTORY

Please list all hospitalizations, surgeries, broken bones and injuries and car accidents and the year they occurred.

_____

_____

Please list <u>all</u> current medications and <u>duration of use</u> including birth control pills/injections/patches and over the counter medications_____

List all past, including childhood, medications, and duration of use, including oral contraceptives and antibiotics.

_____

List all current vitamins, herbs, homeopathy and any other supplements.

_____

Physical Chemical and Emotional Stresses play a big part in our overall health. These questions are used to identify what stresses you have experienced both in the past and presently that could be contributing to your current health condition.

CHEMICAL STRESS **Circle all that applies**

Alcohol Past Present
How often? _____

Soft drinks Past Present
OZ per Day_____

Smoking Past Present
How often? _____ How long? _____

Second Hand Smoke Past Present
How many years? _____

Coffee/Tea Past Present
How often? _____

Excessive Sugar Past Present
How often? _____

Artificial Sweeteners Past Present
What kind? _____

Junk foods Past Present
How often? _____

Recreational Drugs Past Present
What kind? _____
How often? _____

Over-the-Counter Meds. (ex. Tylenol, Advil, etc.)
Past Present
What kind? _____
How often? _____

EMOTIONAL STRESS **Circle all that applies**

Relationships Past Present
Explain_____

Career Past Present
Explain_____

Children Past Present
Explain_____

Money Past Present
Explain_____

Hectic Life Past Present
Explain_____

Hold in feelings Past Present
Explain_____

Verbal abuse Past Present
Explain_____

Physical abuse Past Present
Explain_____

Sickness or Loss of Loved One Past Present
Explain_____

What do you feel is your greatest stress?
_____
_____

DIET HISTORY

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____-____

Water consumption: How many glasses a day? _____

What are your daily activities and hobbies? _____

What kind of exercise do you do? _____

How often? _____

FAMILY HISTORY M = Mother, F =Father S = Sibling GP = Grandparents

Cancer: _____ Stroke: _____Diabetes: _____ Arthritis: _____ Heart Disease: _____

Auto Immune Disorders: _____ Other: _____

Our priority is helping you achieve your health goals. What are your goals?

_____

_____

Date:_____ Patient Name _____

The Holmes and Rahe Stress Scale

- Slowly, read down through the list.
- Each life event is assigned a Stress Score– the number after it.
- If this event has occurred in your life ***over the past year***, circle that stress score or write it on the corresponding line.
- If it doesn't apply to you, leave the line blank.
- At the bottom, total up the scores you have written on the lines and compare them to the Scoring Key.

Death of spouse	**100**	_____
Divorce	73	_____
Marital separation	**65**	_____
Imprisonment	63	_____
Death within family	**63**	_____
Personal illness or injury	53	_____
Marriage	**50**	_____
Redundancy from work	47	_____
Reconciliation of marriage	**45**	_____
Retirement	45	_____
Illness within family	**44**	_____
Pregnancy	40	_____
Sexual difficulties	**39**	_____
New family member	39	_____
Business changes or restructuring	**39**	_____
Changes in financial situation	38	_____
Death of close friend	**37**	_____
Change of occupation	36	_____
Increased conflict with spouse	**35**	_____
Large mortgage or loan	31	_____
Foreclosure of mortgage or loan	**30**	_____
New responsibilities at work	29	_____
Children leaving home	**29**	_____
Trouble with in-laws	29	_____
Great personal achievement	**28**	_____
Spouse starts or stops work	26	_____
Start or end of school or college	**26**	_____
Change in living conditions	25	_____

Date:_____ Patient Name _____

Change in personal habits	**24**	_____
Trouble with employer or boss	23	_____
Change in work conditions	**20**	_____
Moving house	20	_____
Changing school or college	**20**	_____
Change in recreation	19	_____
Change in church activity	**19**	_____
Change in social activity	18	_____
Moderate mortgage or loan	**17**	_____
Change in sleep patterns	16	_____
Change in number of family meetings	**15**	_____
Change in eating habits	15	_____
Holiday	13	_____
Christmas	12	_____
Minor law infringements	11	_____

Your Total Score _____

This allows you to determine the total amount of stress you are experiencing by adding up the relative stress values, known as Life Change Units (LCU), for various events.

A score of 250 or more is considered high. Persons with a low stress tolerance may find themselves overstressed with a score of 150. The test is used to determine disease susceptibility.

SCORING KEY

— These scores are a *general* measure of stress. People handle stress differently. Some are able to carry stress more than others.

Score less than 150 or Less: You have a 37% chance of becoming seriously ill.

If your score is 150+, your health is at considerable risk.

Score between 150 to 300: You have a 51% chance of becoming seriously ill.

Score over 300: You have an 80% chance of serious illness in the next 2 years.

Adapted from the "Social Readjustment Rating Scale" by Thomas Holmes and Richard Rahe. This scale was first published in the Journal of Psychosomatic Research. 1967, vol. II p. 214.

SYSTEMS SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Vegetarian ☐ Gluten-free ☐

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

●○○ Fill in the circle marked 1 for MILD symptoms (occurs rarely).
○●○ Fill in the circle marked 2 for MODERATE symptoms (occurs several times a month).
○○● Fill in the circle marked 3 for SEVERE symptoms (occurs almost constantly).
○○○ **Leave circles BLANK if they don't apply to you!**

GROUP 1 - Sympathetic Dominance

	1	2	3	
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Gag occasionally
8	○	○	○	Unable to relax; startles easily
9	○	○	○	Extremities cold, clammy
10	○	○	○	Strong light irritates
11	○	○	○	Occasionally weak urine flow
12	○	○	○	Heart pounds after retiring
13	○	○	○	"Nervous" stomach
14	○	○	○	Appetite reduced occasionally
15	○	○	○	Cold sweats often
16	○	○	○	Get heated easily
17	○	○	○	Nerve discomfort
18	○	○	○	Staring, blinks little
19	○	○	○	Sour stomach frequent

GROUP 2 - Parasympathetic Dominance

	1	2	3	
20	○	○	○	Joint stiffness on arising
21	○	○	○	Muscle-leg-toe cramps at night
22	○	○	○	"Butterfly" stomach, cramps
23	○	○	○	Eyes or nose watery
24	○	○	○	Eyes blink often
25	○	○	○	Eyelids swollen, puffy
26	○	○	○	Indigestion soon after meals
27	○	○	○	Always seems hungry; feels "lightheaded" often
28	○	○	○	Digestion rapid
29	○	○	○	Vomiting occasionally
30	○	○	○	Hoarseness frequent
31	○	○	○	Uneven breathing
32	○	○	○	Pulse slow
33	○	○	○	Gagging reflex slow
34	○	○	○	Difficulty swallowing
35	○	○	○	Temporary constipation or diarrhea
36	○	○	○	"Slow starter"
37	○	○	○	Get "chilled"
38	○	○	○	Perspire easily
39	○	○	○	Sensitive to cold
40	○	○	○	Upper respiratory challenges

GROUP 3 - Sugar Handling

	1	2	3	
41	○	○	○	Eat when nervous
42	○	○	○	Excessive appetite
43	○	○	○	Hungry between meals
44	○	○	○	Irritable before meals
45	○	○	○	Get "shaky" if hungry
46	○	○	○	Fatigue, eating relieves
47	○	○	○	"Lightheaded" if meals delayed
48	○	○	○	Heart palpitates if meals missed or delayed
49	○	○	○	Fatigue in afternoons
50	○	○	○	Overeating sweets upsets
51	○	○	○	Awaken after few hours sleep - hard to get back to sleep
52	○	○	○	Crave candy or coffee in afternoons
53	○	○	○	Moods of “blues” or melancholy
54	○	○	○	Craving for sweets or snacks

GROUP 4 - Cardio-Vascular

	1	2	3	
55	○	○	○	Hands and feet go to sleep easily, numbness
56	○	○	○	Sigh frequently, "air hunger"
57	○	○	○	Aware of "breathing heavily"
58	○	○	○	High altitude discomfort
59	○	○	○	Opens windows in closed rooms
60	○	○	○	Immune system challenges
61	○	○	○	Afternoon "yawner"
62	○	○	○	Get "drowsy" often
63	○	○	○	Swollen ankles, worse at night
64	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
65	○	○	○	Difficulty catching breath especially during exercise
66	○	○	○	Tightness or pressure in chest, worse on exertion
67	○	○	○	Skin discolors easily after impact
68	○	○	○	Tendency to anemia
69	○	○	○	Noises in head, or "ringing in ears"
70	○	○	○	Fatigue upon exertion

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5 - Biliary / Liver

	1	2	3	
71	○	○	○	Dizziness
72	○	○	○	Dry skin
73	○	○	○	Burning feet
74	○	○	○	Blurred vision
75	○	○	○	Itching skin and feet
76	○	○	○	Hair loss
77	○	○	○	Occasional skin rashes
78	○	○	○	Bitter, metallic taste in mouth in mornings
79	○	○	○	Occasional constipation
80	○	○	○	Worrier, feels insecure
81	○	○	○	Nausea occasionally after eating
82	○	○	○	Greasy foods upset
83	○	○	○	Stools light colored
84	○	○	○	Skin peels on foot soles
85	○	○	○	Discomfort between shoulder blades
86	○	○	○	Occasional laxative use
87	○	○	○	Stools alternate from soft to watery
88	○	○	○	Sneezing attacks
89	○	○	○	Dreaming, nightmare type bad dreams
90	○	○	○	Bad breath (halitosis)
91	○	○	○	Milk products cause upset
92	○	○	○	Sensitive to hot weather
93	○	○	○	Burning or itching anus
94	○	○	○	Crave sweets

GROUP 6 - Digestive

	1	2	3	
95	○	○	○	Loss of taste for meat
96	○	○	○	Lower bowel gas several hours after eating
97	○	○	○	Burning stomach sensations, eating relieves
98	○	○	○	Coated tongue
99	○	○	○	Pass large amounts of foul-smelling gas
100	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours after
101	○	○	○	Watery or loose stool
102	○	○	○	Gas shortly after eating
103	○	○	○	Stomach "bloating"

GROUP 7 - Endocrine

(A) - Hyperthyroid

	1	2	3	
104	○	○	○	Difficulty sleeping
105	○	○	○	On edge
106	○	○	○	Can't gain weight
107	○	○	○	Intolerance to heat
108	○	○	○	Highly emotional
109	○	○	○	Flush easily
110	○	○	○	Night sweats
111	○	○	○	Thin, moist skin
112	○	○	○	Inward trembling
113	○	○	○	Heart races
114	○	○	○	Increased appetite without weight gain
115	○	○	○	Pulse fast at rest
116	○	○	○	Eyelids and face twitch
117	○	○	○	Irritable and restless
118	○	○	○	Can't work under pressure

(B) - Hypothyroid

	1	2	3	
119	○	○	○	Increase in weight
120	○	○	○	Decrease in appetite
121	○	○	○	Fatigue easily
122	○	○	○	Ringing in ears
123	○	○	○	Sleepy during day
124	○	○	○	Sensitive to cold
125	○	○	○	Dry or scaly skin
126	○	○	○	Temporary constipation
127	○	○	○	Mental sluggishness
128	○	○	○	Hair coarse, falls out
129	○	○	○	Tension in head upon arising wears off during day
130	○	○	○	Slow pulse, below 65
131	○	○	○	Changing urinary function
132	○	○	○	Sounds appear diminished
133	○	○	○	Reduced initiative

(C) - Hyperpituitary

	1	2	3	
134	○	○	○	Failing memory with age
135	○	○	○	Increased sex drive
136	○	○	○	Episodes of tension in head
137	○	○	○	Decreased sugar tolerance

(D) - Hypopituitary

	1	2	3	
138	○	○	○	Abnormal thirst
139	○	○	○	Bloating of abdomen
140	○	○	○	Weight gain around hips or waist
141	○	○	○	Sex drive reduced or lacking
142	○	○	○	Tendency for stomach issues
143	○	○	○	Increased sugar tolerance
144	○	○	○	Menstrual disorders

(E) - Hyperadrenal

	1	2	3	
145	○	○	○	Dizziness
146	○	○	○	Headaches
147	○	○	○	Hot flashes
148	○	○	○	Hair growth on face or body (female)
149	○	○	○	Sugar in urine (not diabetes)
150	○	○	○	Masculine tendencies (female)

(F) - Hypoadrenal

	1	2	3	
151	○	○	○	Weakness, dizziness
152	○	○	○	Tired throughout day
153	○	○	○	Nails weak, ridged
154	○	○	○	Sensitive skin
155	○	○	○	Stiff joints
156	○	○	○	Perspiration increase
157	○	○	○	Bowel discomfort
158	○	○	○	Poor circulation
159	○	○	○	Swollen ankles
160	○	○	○	Crave salt
161	○	○	○	Areas of skin darkening
162	○	○	○	Upper respiratory sensitivity
163	○	○	○	Tiredness
164	○	○	○	Breathing challenges

SYSTEMS SURVEY FORM - PAGE 3

GROUP 8 - Foundational

	1	2	3	
165	○	○	○	Muscle weakness
166	○	○	○	Lack of Stamina
167	○	○	○	Drowsiness after eating
168	○	○	○	Muscular soreness
169	○	○	○	Heart races
170	○	○	○	Hyper-irritable
171	○	○	○	Feeling of a band around your head
172	○	○	○	Melancholia (feeling of sadness)
173	○	○	○	Swelling of ankles
174	○	○	○	Change in urinary function
175	○	○	○	Tendency to consume sweets or carbohydrates
176	○	○	○	Muscle spasms
177	○	○	○	Blurred vision
178	○	○	○	Involuntary muscle action
179	○	○	○	Numbness
180	○	○	○	Night sweats
181	○	○	○	Rapid digestion
182	○	○	○	Sensitivity to noise
183	○	○	○	Redness of palms of hands and bottom of feet
184	○	○	○	Visible veins on chest and abdomen
185	○	○	○	Hemorrhoids
186	○	○	○	Apprehension (feeling that something bad will happen)
187	○	○	○	Nervousness causing loss of appetite
188	○	○	○	Nervousness with indigestion
189	○	○	○	Gastritis
190	○	○	○	Forgetfulness
191	○	○	○	Thinning hair

FEMALE ONLY

	1	2	3	
192	○	○	○	Very easily fatigued
193	○	○	○	Premenstrual tension
194	○	○	○	Menses more painful than usual
195	○	○	○	Depressed feelings before menstruation
196	○	○	○	Painful breasts during menses
197	○	○	○	Menstruate too frequently
198			○	Hysterectomy / ovaries removed
199	○	○	○	Menopausal hot flashes
200	○	○	○	Menses scanty or missed
201	○	○	○	Acne, worse at menses

IMPORTANT

Please list the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

MALE ONLY

	1	2	3	
202	○	○	○	Less involved in exercise/social activities
203	○	○	○	Difficult to postpone urination
204	○	○	○	Weak urinary stream
205	○	○	○	Feeling of "blues" or melancholy
206	○	○	○	Feeling of incomplete bowel evacuation
207	○	○	○	Lack of energy
208	○	○	○	Muscles in arms and legs seem softer/smaller
209	○	○	○	Tire too easily
210	○	○	○	Avoids activity
211	○	○	○	Leg nervousness at night
212	○	○	○	Diminished sex drive

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES

Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES

The 2nd and 3rd day of flow OR any 5 days in a row

MALES

Any 2 days during the month

RESTRICTIONS ON USE

THE SYSTEMS SURVEY IS TO BE USED ONLY BY TRAINED HEALTH CARE PRACTITIONERS. IF YOU ARE A PATIENT, YOU SHOULD NOT USE THE SYSTEMS SURVEY. IF YOU ARE NOT A TRAINED HEALTH CARE PRACTITIONER, YOU SHOULD NOT USE THE SYSTEMS SURVEY. HEALTH CARE PRACTITIONERS SHOULD ONLY USE THE SYSTEMS SURVEY TO PROVIDE SERVICES THAT ARE WITHIN THE SCOPE OF THEIR LICENSE OR PROFESSIONAL TRAINING. THE SYSTEMS SURVEY IS NOT INTENDED TO DIAGNOSE ANY DISEASE. THE SYSTEMS SURVEY IS INTENDED TO BE USED AS A HELPFUL TOOL FOR HEALTH CARE PRACTITIONERS IN COLLECTING INFORMATION CONCERNING THE HEALTH AND WELLNESS OF PATIENTS.

SYSTEMS SURVEY FORM - PAGE 4

Please list any medications you are taking: ☐ No Medications

Please list any vitamins, herbs, or supplements you are taking: ☐ No Vitamins

Please list any allergies you have: ☐ No Allergies

Please list any surgeries you have had in the past 12 months: ☐ No Recent Surgeries

Please list any other surgeries or medical procedures you have had: ☐ No Other Surgeries

TO BE COMPLETED BY DOCTOR

Blood Pressure: Recumbent _____ Standing _____

Pulse: Recumbent _____ Standing _____

Hema-Combistix Urine Readings: pH _____ Albumin % _____ Glucose % _____

Occult Blood _____ pH of Saliva _____ pH of Stool Specimen _____

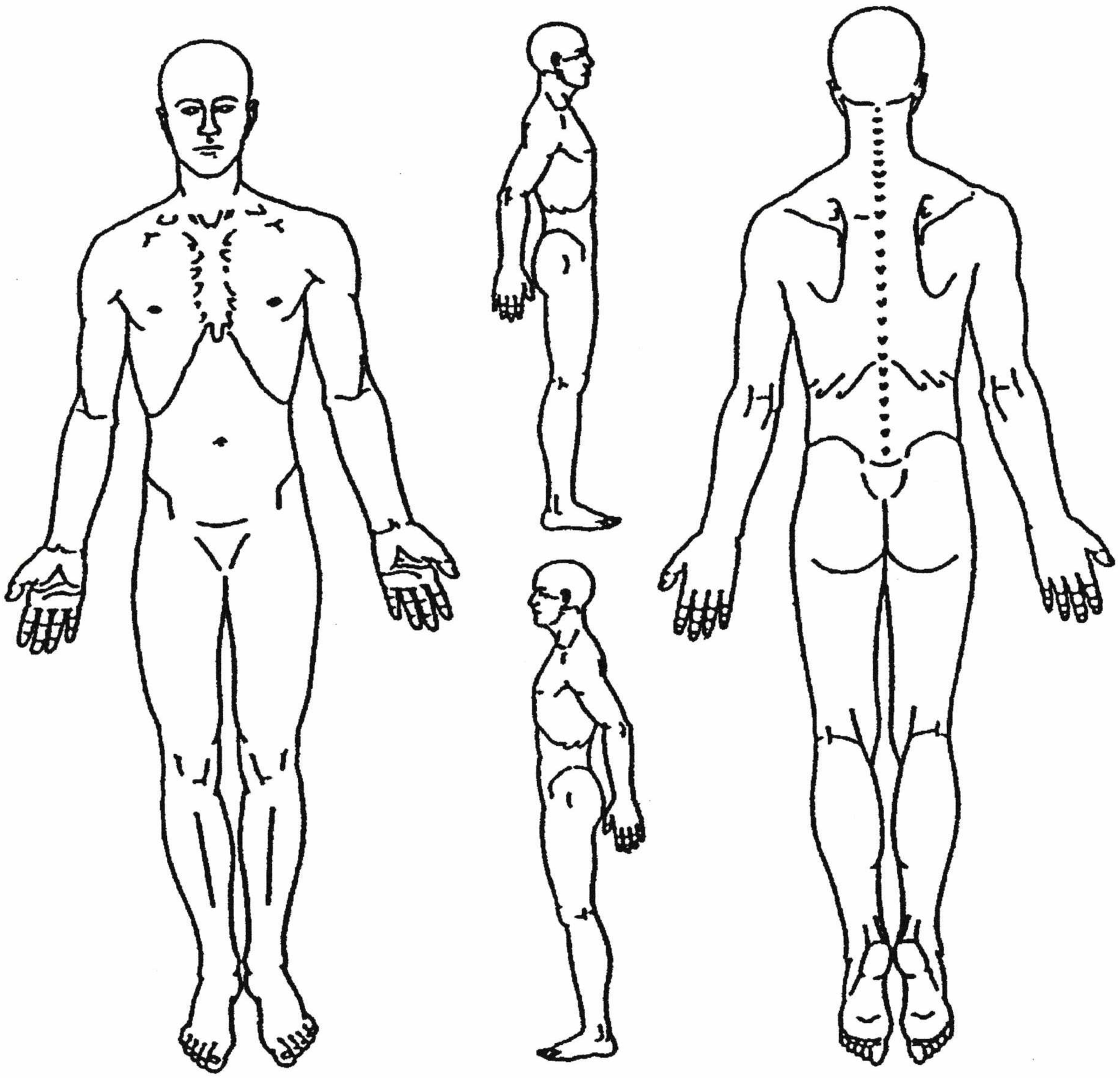
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

SYSTEMS SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a purification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Rheumatoid arthritis	0 1 2 3 4
c. Osteoarthritis	0 1 2 3 4
d. Stiffness or limited movement	0 1 2 3 4
e. Pain or aches in muscles	0 1 2 3 4
f. Recurrent back aches	0 1 2 3 4
g. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: ____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a purification program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.