

Life Essentials Natural Healing Clinic

“The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and cause and prevention of disease.” - Thomas Edison

PATIENT INFORMATION (Please Print)

NAME _____ DATE ____/____/____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE # (____) _____ E-MAIL _____

AGE _____ WEIGHT _____ HEIGHT _____ SEX: Male Female MARRIED: Yes No

OCCUPATION: _____ HOW DID YOU HEAR ABOUT US? _____

HEALTH HISTORY: *Circle all that are applicable*

- | | | | | |
|--------------------|---------------------|--------------------|----------------------|--------------------|
| AIDS/HIV | Cataracts | Hepatitis | Osteoporosis | Suicide Attempt |
| Alcoholism | Chemical Dependency | Hernia | Pacemaker | Thyroid Problems |
| Allergy Shots | Chicken Pox | Herniated Disc | Parkinson's Disease | Tonsillitis |
| Anemia | Depression | Herpes | Pinched Nerve | Tuberculosis |
| Anorexia | Diabetes | High Cholesterol | Pneumonia | Tumors, Growths |
| Appendicitis | Emphysema | Kidney Disease | Polio | Typhoid Fever |
| Arthritis | Epilepsy | Liver Disease | Prostate Problems | Ulcers |
| Asthma | Fractures | Measles | Prosthesis | Vaginal Infections |
| Bleeding Disorders | Glaucoma | Migraine Headaches | Psychiatric Care | Venereal Disease |
| Breast Lump | Goiter | Miscarriage | Rheumatoid Arthritis | Whooping Cough |
| Bronchitis | Gonorrhea | Mononucleosis | Rheumatic Fever | Other _____ |
| Bulimia | Gout | Multiple Sclerosis | Scarlet Fever | |
| Cancer | Cancer | Mumps | Stroke | |

(Women) Are you pregnant? _____ Nursing? _____ Taking birth control pills? _____

DO YOU HAVE ANY AMALGAM (SILVER) DENTAL FILLINGS? _____

PLEASE LIST BELOW YOUR MAIN HEALTH COMPLAINTS IN ORDER OF IMPORTANCE.

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

HEALTH GOALS _____

I UNDERSTAND THAT THE SERVICES PROVIDED ARE STRICTLY VOLUNTARY AND IN NO WAY ARE INTENDED TO DIAGNOSE, PRESCRIBE, TREAT OR CURE DISEASE. IF I NEED THE SERVICES OF A PHYSICIAN, I WILL CONTACT ONE.

SIGNATURE _____ DATE _____

HEALTH EVALUTION

Place number next to the symptoms which apply to you:
Use (1) for MILD symptoms (2) for MODERATE symptoms (3) for SEVERE symptoms

GROUP ONE

- | | | |
|--|--|---|
| <input type="checkbox"/> "Nervous" Stomach | <input type="checkbox"/> Mentally alert, quick | <input type="checkbox"/> Cold sweats often |
| <input type="checkbox"/> Dry Mouth, eyes, nose | <input type="checkbox"/> Extremities cold, clammy | <input type="checkbox"/> Fever easily raised |
| <input type="checkbox"/> Pulse speeds after meal | <input type="checkbox"/> Heart pounds after retiring | <input type="checkbox"/> Neuralgia-like pains |
| <input type="checkbox"/> Keyed up – fail to calm | <input type="checkbox"/> Acid foods upset | |
| <input type="checkbox"/> Are your symptoms made worse by emotional stress? | | |

GROUP TWO

- | | | |
|---|---|---|
| <input type="checkbox"/> Perspire easily | <input type="checkbox"/> Digestion rapid | <input type="checkbox"/> Joint stiffness after rising |
| <input type="checkbox"/> Muscle-leg-toe cramps | <input type="checkbox"/> Vomiting frequent | <input type="checkbox"/> Circulation poor, sensitive to cold |
| <input type="checkbox"/> Eyelids swollen, puffy | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Subject to colds, asthma, bronchitis |
| <input type="checkbox"/> Indigestion soon after meals | <input type="checkbox"/> Constipation, diarrhea | |
| <input type="checkbox"/> Are your symptoms made worse by physical stress? | | |

GROUP THREE

- | | | |
|---|--|--|
| <input type="checkbox"/> Afternoon headaches | <input type="checkbox"/> Heart palpitates if meals missed or delayed | <input type="checkbox"/> Crave candy or coffee in afternoons |
| <input type="checkbox"/> Get "shaky" if hungry | <input type="checkbox"/> Awaken after few hours' can't get back to sleep | <input type="checkbox"/> Abnormal craving for sweets or snacks |
| <input type="checkbox"/> Faintness if meals delayed | | |

GROUP FOUR

- | | | |
|--|--|--|
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Hands & feet go to sleep easily, numbness |
| <input type="checkbox"/> Sigh frequently | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Tendency to anemia |
| <input type="checkbox"/> Breath heavily | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Tension under breastbone or "tightness" |
| <input type="checkbox"/> Opens window in rooms | <input type="checkbox"/> Dull pain in chest or radiating into left arm | |
| <input type="checkbox"/> Susceptible to colds/fevers | | |

GROUP FIVE

- | | | |
|---|---|--|
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Bilioussness (constipation, headaches) | <input type="checkbox"/> Laxatives used often |
| <input type="checkbox"/> Skin rashes frequent | <input type="checkbox"/> Greasy foods upset | <input type="checkbox"/> Gallbladder attacks or gallstones |
| <input type="checkbox"/> Bitter metallic taste in mouth in mornings | <input type="checkbox"/> Stools light colored | <input type="checkbox"/> Sneezing attacks |
| <input type="checkbox"/> Bowel movements painful or difficult | <input type="checkbox"/> Pain between shoulder blades | |

GROUP SIX

- | | | |
|--|--|--|
| <input type="checkbox"/> Lower bowel gas several hours after eating | <input type="checkbox"/> Coated tongue | <input type="checkbox"/> Gas shortly after eating |
| <input type="checkbox"/> Burning stomach sensations, eating relieves | <input type="checkbox"/> Indigestion ½ - 1 hour after eating; may continue for 3-4 hours | <input type="checkbox"/> Stomach “bloating” after eating |

GROUP SEVEN

- | | | |
|--|---|---|
| (A) | (C) | (E) |
| <input type="checkbox"/> Pulse fast at rest | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Failing memory | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Can't gain weight | <input type="checkbox"/> Increased sex desire | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Intolerance to heat | <input type="checkbox"/> Headaches | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Highly emotional | <input type="checkbox"/> Decreased sugar tolerance | <input type="checkbox"/> Sugar in urine(not diabetes) |
| <input type="checkbox"/> Flush easily | | <input type="checkbox"/> Masculine tendencies-female |
| <input type="checkbox"/> Night sweats | | |
| <input type="checkbox"/> Inward trembling | | |
| <input type="checkbox"/> Heart palpitates | | |
| <input type="checkbox"/> Insomnia | | |
| (B) | (D) | (F) |
| <input type="checkbox"/> Impaired hearing | <input type="checkbox"/> Bloating of intestines | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Decrease in appetite | <input type="checkbox"/> Abnormal thirst | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Weight gain around hips or waist | <input type="checkbox"/> Weakness, dizziness |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Sex desire reduced or lacking | <input type="checkbox"/> Tendency to hives |
| <input type="checkbox"/> Mental sluggishness | <input type="checkbox"/> Tendency to ulcers, colitis | <input type="checkbox"/> Arthritic tendencies |
| <input type="checkbox"/> Headaches upon arising, wear off during the day | <input type="checkbox"/> Increased sugar tolerance | <input type="checkbox"/> Perspiration-easily |
| <input type="checkbox"/> Slow pulse, below 65 | <input type="checkbox"/> Menstrual disorders | <input type="checkbox"/> Crave salt |
| <input type="checkbox"/> Increase in weight | <input type="checkbox"/> Delayed menstruation | <input type="checkbox"/> Brown spots on skin |
| | | <input type="checkbox"/> Allergies – asthma |
| | | <input type="checkbox"/> Exhaustion |
| | | <input type="checkbox"/> Respiratory issues |

GROUP EIGHT

(Female Only)

- | | | |
|---|---|---|
| <input type="checkbox"/> Painful menses | <input type="checkbox"/> Menstruation excessive and prolonged | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Premenstrual tension | | <input type="checkbox"/> Menopause, hot flashes |
| <input type="checkbox"/> Very easily fatigued | <input type="checkbox"/> Painful breasts | <input type="checkbox"/> Menses scanty |
| <input type="checkbox"/> Depressed feeling before | <input type="checkbox"/> Menstruate too frequently | <input type="checkbox"/> Acne, worse at menses |

(Male Only)

- | | | |
|---|---|---|
| <input type="checkbox"/> Tire too easily | <input type="checkbox"/> Pain on inside of legs or heel | <input type="checkbox"/> Prostate trouble |
| <input type="checkbox"/> Urination difficult | <input type="checkbox"/> Feeling of incomplete bowel evacuation | <input type="checkbox"/> Leg nervousness at night |
| <input type="checkbox"/> Night urination frequent | | <input type="checkbox"/> Diminished sex desire |

GROUP NINE

- | | | |
|--|---|---|
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Bronchitis (frequent) |
| <input type="checkbox"/> Pain around ribs | <input type="checkbox"/> Coughing up phlegm | <input type="checkbox"/> Infections settle in lungs |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Sensitive to smog |
| <input type="checkbox"/> Chest pain | | |

GROUP TEN

- | | | |
|---|--|---|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Painful/burning when passing urine |
| <input type="checkbox"/> Rose colored (bloody) | <input type="checkbox"/> Rarely need to urinate | |
| <input type="checkbox"/> Dripping after urination | <input type="checkbox"/> Strong smelling urine | <input type="checkbox"/> Urination when you cough or sneeze |
| <input type="checkbox"/> Difficulty passing urine | <input type="checkbox"/> Frequent bladder infections | |

GROUP ELEVEN

- | | | |
|--|--|--|
| <input type="checkbox"/> Throat infections | <input type="checkbox"/> Gets boils or styes | <input type="checkbox"/> Bumpy skin on back of arms |
| <input type="checkbox"/> Poor wound healing | <input type="checkbox"/> Swollen lymph glands | <input type="checkbox"/> Inflamed or bleeding gums |
| <input type="checkbox"/> Slow to recover from colds or flu | <input type="checkbox"/> Catch colds or flu easily | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Chronic lung congestion | <input type="checkbox"/> Breathe through mouth | <input type="checkbox"/> Food sensitivity or allergies |
| <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Swollen tongue | |