TRINITY HOLISTIC WELLNESS

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SYMPTOM SURVEY FORM

Name _____

Date_____ Age_____ Blood Type_____

INSTRUCTIONS: Fill in only the circles which apply to you.
- ● O O Mild Symptoms (occurred once or twice last 6 months)
- O ● O MODERATE symptoms (occurred once or twice in last month)
- O O ● SEVERE symptoms (chronic, occurred once or twice in last week)
- O O O **Leave circles BLANK if they don't apply to you!**

Group 1

O O O Get chilled often
O O O Dry mouth– eyes-nose
O O O Cut heals slowly
O O O Unable to relax; startles easily
O O O Heart pounds after retiring
O O O "Nervous" stomach
O O O Appetite reduced
O O O Cold sweats often
O O O Neuralgia-like pains

Dr. Notes:

_____
_____
_____

Group 2

O O O Joint stiffness on arising
O O O Muscle-leg-toe cramps at night
O O O Eyes or nose watery
O O O Eyelids swollen, puffy
O O O Perspire easily
O O O Circulation poor, sensitive to cold
O O O Subject to colds, asthma, bronchitis, fever

Dr. Notes:

_____
_____
_____

Group 3

O O O Eat when nervous
O O O Excessive appetite
O O O Hungry between meals
O O O Irritable before meals
O O O Get "shaky" if hungry
O O O Fatigue, eating relieves
O O O Afternoon headaches
O O O Awaken after few hours sleep
O O O Crave candy or coffee in afternoon
O O O Moods of depression- "blues"
O O O Cravings for sweets or snacks

Dr. Notes:

_____
_____

Group 4

O O O Hands and feet go to sleep easily
O O O O Sigh frequently, "air hunger"
O O O Afternoon "yawner"
O O O Swollen ankles, worse at night
O O O Muscle cramps, worse during night
O O O Shortness of breath on exertion
O O O Dull pain in chest radiating into left arm
O O O Bruise easily, "black and blue" spots
O O O Tendency to anemia
O O O "Nose bleeds" frequent
O O O Noises in head or ringing in ears
O O O Tension under the breastbone
O O O Increased blood pressure

Dr. Notes:

_____
_____
_____

Group 5

O O O Dry skin
O O O Burning feet
O O O Blurred vision
O O O Itching skin and feet
O O O Frequent skin rashes
O O O Bitter, metallic taste in mouth in AM
O O O Feeling queasy; headache over eyes
O O O Greasy foods upset
O O O Stools light covered
O O O Skin peels on foot soles
O O O Pain between shoulder blades
O O O Use laxatives
O O O Stools alternate from soft to watery
O O O History of gallbladder attacks/stones
O O O Dreaming, nightmare type bad dreams
O O O Bad breath (halitosis)
O O O Milk products cause distress
O O O Burning or itching anus

Dr. Notes:

_____
_____
_____

FILE: Left side of chart directly under Patient Records tab.

Group 6

O O O Loss of taste for meat
O O O Lower bowel gas after eating
O O O Burning stomach sensations
O O O Coated tongue
O O O Pass large amounts of foul smelling gas
O O O Indigestion 1/2-1+ hour after eating
O O O Mucous colitis or "irritable bowel"
O O O Stomach bloating after eating
O O O Digestion rapid
O O O Constipation, diarrhea alternating
O O O Bowel movements painful or difficult
O O O Tendency to ulcers, colitis

Dr. Notes:

_____
_____
_____
_____

Group 7A

O O O Can't gain weight
O O O Intolerance to heat
O O O Highly emotional
O O O Night sweats
O O O Inward trembling, Nervousness
O O O Heart palpitations
O O O Can't work under pressure

Dr. Notes:

_____
_____
_____
_____

Group 7B

O O O Increase in weight
O O O Decrease in appetite
O O O Fatigue easily
O O O Sleepy during day
O O O Sensitive to cold
O O O Constipation
O O O Mental sluggishness
O O O Hair coarse, falls out
O O O Frequency of urination
O O O Impaired hearing
O O O Reduced initiative
O O O Headaches upon arising, wear off during day

Dr. Notes:

_____
_____
_____
_____

Group 7C

O O O Failing memory
O O O Low blood pressure

Group 7D

O O O Abnormal thirst
O O O Bloating of abdomen
O O O Weight gain around hips or waist
O O O Sex drive reduced or lacking

Dr. Notes:

_____
_____

Group 7F

O O O Chronic fatigue
O O O Nails weak, ridged
O O O Tendency to hives
O O O Arthritic tendencies
O O O Poor Circulation
O O O Crave salt
O O O Brown spots or bronzing of the skin
O O O Allergies– tendency to asthma
O O O Weakness after colds, influenza

Dr. Notes:

_____
_____

Group 8

O O O Irritability
O O O Morbid fears
O O O Never seem to get well
O O O Forgetfulness
O O O Muscular soreness
O O O Depression; feelings of dread
O O O Noise sensitivity
O O O Acoustic hallucinations
O O O Tendency to cry without reason
O O O Anxiety
O O O Inability to concentrate; confusion
O O O Allergy to some foods
O O O Loose joints

Dr. Notes:

_____
_____

Allergies

Food Allergies: ☐ None ☐ Yes

Explain: _____

_____

Environmental Allergies:

☐ None ☐ Dust ☐ Pollen ☐ Ragweed ☐ Molds ☐ Grass Other: _____

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Sleep

How many sleep hours do you get? _____

How many do you think you need? _____

Describe how you fall asleep?

□ Watch TV □ Read a Book □ Go to Bed

Other: _____

Do you have trouble falling asleep?

□ Yes □ No □ Sometimes

How long does it take you to fall asleep? _____

If you awaken at night, do you have trouble falling back asleep? □ Yes □ No □ Sometimes

How long does it take to fall back asleep? _____

What time do you go to bed? _____

What time do you get up? _____

Are your sleep habits routine? □ Yes □ No

Why not?_____

Do you have trouble waking up in the morning?

□ Yes □ No □ Sometimes

Do you feel well rested upon awakening?

□ Yes □ No □ Sometimes

Do you get tired during the day?

□ Yes □ No □ Sometimes What times?_____

Do you get a second wind late at night?

□ Yes □ No □ Sometimes How often/ week? _____

On a scale 1-10 highest what is your present energy level? □1 □2 □ 3 □4 □5 □6 □7 □8 □9 □10

Exercise Programs

Are you doing any type of exercise?

☐ Consistently ☐ Yes ☐ No

Explain:_____

_____

_____

Weight/Height

Present Weight _____lbs.

Height _____ft._____inches

MAX. Weight as an Adult _____

When _____Circumstances _____

MIN. Weight as an Adult _____

When _____ Circumstances _____

What is your healthy weight?_____

Bowel Movements

Number per day? _____ Number per week? _____

Do you notice a change w/diet? If yes, what change?

_____

_____

How many times per week for solid stools? _____

For runny or loose stools? _____

What color? ☐ Clay ☐ Lt. Brown ☐ Med. Brown ☐ Dark Brown ☐ Black ☐ Tan ☐ Red

Dr. Notes: _____

_____

_____

Sexual Activity

Do you still have pain or discomfort with sexual intercourse? ☐ Yes ☐ No If yes, explain _____

What is the frequency of your present sexual activity?

Per Week/Month/Year_____

Do you find your present method satisfactory for your health? ☐ Yes ☐ No

Have you ever had a sexually transmitted disease?

☐ Yes ☐ No If yes, explain _____

Daily Beverages & Food Cravings

Water: Daily, in ounces: (by itself) _____

Caffeine Free Beverages:

Type:_____

Type:_____

Type:_____

Type:_____

Caffeinated Beverages:

Type:_____

Type:_____

Type:_____

Type:_____

When you have intense cravings, which foods or type of foods do you usually crave? ☐ Chocolate ☐ Sweets ☐ Salty ☐ Other: _____

Dr. Notes:

_____

_____

_____

_____

Female Only

Menstrual History

O O O Premenstrual tension
O O O Painful menses
O O O Depressed feeling before period
O O O Menstruation excessive
O O O Painful breasts
O O O Menstruate too frequently
O O O Hysterectomy/ ovaries removed
O O O Menses scanty or missed
O O O Acne worse at menses
O O O Depression of long standing

Dr. Notes: _____

_____

_____

_____

Age at First Menstrual Period _____

Date Last Menstrual Period_____

How many days from start of one period to start of the next?_____

How many days does (did) your period last? _____

Is (was) your cycle regular?

☐ Yes ☐ No ☐Not Always

Do (did) you pass any clots? ☐ Yes ☐ No

Is (was) the flow ☐ Heavy ☐ Medium ☐ Light

Age and year of menopause_____

Dr. Notes:

_____

_____

_____

_____

Pre/Peri/Post Menopausal

Do you have hot flashes/night sweats?

☐Yes ☐No # during day _____

☐ Mild ☐Moderate ☐Severe

☐Yes ☐No # during night ____

☐Mild ☐ Moderate ☐ Severe

Ever taken HRT or BHRT?

☐ Yes ☐ No

Name:_____Dosage:_____

Age while on HRT/BHRT_____

How many years on it _____

Dr. Notes:

_____

_____

Urogenital

Any increase of urinary frequency or urgency?

☐ Yes ☐ No How Long? _____

Any urinary incontinence? ☐ Yes ☐ No

UTI's? ☐ Yes ☐ No If yes, when_____

Blood in urine ☐ Yes ☐ No

Dr. Notes: _____

_____

Female Reproductive History

Have you been treated for infertility?

☐Yes ☐ No Please indicate what type and duration:

☐1 Injections: _____ ☐2 Clomid: _____

☐3 IVF: _____ ☐4 Other : _____

Have you used an IUD? ☐Yes ☐ No

Describe any problems with IUD: _____

Have used any form of Birth Control Pill Patch or Shot?

☐Yes ☐ No Please indicate how long:

☐1 Pill: _____ ☐2 Shot : _____

☐3 Patch: _____ ☐4 Other : _____

Age while on BC _____

Have you ever been pregnant? ☐Yes ☐ No

Number of Pregnancies:

☐1 ☐2 ☐3 ☐ 4 ☐ 5 ☐ 6 ☐7 ☐ 8 ☐9

How old were you during pregnancies _____

Describe any complications with pregnancies/deliveries?

_____

How much did each child weigh _____

_____

_____

Did you breastfeed? ☐ Yes ☐ No

If so, how long? _____

Number of Miscarriages _____

Number of stillbirths _____

Number of premature births _____

Number of cesarean births _____

Number of abortions _____

Dr. Notes: _____

_____

_____

_____

Childhood History

Childhood Diseases and/or Accidents

Disease/Surgery/ And/or Type of Accident Age

1._____

2._____

3._____

4._____

Birth Order _____ Birth Weight _____lb. _____oz.

Number of Siblings

Full_____ Half siblings_____ Step_____

Parents: Married ☐Yes ☐ No

If no, your age at separation/divorce_____

Is your mother living? ☐Yes ☐ No

If no, how old was she at time of death?_____

How old were you?_____

Is your father living?☐Yes ☐ No

If not, how old was he at time of death?_____

How old were you?_____

Microbial Issues

Do you currently experience yearly sinus, strep, ear and/or yeast infections? ☐Yes ☐ No If yes, how many times per year:

Sinus_____ Strep_____ Yeast_____

Ear_____ Other (name)_____

Have you experienced yearly sinus, strep, ear and/or yeast infections in the past?

☐Yes ☐ No If yes, how many times per year and duration for:

Sinus_____ Strep_____ Yeast_____

Ear_____ Other (name)_____

International Travel

Have you traveled internationally?

☐Yes ☐ No If yes, list year, your age at time of travel and destination.

Destination: _____Year/age_____/____

Destination: _____Year/age_____/____

Destination: _____Year/age_____/____

Destination: _____Year/age_____/____

Did you or any of your travel companions experience an illness or GI complaint during travel? ☐Yes ☐ No If yes, explain.

_____

_____

_____

_____

_____

Goals:

(What do you want to accomplish at Trinity Holistic Wellness).

1._____

2. _____

3._____

4. _____

What percent are you committed to getting well? _____

Is there anything you would like to add? Use back of page if necessary.