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** _____

DATE OF BIRTH_____**WEIGHT**_____**HEIGHT**_____**SEX:** ☐ Male ☐ Female **MARRIED:** ☐ Yes ☐ No

OCCUPATION:_____**HOW DID YOU HEAR ABOUT US?**_____**BLOOD TYPE** _____

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. _____
5. _____
6. _____

HEALTH GOALS _____

LIST SURGERIES YOU HAVE HAD _____

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 EVALUATION INSTRUCTIONS

Place number next to the symptoms which apply to you:

Use (1) for MILD symptoms = Symptoms occurring once or twice a month
Use (2) for MODERATE symptoms = Symptoms occurring once or twice a week
Use (3) for SEVERE symptoms = Symptoms occurring daily

LEAVE IT BLANK IF YOU DO NOT HAVE THE SYMPTOM

GROUP ONE

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

GROUP TWO

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

GROUP THREE

___ Afternoon headaches
___ Get "shaky" if hungry
___ Faintness if meals delayed
___ Family history of diabetes
___ Heart palpitates if meals missed or delayed
___ Eat when nervous
___ Awaken after few hours' hard to get back to sleep
___ Crave candy or coffee in afternoon
___ Dizziness when standing up quickly
___ Wake up in middle of night to eat
___ Abnormal craving for sweets or snacks

GROUP FOUR

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

GROUP FIVE

___ Dry skin
___ Skin rashes frequent
___ Bitter metallic taste in mouth in mornings
___ Biliousness (constipation, headaches)
___ Greasy foods upset
___ Stools light colored
___ Pain between shoulder blades
___ Laxatives used often
___Gallbladder attacks or gallstones
___ Gallbladder removed
___ Sneezing attacks
___ Bowel movements painful or difficult

GROUP SIX

___ Lower bowel gas several hours after eating
___ Burning stomach sensations, eating relieves
___ Coated tongue
___ Indigestion ½ - 1 hour after eating
___ Gas shortly after eating
___ Stomach "bloating" after eating
___ History of ulcers

GROUP SEVEN

(A)

___ Pulse fast at rest
___ Nervousness
___ Can't gain weight
___ Intolerance to heat
___ Highly emotional
___ Flush easily
___ Night sweats
___ Inward trembling
___ Heart palpitates
___ Insomnia

(C)

___ Low blood pressure
___ Failing memory
___ Increased sex desire
___ Headaches
___ Decreased sugar tolerance

(E)

___ Hot flashes
___ Headaches
___ Dizziness
___ High blood pressure
___ Sugar in urine(not diabetes)
___ Masculine tendencies-female

(B)

___ Impaired hearing
___ Decrease in appetite
___ Ringing in ears
___ Constipation
___ Mental sluggishness
___ Headaches upon arising, wear off during the day
___ Slow pulse, below 65
___ Increase in weight
___ Loss of outside eyebrow
___ Chronic fatigue

(D)

___ Bloating of intestines
___ Abnormal thirst
___ Weight gain around hips or waist
___ Sex desire reduced or lacking
___ Tendency to ulcers, colitis
___ Increased sugar tolerance
___ Menstrual disorders
___ Delayed menstruation

(F)

___ Low blood pressure
___ Chronic fatigue
___ Weakness, dizziness
___ Tendency to hives
___ Arthritic tendencies
___Perspiration-easily
___ Crave salt
___ Brown spots on skin
___ Allergies – asthma
___Exhaustion
___Respiratory issues

GROUP EIGHT

(*Female Only*)

___ Painful menses
___ Premenstrual tension
___ Menopause, hot flashes
___ Very easily fatigued
___ Menstruation excessive and prolonged
___Acne, worse at menses
___ Depressed feeling before
___ Painful breasts
___Vaginal discharge
___ Menstruate too frequently
___ Menses scanty

(Male Only)

___ Tire too easily
___ Urination difficult or slow
___ Night urination frequent
___ Pain on inside of legs or heel
___ Feeling of incomplete bowel evacuation
___ Dripping after urination
___ Prostate trouble
___ Leg nervousness at night
___ Diminished sex desire

GROUP NINE

___ Chronic cough	___ Difficulty breathing	___ Bronchitis (frequent)
___ Pain around ribs	___ Coughing up phlegm	___ Infections settle in lungs
___ Shortness of breath	___ Coughing up blood	___ Sensitive to smog
___ Chest pain		

GROUP TEN

___ Frequent urination	___ Cloudy urine	___Painful/burning when passing urine
___ Rose colored (bloody)	___ Rarely need to urinate	___ Urination when you cough or sneeze
___ Dripping after urination	___ Strong smelling urine	
___ Difficulty passing urine	___ Frequent bladder infections	

GROUP ELEVEN

___ Throat infections	___ Gets boils or styes	___ Bumpy skin on back of arms
___ Poor wound healing	___ Swollen lymph glands	___ Inflamed or bleeding gums
___ Slow to recover from colds or flu	___ Catch colds or flu easily	___ Hyperactivity
___ Chronic lung congestion	___ Breathe through mouth	___ Food sensitivity or allergies
___ Post nasal drip	___ Swollen tongue	

Please list any medications that you are taking at the present and the reason for taking:

1._____

2._____

3._____

4. _____

5. _____

6. _____

7._____

8._____

9._____

10._____