Dr. Viviane Renard, RN, DOM
Acupuncture • Herbs • Essential Oils • Nutrition • Life Style Coaching • Detox
10900 Menaul Blvd., Suite E, Albuquerque, NM 87112
Cell: 505-280-8327 Fax: 505-312-7613
Email: acudocnm07@comcast.net • Website: www.dr-renard.com

Dear:

Congratulations for wanting to improve your health–your appointment is greatly appreciated. Thank you for your interest in Acupuncture treatments and inquiring about information to improve your overall wellness. I am here to help.

As a Doctor of Oriental Medicine and Licensed Acupuncturist, I'll be asking you many questions. Every question is important to help make the right diagnosis and complete an accurate picture of your heath condition. Some of the questions may seem repetitive, because I work with two systems that dovetail Western and Oriental Medicine together. Your first appointment will be lengthy, it consists of an interview, examination, evaluation and treatment, so count on being in the clinic for one to one and a half hours–sometimes longer. Your return appointments will be about one hour.

Please wear comfortable clothes and eat something before your appointment. Do not brush your tongue before your treatment because tongue and pulse diagnosis are important parts of your diagnosis. Also, please bring any lab work results you have to your first appointment.

I also perform Ionized Detox foot baths. This is a noninvasive detox of heavy metals, chemicals, parasites and all kinds of lifetime toxins build up, which often is the cause of low energy and various health problems. (Please note that this is not covered by insurances).

I am a Provider for BCBS, Presbyterian, Lovelace, Cigna and United so bring your insurance card.

Please call your insurance provider to see if you are covered for Acupuncture and how many treatments you are allowed or if you have meet your deductibles.

I look forward to meeting you, and feel honored to work with you on your wellness issues and living a life of better health. If you have any questions, please contact me on my cell phone number: **505-280-8327** I'll try to return your call as soon as possible. I would appreciate a call 24 hours prior to your appointment if you need to cancel.

Please fill out the entire questionnaire and bring it with you on your first appointment or fax it to **505-312-7613.**

Blessings,
Dr. Viviane Renard, RN, DOM
State Board Certified
25 years of Health Care Experience

Se Habla Español

The following information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Dr. Renard, DOM, 24 hours prior to any cancellations or changes to my appointment time and that if I do not, I may be charged for the appointment.

X Signed:_____ Date: _____

Parent/Guardian (If applicable): _____

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Confidential New Patient Information (Mark what is applicable)

Today's Date: _____
Name:_____ Date of Birth:_____
Address:_____City\State _____
Home Phone:_____Cell:_____ Zip Code:_____
Email Address:_____
Height:_____ Weight:_____Age:_____Sex: Female_____ Male_____
Occupation:_____ Emergency Phone Number:_____
Number of children living with you:_____Ages of children:_____
Number who lives with you: _____ Others living with you: _____
Employed by:_____Work Phone:_____
Martial Status: Single_____Married_____Divorced_____Widowed_____Separated_____
Dom. Partner_____Spouse\Partner Name:_____ Employed by:_____
Name of Insured:_____Insured's Date of Birth:_____
Name of Insurance Co:_____Name of Plan:_____
Insured's ID Number:_____Insured's Group Number:_____
Insurance Address:_____Insurance Phone:_____
How did you hear of us: Yellow Pages_____Article_____Brochure_____Bussiness Card_____Other_____
Referred by:_____

Medical History

Reason for your visit today:_____

_____

From "0-10" with 10 as the strongest commitment, how committed are you to get better with treatments and possible necessary lifestyle changes?_____

What are your expectations with the acupuncture treatments?_____

_____

Primary Care Doctor:_____Phone:_____
Has this condition been diagnosed by your MD? Yes_____No_____
If yes, who?_____
Have these treatments helped? Yes_____Somewhat_____Not Much_____Not at all_____
How does this condition affect you, your daily life?_____
How long have you had this condition?_____
Were X-rays\labs taken previously for this problem?_____When?_____
Where?_____
Surgeries: Please specify_____
Allergies: food_____environmental_____medicines_____
Allergic reactions?_____

Medications

Please list all prescriptions and over the counter medications you are currently taking:

Drug Name:	Reason for taking:	For how long:	Dose:	Frequency:

Please list all supplements and herbs you are currently taking:

Supplement:	Reason for taking:	For how long:	Potency:	Frequency:

Lifestyle

(Daily amount used within the past 2 months)

Tobacco: ❑ Yes ❑ No Amount_____ Alcohol: ❑ Yes ❑ No Amount_____
Coffee: ❑ Yes ❑ No Amount_____ Recreational Drugs: ❑ Yes ❑ No Amount_____
Do you feel you are at or near your ideal weight? ❑ Yes ❑ No
Do you feel you have enough Energy? ❑ Yes ❑ No
Best time of day:_____ Worst time of day:_____
Favorite Season:_____ Hours of sleep\night?_____
Do you feel rested after a night's sleep?_____ Do you remember your dreams?_____
Typical day's meals:
Breakfast:_____
Lunch:_____
Dinner:_____
Food Cravings:_____
Skipping meals:_____
Religion or other spiritual practice:_____
Hobbies or other recreation:_____
What kind of physical exercise do you do regularly?_____
Hours of television watched per week?_____ Hours of work per week?_____
Highest level of education completed? ❑ High School ❑ Bachelors ❑ Masters ❑ Doctorate ❑ Other
How would you rate your current stress level? ❑ Extreme ❑ Very High ❑ High ❑ Moderate ❑ Low

Family History

	Diabetes	Cardiac	Mental Issues	Alive	Cause of Death
Mother:	❑	❑	❑	❑	❑
Father:	❑	❑	❑	❑	❑
Siblings:	❑	❑	❑	❑	❑
Other Family Member:	❑	❑	❑	❑	❑

Number of biological Brothers: _____ Sisters: _____ Were you adopted? ❑ Yes ❑ No

Childhood diseases/trauma: ❑ Yes ❑ No

Did you feel safe and nurtured as a child? ❑ Always ❑ Usually ❑ Sometimes ❑ Never

What would you characterize as your predominant emotion right now? ❑ Anxiety/Worry ❑ Anger ❑ Grief ❑ Fear/Dread ❑ Depression ❑ Melancholy ❑ Happiness ❑ Contentment ❑ Joy ❑ Numbness ❑ Apathy ❑ Other _____

Mental or emotiotional issues: ❑ Yes ❑ No

Any addictions? ❑ Alcohol ❑ Drugs ❑ Smoking ❑ Sex ❑ Gambling ❑ Food ❑ Other_____

If yes, which ones?_____

Do you enjoy your work? ❑ Yes ❑ Usually ❑ Sometimes ❑ Rarely ❑ No

Why or why not?_____

Do you have animals/pets? ❑ Yes ❑ No

If yes, which ones?_____ How many?_____

Do you love where you live? ❑ Yes ❑ Usually ❑ Sometimes ❑ Rarely ❑ No

Why or why not?_____

Do you feel you have a higher purpose for your life? ❑ Yes ❑ Usually ❑ Sometimes ❑ Rarely ❑ No

Do you feel safe in your personal relationship(s)? ❑ Always ❑ Usually ❑ Sometimes ❑ Never

Do you feel nurtured by your current significant relationship(s)? ❑ Always ❑ Usually ❑ Sometimes ❑ Never

Are you happy with your current significant relationship(s)? ❑ Always ❑ Usually ❑ Sometimes ❑ Never

Are you satisfied with your sex life? ❑ Yes ❑ Usually ❑ Sometimes ❑ Rarely ❑ No

If you were guaranteed success, and money and time were not obstacles, what would you do with your life?

_____

_____

Please feel free to express any concerns or thoughts you feel may be relevant to your health below:
Use the diagram if desired to mark your pain spots.

_____

_____

_____

_____

_____

_____

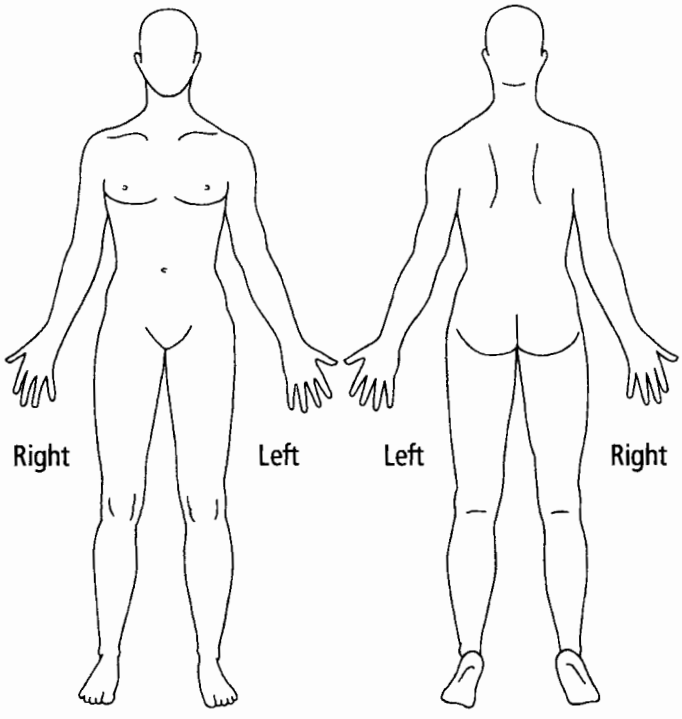
_____

_____

_____

_____

_____



Women Only

Are you pregnant right now? ❑ Yes ❑ No ❑ Trying ❑ Maybe

Method of Birth Control: _____

Age at first period: _____ Date of last menses: _____

Age at Menopause: _____

Typical length of cycle (Days): _____ Number of Pregnancies: _____

Births: _____ Abortions: _____ Miscarriages: _____

Hysterectomy: ❑ Yes ❑ No

Check all that apply:

___ Low Libido ___ Excessive Libido ___ Painful Intercourse ___ Clotting

___ Painful Periods ___ Heavy Flow ___ Scanty Flow ___ Bleeding Between Cycles ___ Irregular Cycles

___ Vaginal Discharge ___ Breast lumps/tenderness ___ Nipple Discharge ___ Infertility

___ Menopausal Symptoms ___ Premenstrual Problems

Health Inventory

Cardiovascular Conditions
___ Heart Disease
___ Pacemaker
___ High Blood Pressure
___ Low Blood Pressure
___ Chest Pain
___ Palpitations
___ Stroke
___ Varicose Veins
___ Edema–Where?
___ Cholesterol Issues
___ Other:_____

Musculo-Skeletal
___ Neck/Shoulder Pain
___ Muscle Spasms/ Cramps
___ Arm Pain
___ Upper Back Pain
___ Mid Back Pain
___ Low Back Pain
___ Leg Pain
___ Osteoporosis/ Osteopenia
___ Arthritis
___ Joint Pain
___ Gout
___ Other: _____

Endocrine
___ Hypothyroid
___ Hashimoto's
___ Hypoglycemia
___ Hyperthyroid
___ Grave's
___ Diabetes Type I
___ Diabetes Type II
___ Night Sweats
___ Unusual Sweating
___ Feeling Hot or Cold
___ Weight Loss
___ Weight Gain
___ Other: _____

Emotional/Mental
___ Clinical Depression
___ Mild Depression
___ ADD or ADHD
___ Schizophrenia
___ Mood Swings
___ Panic Attacks
___ Nervousness
___ Anxiety
___ Bulemia
___ Anorexia
___ Other: _____

Head, Eye, Ear, Nose, Throat
___ Impaired Vision
___ Eye Pain/Strain
___ Glaucoma
___ Glasses/Contacts
___ Tearing/Dryness
___ Impaired Hearing
___ Ringing in Ears
___ Earaches
___ Ear Infections
___ Headaches
___ Sinus Problems
___ Nose Bleeds
___ Teeth Grinding
___ Frequent Sore Throat
___ TMJ/Jaw Problems
___ Hay Fever
___ Other: _____

Other
___ Cancer–When?____ Type? _____
___ Fibromyalgia
___ Lupus
___ Candida/Yeast
___ Anemia
___ Rashes
___ Eczema/Hives
___ Cold Hands/Feet
___ Hemophilia
___ Thin/Graying Hair
___ Lyme disease
___ Herpes I, II
___ Shingles
___ HIV
___ Other: _____

Energy & Immunity
___ Chronic Fatigue Syndrome
___ General Fatigue
___ Slow Wound Healing
___ Easy Bruising
___ Chronic Infections
___ Frequent Allergies
___ Insomnia
___ Other: _____

Genito-Urinary Tract
___ Kidney Disease
___ Kidney Stones
___ Painful Urination
___ Dribbling Urination
___ Frequent UTI
___ Blood in Urine
___ Discharge
___ Incontinence
___ Other: _____

Neurological
___ Vertigo/Dizziness
___ Paralysis
___ Numbness/Tingling
___ Loss of Balance
___ Seizures/Epilepsy
___ Dyslexia
___ Alzheimer's
___ Poor Memory
___ Dementia
___ Parkinson's
___ MS
___ Other: _____

Liver Conditions
___ Hepatitis A
___ Hepatitis B
___ Hepatitis C
___ Enlarged Liver
___ Fatty Liver
___ Severe Alcohol Use
___ Other: _____

Respiratory
___ Pneumonia
___ Asthma
___ Frequent Common Colds
___ Difficulty Breathing
___ Emphysema
___ Persistent Cough
___ Pleurisy
___ Tuberculosis
___ Shortness of Breath
___ Other: _____

Gastrointestinal
___ Stomach Ulcers
___ Changes in Appetite
___ Nausea/Vomiting
___ Epigastric/Abdominal Pain
___ Passing Gas
___ Heart Burn
___ Belching
___ Gall Bladder Disease
___ Gall Bladder Stones
___ Gall Bladder Removal
___ Hemorrhoids
___ Constipation
___ Diarrhea
___ Celiac
___ Gluten sensitive
___ IBS
___ Crohn's
___ Other: _____

Men Only
___ Impotence
___ Vasectomy Date: _____
___ Prostate Problems
___ Testicular Pain/ Redness/Swelling
___ Low Libido
___ Excessive Libido
___ Painful Intercourse
___ Seminal Emissions
___ Elevated PSA
___ Other: _____

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Informed Consent to Health Care by a Doctor of Oriental Medicine

I hereby request and consent to the performance of Acupuncture treatments and other procedures within the scope of practice of Oriental Medicine on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Oriental Medicine, Dr. Viviane Renard, D.O.M. and\or other doctors of Oriental Medicine who now or in the future treat me while employed by, working or associated with or serve as back-up for Dr. Renard, including those working at the clinic or office listed below, any other office or clinic, whether signatories to this form or not. The modalities utilized include, but are not limited to: acupuncture, oral history taking, pulse and tongue diagnosis, manipulation of various parts of the body, observation,range of motion evaluation, muscle, orthopedic and neurologic testing, tui na (massage), heat or cold therapy, electrical stimulation, cupping, ear acupuncture, herbal and nutritional counseling and considerations, exercise and lifestyle counseling. I understand that if I become pregnant, I must inform Dr. Renard, D.O.M. immediately as certain acupuncture points can cause spontaneous abortion and certain herbs are not permitted during pregnancy or breast feeding. I understand that I must inform Dr. Renard with any change in my conditions at the next clinical visit. I understand that while unlikely, possible risks include but are not limited to the treatment, some bruising of the skin and\or slight bleeding, puncture of organs, pneumothorax (puncture of the lung), pain caused by insertion of the needles which may occur at the site of insertion or travel to a distal point. If Moxibution or heat therapies are used there is a risk of bruising and scarring. The risk of infection is small when all needles are sterile. Needles are considered sterile when they are disposable. Only disposable needles are used. I do not expect the doctor to be able to anticipate and explain all risks and complications. I do rely on the doctor to exercise judgment which the doctor feels at the time is in my best interest, based upon the facts then known, during the course of the procedure.

I have had the opportunity to discuss with Dr. Renard, D.O.M. the nature and purpose of Oriental Medicine. I understand that results are not guaranteed. I also understand that it is expected normal practice for a medical practitioner to seek consultations with other practitioners, and that while our work together may not be part of the process, my identity will not be discussed. I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment or any part of it, before or during the course of the treatments. I understand that the doctor is not providing Western (allopathic) medical care, and that I should look to my Western primary practitioner for those services and for routine check-ups. I understand that all medical record and what I share with Dr. Renard will remain strictly confidential within certain legal limits. At the present time Medicare and Medicaid will not pay for the above described treatments\services. Payment by private insurance companies vary according to each plan. I understand that I will be responsible for the full payment. Unless there is an emergency, I agree to cancel an appointment at least 24 hours ahead of time or I will be charged for the missed appointment. I have read, or had read to me the above consent. I also had the opportunity to ask questions and its content, and by signing below I agree to the above procedures. I intend for this consent form to cover the entire course of treatment for the present condition and for any future conditions for which I seek treatment.

I understand that Dr. Renard reserves the right to make appropriate Western\psychological referral for my condition. As a result, I understand that I may not be able to receive treatment, as my condition does not fall within the scope of Oriental Medicine.

The following is to be completed by the patient or by the patient's representative if the patient is a minor or legally Incapacitated for any reason.

Printed Name of Patient	Printed Name of Patient Representative
Signature of Patient	Signature of Representative
Date Signed	Relationship to Patient

BALANCING BODY CHEMISTRY *HEALTH ASSESSMENT*

Balancing Body Chemistry

Name: _____ Sex: ___ D.O.B. ____ Date: _____

Patient's Health Professional: _____

PART I

Circle any of the following medications you are taking:

- Antacids
- Antibiotic/Antifungal
- Antidepressants
- Antidiabetic/Insulin
- Aspirin/Tylenol
- Chemotherapy
- Cortisone Anti-Inflammatories
- Diuretics
- Heart Medications
- High Blood Pressure
- Hormones
- Laxatives
- Lithium
- Oral Contraceptives
- Radiation
- Relaxants/Sleeping Pills
- Recreational Drugs Specify _____
- Thyroid
- Ulcer Medications
- Other _____

Circle if you eat, drink, or use:

- Alcohol
- Candy
- Carbonated Beverages
- Cigarettes
- Coffee
- Distilled Water
- Fluoridated/Chlorinated Water
- At fast food restaurants regularly
- Fried Foods
- Refined (White) Flour Products
- Luncheon Meats
- Margarine
- Refined Sugars
- Milk Products
- Artificial Sweetners
- Non-Herbal Teas
- Chew Tobacco
- Vitamins & Minerals
- Specify _____

Circle if you:

- Diet often
- Salt food without tasting
- Exercise less than 3 times weekly
- Are under excessive stress
- Are exposed to chemicals at work
- Are exposed to cigarette smoke

DIRECTIONS: **Please read each description and darken the number which best describes the frequency of your symptoms within the past year. If you do not understand a symptom, put a (?) *before* the symptom's number.**

KEY: **0 = Never** **1 = Mild** (Occurs once a month or less) **2 = Moderate** (Occurs several times monthly) **3 = Severe** (Aware of it almost constantly)

PART II

IMPORTANT

Dear Patient, Please list your five major health concerns in order of importance:

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

PART III

CATEGORY I

Section A:

1. Bad breath, halitosis	0	1	2	3
2. Loss of taste for high protein foods (meat, etc.)	0	1	2	3
3. Burning ("acid") or nervous stomach, eating relieves	0	1	2	3
4. Gas shortly after eating	0	1	2	3
5. Indigestion 1/2 to 1 hour after eating, may last 3-4 hours	0	1	2	3
6. Difficulty digesting fruits or vegetables; undigested foods found in stools	0	1	2	3
7. Acid or spicy foods upset stomach	0	1	2	3

Section B:

8. Lower bowel gas and or bloating several hours after eating	0	1	2	3
9. Feet burn	0	1	2	3
10. "Whites" of eyes (sclera) yellow	0	1	2	3
11. Dry skin, itchy feet and/or skin peels on feet	0	1	2	3
12. Brown spots or bronzing of skin	0	1	2	3
13. Bitter metallic taste in mouth	0	1	2	3
14. Blurred vision	0	1	2	3
15. Headache over eyes	0	1	2	3
16. Feel nauseous, queasy or gag easily	0	1	2	3
17. Color of stools light brown or yellow	0	1	2	3
18. Greasy or high fat foods cause distress	0	1	2	3
19. Pain between shoulder blades	0	1	2	3
20. Dark circles under eyes	0	1	2	3
21. "Acid" breath	0	1	2	3
22. History of gallbladder attacks or gallstones OR gallbladder removed	YES		NO	
23. Appetite reduced	0	1	2	3

Section C:

24. Coated tongue or "fuzzy" debris on tongue	0	1	2	3
25. Pass large amounts of foul smelling gas	0	1	2	3
26. Irritable bowel or mucous colitis	0	1	2	3
27. Constipation, diarrhea alternating or stools alternate from soft to watery	0	1	2	3
28. Bowel movements painful or difficult, constipation, and/or laxatives used	0	1	2	3
29. Burning or itching anus	0	1	2	3

CATEGORY II:

30. Head congestion/"sinus fullness:	0	1	2	3
31. Sneezing attacks	0	1	2	3
32. Dreaming, nightmare-like bad dreams	0	1	2	3
33. Milk products and/or wheat products cause distress	0	1	2	3
34. Eyes and nose watery	0	1	2	3
35. Eyes swollen and puffy	0	1	2	3
35. Pulse speeds after meals and/or heart pounds after retiring	0	1	2	3

CATEGORY III:

Section A:

37. Crave sweets or coffee in afternoon or mid-morning	0	1	2	3
38. Hungry between meals or excessive appetite	0	1	2	3
39. Overeating sweets upsets	0	1	2	3
40. Eat when nervous	0	1	2	3
41. Irritable before meals	0	1	2	3
42. Get "shaky" or light-headed if meals delayed	0	1	2	3
43. Fatigue, eating relieves	0	1	2	3
44. Heart palpitates if meals missed or delayed	0	1	2	3
45. Awaken a few hours after sleep, hard to get back to sleep	0	1	2	3

Section B:

46. Muscle soreness after moderate exercise	0	1	2	3
47. Vulnerability to insect bites (especially fleas and mosquitoes)	0	1	2	3
48. Loss of muscle tone or "heaviness" in arms or legs	0	1	2	3
49. Enlarged heart and/or heart failure	0	1	2	3
50. Worrier, feel insecure and/or highly emotional	0	1	2	3
51. Pulse slow/below 65 or irregular pulse	YES		NO	

PART III (Continued)

CATEGORY IV

Section A:

52. Sex drive increased 0 1 2 3
53. "Splitting" type headaches 0 1 2 3
54. Memory failing 0 1 2 3
55. Tolerance for sugar reduced 0 1 2 3

Section B:

56. Sex drive reduced or absent 0 1 2 3
57. Abnormal thirst 0 1 2 3
58. Weight gain around hips or waist 0 1 2 3
59. Tendency to ulcers or colitis 0 1 2 3
60. Increased abilitly to eat sugar without symptoms ... 0 1 2 3
61. Menstrual disorders (women) 0 1 2 3
62. Lack of menstruation (young girls) 0 1 2 3

Section C:

63. Difficulty gaining weight, even if large appetite 0 1 2 3
64. Heart palpitations 0 1 2 3
65. Nervous, emotional, and/or can't work under pressure 0 1 2 3
66. Insomnia 0 1 2 3
67. Inward Trembling 0 1 2 3
68. Night Sweats 0 1 2 3
69. Fast pulse at rest 0 1 2 3
70. Intolerant to high temperatures 0 1 2 3
71. Easily flushed 0 1 2 3

Section D:

72. Difficulty losing weight 0 1 2 3
73. Reduced initiative and/or mental sluggishness 0 1 2 3
74. Easily fatigued, sleepy during the day 0 1 2 3
75. Sensitive to cold, poor circulation (cold hands and feet) 0 1 2 3
76. Dry or scaly skin 0 1 2 3
77. "Ringing" in ears/noises in head 0 1 2 3
78. Hearing impaired 0 1 2 3
79. Constipation 0 1 2 3
80. Excessive falling hair and/or coarse hair 0 1 2 3
81. Headaches when awaken/wear off during day 0 1 2 3

Section E:

82. Blood pressure increased 0 1 2 3
83. Headaches 0 1 2 3
84. Hot flashes 0 1 2 3
85. Hair growth on face or body (Question to females) 0 1 2 3
86. Masculine tendencies (Question to females) 0 1 2 3

Section F:

87. Blood pressure low 0 1 2 3
88. Crave salt 0 1 2 3
89. Chronic fatigue/get drowsy 0 1 2 3
90. Afternoon yawning 0 1 2 3
91. Weakness/dizziness 0 1 2 3
92. Weakness after colds/slow recovery 0 1 2 3
93. Circulation poor 0 1 2 3
94. Muscular and nervous exhaustion 0 1 2 3
95. Subject to colds, asthma, bronchitis (respiratory disorders) 0 1 2 3
96. Allergies and/or hives 0 1 2 3
97. Difficulty maintaining manipulative correction 0 1 2 3
98. Arthritic tendencies 0 1 2 3
99. Nails weak, ridged 0 1 2 3
100. Perspire easily 0 1 2 3
101. Slow starter in morning 0 1 2 3
102. Afternoon headaches 0 1 2 3

CATEGORY V

Section A:

103. Frequent skin rashes and/or hives 0 1 2 3
104. Muscle-leg-toe cramping at rest and/or while sleeping 0 1 2 3
105. Fever easily raised/fevers common 0 1 2 3
106. Crave Chocolate 0 1 2 3
107. Feet have bad odor 0 1 2 3
108. Hoarseness frequent 0 1 2 3
109. Difficulty swallowing 0 1 2 3
110. Joint stiffness after rising 0 1 2 3
111. Vomiting frequent 0 1 2 3
112. Tendency to anemia 0 1 2 3
113. "Whites" of eyes (sclera) blue 0 1 2 3
114. "Lump" in throat 0 1 2 3
115. Dry mouth-eyes-nose 0 1 2 3
116. White spots on finger nails 0 1 2 3
117. Cuts heal slowly and/or scar easily 0 1 2 3
118. Reduced or "lost" sense of taste and/or smell 0 1 2 3
119. Susceptible to colds, fevers, and/or infections 0 1 2 3
120. Strong light irritates eyes 0 1 2 3
121. Noises in head or ringing in ears 0 1 2 3
122. Burning sensations in mouth 0 1 2 3
123. Numbness in hands and feet (extremities "go to sleep") 0 1 2 3
124. Intolerant to monosodium glutamate (MSG) ..... YES 3 NO 0
125. Cannot recall dreams 0 1 2 3
126. Nose bleeds frequent 0 1 2 3
127. Bruise easily, "black and blue" spots 0 1 2 3
128. Muscle cramps, worse with exercise ("charley horses") 0 1 2 3

CATEGORY VI

129. Aware of heavy and/or irregular breathing 0 1 2 3
130. Discomfort in high altitudes 0 1 2 3
131. "Air hunger"/sigh frequently 0 1 2 3
132. Swollen ankles/worse at night 0 1 2 3
133. Shortness of breath with exertion 0 1 2 3
134. Dull pain in chest and/or pain radiating into left arm, worse on exertion 0 1 2 3

CATEGORY VII

Female Only

135. Premenstrual tension 0 1 2 3
136. Painful menses (cramping,etc.) 0 1 2 3
137. Menstruation excessive or prolonged 0 1 2 3
138. Painful/tender breasts 0 1 2 3
139. Menstruate too frequently 0 1 2 3
140. Acne, worse at menses 0 1 2 3
141. Depressed feelings before menstruation 0 1 2 3
142. Vaginal discharge 0 1 2 3
143. Menses scanty or missed 0 1 2 3
144. Hysterectomy/ovaries removed ..... YES 3 NO 0
145. Menopausal hot flashes 0 1 2 3
146. Depression 0 1 2 3

CATEGORY VIII

Male Only

147. Prostate trouble 0 1 2 3
148. Urination difficult or dribbling 0 1 2 3
149. Night urination frequent 0 1 2 3
150. Pain on inside of legs or heels 0 1 2 3
151. Feeling of incomplete bowel evacuation 0 1 2 3
152. Leg nervousness at night 0 1 2 3
153. Tire easily/avoid activity 0 1 2 3
154. Reduced sex drive 0 1 2 3
155. Depression 0 1 2 3
156. Migrating aches and pains 0 1 2 3