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WELLNESS CHART

Please READ THIS FIRST before beginning to fill the form in

Welcome! To provide the best care possible, we need to evaluate your entire case by piecing together a complete profile and understanding all the features that make you unique as an individual. The WHOLE is always the SUM of the parts.

To collaborate in treatment it is important to get to know all the details of your experience. This includes your reactions to various factors, physical sensations (what does it feel like), and function (how it impacts you) what makes it better or worse, your past and family history and your mental makeup. This information enables us to get a fuller understanding of how we together.

In order know all about you, I will be asking you many questions. Each one of these questions has a definite meaning and significance. There is not a single question that is useless. Even something that you may think is not connected with your challenges, may be the most important factor in deciding the best course of treatment. That is why you must be free and honest and give the fullest possible information on each question and statement asked below.

Please read each question carefully, think, and if necessary, consult someone close to you and then answer completely. Do not keep anything back. Remember, whatever you write or discuss will remain absolutely confidential. You will spend approximately 30 min to an hour in this part of the process.

THIS QUESTIONNAIRE HAS 3 PARTS:
About your past illnesses. Please take time to answer this part with the help of your family members before coming to your appointment.

1. Present and past history
2. Physical experiences
3. About your mental state and your emotional nature.

Today's Date: _____

Name: _____
Age: _____ Birth date:_____ Sexual Identity: _____
Phone: (home)_____ (work)_____(cell)_____
Email:_____
(Please indicate preferred hours to reach you, at which number, and if it is appropriate for me to leave a message should it not be a private line/email address.)
Mailing Address:_____
_____
_____
I I live alone / with:_____
Were you referred? If so, by who? If not, how did you hear?
_____
_____
Name of current General Practitioner (MD):_____
Last visit to your GP: _____
Reason for your last visit:_____

When was your last physical exam?_____
Are you seeing a medical specialist?_____
Specialist's name:_____
For what reason:_____
When was your last visit to the dentist?_____
Do you see another type of complimentary health practitioner and if so what kind and how often?_____
_____
_____

How would you describe your general, overall state of health?
Excellent____ Good____ Fair____ Poor____

PREVIOUS DISEASES & DRUG USED

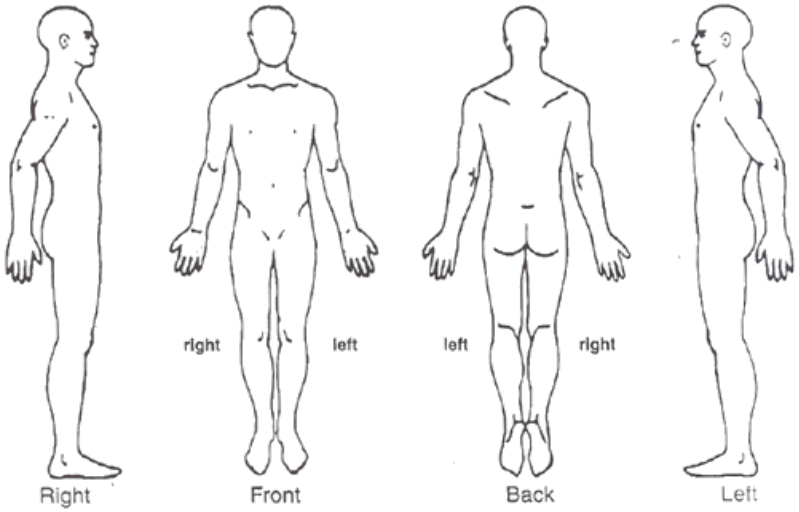
Every disease, poisoning, drug or accident leaves its mark and remains as a weak point in the system, much more than we imagine. The goal is to strengthen your body. Therefore, it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

In the list below, circle or indicate below (if working remotely online) names of ALL major illness so far suffered and on the next page give its relevant details.

Typhoid Cholera Food Poisoning Worms Diarrhea Dysentery	Measles German Measles Shingles Chicken-pos Small-pox Mumps Whooping cough	Malaria Jaundice Any Liver Spleen or Gall bladder disease	Miscarriage Abortion Curettage (scraping of skin or internal surface for removing disease tissue or obtain specimen) Sickness during pregnancy Prolapse of uterus
Malnutrition	Venereal Diseases:	Heart Trouble:	Kidney or urine trouble

Rickets Rheumatism Backache	Syphilis Gonorrhea Chlamydia Herpes H.I.V.	High/Low Blood pressure Heart Murmurs Palpitation Giddiness	Diabetes Prostate Cancer Prostatitis
Operations: Tonsils Abdomen Appendix Hernia Uterus Renal stones Gall stones Hydrocele Cataract Mode of Anesthesia: general-local	Diphtheria Septic Tonsils Adenoids Recurrent infections- Sinusitis Bronchitis Eosinophilia (in response to certain drugs, allergies, parasitic infestation)	Cold-Fever Chill Pneumonia Asthma Pleurisy T. B.	Serious shock, grief, disappointments, fright, mental upset, anxiety, depression or nervous break down.
Chronic Headaches Migraines Numbness Cramps Fits Convulsions Polio Paralysis Meningitis Any Lumbar Puncture	Major accident or injury to body or head Occasion of unconsciousness Major bleeding from any part of the body	Skin diseases: Acne Boils Carbuncles Eczema Urticaria Ulcers on any part of the body	Skin diseases (con): Ringworms Fungus Scabies Herpes -cold sores Allergy Unexplained rashes or bumps

Use the symbols to mark areas of concern.



● Pain / tenderness

▲ Numbness / tingling

Stiffness

■ Swelling

Comments:

_____

_____

_____

_____

Were you on antibiotics for an extended period of time over the last ten years and if so, please explain when, why and for how long?

_____
_____
_____

Please list past: injuries, traumas, bites

_____
_____
_____
_____

Please list (as best you can) hospitalizations, surgeries, x-rays and other imaging scans that you've had along with the year in which they took place and what for.

_____
_____
_____
_____

YOU AS A CHILD (IN CASE OF ADULT)

Please check mark once if you as child had any of the below qualities. Place two checks if the symptoms are more intense.

Quality	Check	Quality	Check
Obstinacy		Unusual Fears	
Temper tantrums		Shyness	
Disobedience		Unusual Attachments (to whom?)	
Aggression		Biting Nails	
Hyperactivity		Dullness of memory	
Destructiveness		Slowness (in what?)	
Possessiveness		Laziness/Indolence	
Competition - Winning Spirit		Sensitive/Emotional	
Sibling Jealousy			
Any Special Skills			
Unusual Desires (for what?)			
Stealing			
Telling Lies			

Please describe any other aspects you feel are striking about you as a child.

_____
_____

Describe one incident from the child's life when he/she was very upset. _____
_____

NUTRITION ASSESMENT

HT:	WT:

Weight History _____
Diet History _____
How is your appetite? _____
When are you hungry? _____
What happens if you have to remain hungry for long?
_____
How fast do you eat? _____
How much thirst do you have?
_____
Any particular times are you especially thirsty?
_____

24 Hour Recall/Typical Day

Breakfast:

Snack:

Lunch:

Snack:

Dinner

Please put one check mark if you Like/ Dislike the food or if the food disagrees. Put two check marks, if you strongly like / dislike the food or if the food strongly disagrees.

Taste	Like	Dislike	Disagrees
Bitter			
Extra Salt			
Sweet			
Sour			
Bread			
Butter			
Fats			
Milk			
Coffee			
Eggs			
Spicy Food			
Meat			
Fish			
Warm Food/Drink			
Cold Food/Drink			

STOOL

Do you have any problem with your stools? Yes/No If yes, please explain.
_____
_____
When and how many times a day you pass stools? _____
When is it urgent? _____
Do you have to strain for stool? _____
Even if soft? Yes/No

SWEAT / PERSPIRATION - FEVER - CHILL

How much do you sweat? _____Where and on what part of the body do you sweat most? _____
Do you perspire on the palms or soles? Yes/No
Do you experience any sense of heat or cold in any part of your body at any particular time?
_____

CHEST - HEAT - COLD - COUGH

Is there any trouble with your CHEST or HEART? Yes/No_____
Is there any difficulty in breathing? Yes/No _____

FOR WOMEN

Menses: How are your periods; regular or irregular? _____
At what age did you start? _____
Was there any trouble then? _____
Timing between two periods. _____ Number of days of flow. _____
Menstrual flow: Is there any change now in quantity, color, smell or consistency?
_____
_____
Clots?_____
_____
Do you suffer in any way before, during or after menses?
If so, describe. _____
Number of pregnancies _____
Miscarriages or terminated pregnancies _____
If YES have your processed these experiences? _____

SENSES

VERTIGO - Do you have dizziness - vertigo? Yes/No
Do you ever feel faint? Yes/No
HEAD - Do you get headaches? Yes/No Migraines? If yes, please describe from start
_____
_____

EYES & VISION?_____
EARS & Sense of hearing?_____
NOSE & Sense of smell? _____
FACE & Facial expression?_____
MOUTH & Sense of taste? _____
LIPS : Cracked, peeling of skin

_____
TEETH, GUMS, carious teeth, bleeding gums. swollen gums.

_____
THROAT (including tonsils): _____
Any difficulty in swallowing? Sensations?(eg. a lump, hair or splinter)_____
Do you have any trouble in your BACK, LIMBS OR JOINTS?
Describe_____
_____
_____
Is Are there any senses of weakness? Where? _____
When is it more or less? _____
Is it in any particular part of the body? _____

MIND

Your mind has tremendous influence on your body. For giving proper treatment it is absolutely necessary for us to understand your emotional and intellectual nature. We can thus treat you as a whole. In order to understand you I will be asking questions. Answer them freely, carefully and completely. This information will help us much in giving you the correct remedy. Also such a remedy will help improve your mental makeup. There is no judgment, right or wrong. Answer freely, frankly and completely.

Are you anxious? About which matters?
_____

Are you fearful of anything such as animals, people, being alone, darkness, death, disease, robbers, sudden noises, thunder, of the future, of something unknown, high places, etc.?
_____

Are you doubtful or suspicious? Of what?
_____
What are you jealous about? Of whom? _____
From what symptoms do you suffer when jealous?
_____
In which matter are you impatient? _____
Hurried? _____
How long do you remember hurts caused to you by others? _____
How do feelings of revenge you show up in you? _____
What are you proud of? _____
Does your pride get easily hurt? _____
Depression, Brooding, etc.? _____

Do you ever become suicidal? _____When?_____
_____
Even then, are you afraid of dying? _____
When are you cheerful? _____
How is your memory? _____ For what is it poor? e.g. names, places, faces, what you have read, what you've just heard _____
Do you weep easily? _____What makes you weep?
_____

How do you feel after weeping?
_____
How do you feel if someone offers sympathy and consolation?
_____

Are you easily irritated? Yes/No What makes you angry?
_____
What bodily symptoms do you develop when angry? e.g. trembling, sweating
_____
How are you with criticism?_____
Do you like company? Yes/No Or like to remain alone? (natural preference)Yes/No_____
_____
How seriously are you affected by disorder and uncleanliness in your surrounding?
_____
What are the greatest grievances that you have gone through in your life?
_____
What are the greatest joys that you have had in life?
_____
Moment in your life that changed your thought pattern was?_____
_____

What activities you deeply like-that you're really passionate about?
_____
_____
Are there any matters which you deeply dislike?
_____
In your opinion, which aspects of your mind and moods are not agreeable to you. In-spite of your awareness and maturity, are you unable to change these aspects?
_____
_____

Give a clear cut picture of your situation in life and your relationship with each of your family members, friends and associates in work.
_____
_____
_____
_____

How does the future look to you?

_____

When you are free, what thoughts come to your mind?

_____

Where would you place the level of personal stress you are experiencing right now?
Minimal Average Considerable Intolerable

The main stressor:

What "triggers" your stress?_____

If asked for 3 desires or wishes in life, what will you ask for?

_____

_____

_____

How do symptoms of stress show up in you (physical/emotional)? Any peculiar sensations?

_____

The favorite and least favorite part of your life is_____

_____

Your pet peeves are what?_____

You find yourself most frustrated with what/when?_____

_____ _____

FINISH THESE STATEMENTS

What makes no sense at all about me is_____

_____

I should_____

_____

The repeated thoughts/overplayed tapes in my head are_____

_____

The emotional climate of my home is_____

_____

Workplace is_____

The story of my life right now is..... the title of my biography would be_____

I have never been the same since_____

In what sense?_____

Favorite quote? What does it trigger for you?

_____

_____

Tattoos ? of what and why if of significance for you?_____

_____

What do people tease you about? _____

SLEEP

Describe your posture in sleep, on the back, side, abdomen, etc.

_____

Are you able to sleep in any position? Yes/No In which position can't you sleep and why?

_____

How long does it take you to fall asleep?_____
Do you wake often in the night? Particular time?_____
Do you wake feeling rested?_____
Average number hours of sleep? _____ Optimal # of hours in a perfect world?_____

PLEASE CIRCLE/INDICATE THE TYPES OF DREAMS YOU HAVE

Animals	Robbers	Traveling	Houses	Death, Whose?
Cats Dogs	Thieves	Riding	Fruits	Dead Bodies
Horses	Anxious	Flying	Trees	Dead Persons
Wild Animals	Fearful	Swimming	Water	Parts of a Body
Snakes	Ghosts	Drowning	Snow	Suicide
Being Hungry	Fire	Accidents	Talking	Business
Being Thirsty	Lightening	Falling	Singing	Money
Drinking	Storms	Shooting	Dancing	Day's Work
Eating	Rain	Wars	Pleasant	Forgotten Work or forgetting
Vomiting	Romantic	Pain	Praying	Failure/Exams
Passing Stool	Sexual	Illness	Religious	
Unsuccessful Efforts? For What?				
Urinating	Rape	Blood	Nakedness	
Mutilations	Church	Trains		
Excrements/Soiling	God	Being Unprepared		Vivid dreams?
Grief	Weeping	Vexation	Quarrels	Jealousy Insults
Police	Imprisonment	Crime	Murder Killing	Poison Misfortunes
Insecurity	Danger	Being pursued -By whom ?- For what ?		
Of people	Of events	Physical Exertion		
Children	Remote	Being lost	Mental Exertion	
Parties	Fatigue	Feasts	Future	
Marriage	Prophetic	Colored	Multi-Colored	
paralysis	slow motion	can't see	can't hear	can't speak can't scream

Recurring dreams at any period in or throughout your life or particular theme?

_____
_____
_____