PERSONAL HEALTH APPRAISAL (PHA)

Name _____ Phone (home) _____

Address _____ Phone (business) _____

_____ Occupation _____

Birthdate _____ Referred by _____

Please Follow These Instructions Carefully

IMPORTANT: The information requested in this form is of vital importance to you and your health facilitation. It is designed to help you understand your current state of health. Seeing your complete health picture helps you and your health care professional identify the natural medicines and therapies best suited to the dynamic restoration of YOUR health.

Read each question carefully and score ONLY those statements which pertain to you on a 1 – 5 scale of intensity, 5 being the strongest.

If a question does not apply to you, LEAVE IT BLANK. If you are not sure and have a doubt about a question, or wish to clarify the answer, describe in the space available.

SCORE THE DEGREE OF SEVERITY OF SYMPTOMS IN EACH SQUARE BELOW FROM 1 TO 5.

1 - VERY MILD OR OCCASIONAL
2 - MILD
3 - MODERATE
4 - SEVERE
5 - VERY SEVERE

- EXAMPLE -

[4] **Do you have headaches?** I get headaches on an empty stomach

GENERAL HEALTH ENHANCEMENT

WHAT PRIORITIES WOULD YOU LIKE TO SEE BETTER OR IMPROVED IN YOUR HEALTH?

_____

_____

_____

HEALTHY MEN & WOMEN

DESCRIBE

Women answer questions 1-21. Men answer questions 22-29.

1 [ ] **Are you pregnant?** _____
2 [ ] **Have you had a miscarriage or are you prone to miscarry?** _____
3 [ ] **Is intercourse painful for you?** _____
4 [ ] **Do you have diminished sexual desire?** _____
5 [ ] **Do you have difficulty controlling sexual desire?** _____
6 [ ] **Have you had a hysterectomy?** _____
7 [ ] **Do you have frequent yeast infections?** _____
8 [ ] **Do you have problems with fertility?** _____
9 [ ] **Do you experience morning sickness with pregnancy?** _____
10 [ ] **Are you going through or have symptoms of menopause?** _____
11 [ ] **Do you have pre-menstrual syndrome?** _____
12 [ ] **Do you retain fluid during your period?** _____
13 [ ] **Do you have menstrual pain, cramps or irregularities?** _____
14 [ ] **Do you have feminine discharge?** _____
15 [ ] **Do you have vaginal pain or discomforts?** _____

HEALTHY MEN & WOMEN cont...

DESCRIBE

16 ☐ Have you been diagnosed with endometriosis? _____
17 ☐ Do you have breast cysts/lumps? _____
18 ☐ Do you have breast mastitis? _____
19 ☐ Do you have tender or sore nipples? _____
20 ☐ Do you frequently feel hot or perspire? _____
21 ☐ Do you have any other female disorders? Explain. _____
22 ☐ Do you have prostate enlargement? _____
23 ☐ Do you have dribbling after urination? _____
24 ☐ Do you have an urgency to urinate? _____
25 ☐ Do you have erectile dysfunction? _____
26 ☐ Do you have premature ejaculations? _____
27 ☐ Do you have decreased sexual desire? _____
28 ☐ Do you have difficulty controlling sexual desire? _____
29 ☐ Do you have any other male disorders? Explain. _____

HEALTHY CHILDHOOD

DESCRIBE

1 ☐ Is your child a bed wetter? _____
2 ☐ Does your child have jaundice? _____
3 ☐ Does you baby have colic? _____
4 ☐ Do you or your child have swollen tonsils? _____
5 ☐ Does your child have swollen glands? Where? _____
6 ☐ Does your child have learning disabilities? _____
7 ☐ Does your child have attention deficit disorder? _____
8 ☐ Is your child hyperactive? _____
9 ☐ Does your child have problems with teething? _____
10 ☐ Does your child have recurring fears? _____
11 ☐ Does your child have recurring fevers? _____
12 ☐ Does your child have recurring nightmares? _____
13 ☐ Does your child have recurring tummy aches? _____
14 ☐ Does your child have abnormal growth patterns? _____
15 ☐ Are there any other childhood disorders? Explain. _____
16 ☐ Did or does your child have reactions from vaccinations? Yes ____ No ____ Explain. _____
_____
17 ☐ Does your child suffer from poor appetite? _____
18 ☐ Does your child have excessive appetite? _____

HEALTHY BODY

DESCRIBE

1 ☐ Have you been diagnosed with osteoporosis or weakened bones? _____
2 ☐ Do you have heel spurs? _____
3 ☐ Do you have hair growth abnormalities? _____
4 ☐ Do you have nail growth abnormalities? _____
5 ☐ Are you commonly tired or fatigued? _____
6 ☐ Do you feel weakness or exhaustion? _____
7 ☐ Does eating relieve fatigue? _____
8 ☐ Do you feel shaky when hungry? _____
9 ☐ Are you a diabetic? Yes ____ No ____ What type? _____
10 ☐ Have you ever been diagnosed with low blood sugar problems? _____
11 ☐ Do you have excessive thirst? _____
12 ☐ Do you have increased urination and constipation associated with sugar consumption? _____
13 ☐ Do you experience jet lag or problems with shift changes? _____
14 ☐ Do you have tremors? _____
15 ☐ Do you have tics (twitching)? _____
16 ☐ Do you have excessive plaque and coating build-up on your teeth? _____
17 ☐ Do you have insomnia? _____
18 ☐ Do you have any abnormal sleep patterns? _____
19 ☐ Have you ever had reactions from vaccinations? Yes ____ No ____ Explain. _____
20 ☐ Do you have ringing in the ears, hearing loss, or acute sensitivity to sounds? _____
21 ☐ Please describe any known genetic weaknesses within you or your family. _____
_____
22 ☐ Do you suffer from restless leg syndrome? _____
23 ☐ Do you suffer from leg cramps? _____

HEALTHY SKIN

DESCRIBE

1 ☐ Do you have teenage acne? _____
2 ☐ Do you have middle age acne? _____
3 ☐ Is your skin generally unhealthy? _____
4 ☐ Do you have premature aging and wrinkles? _____
5 ☐ Do you have any abnormal skin growths or discolorations? _____
6 ☐ Do you have athlete's foot? _____
7 ☐ Do you have insect bite reactions or allergies? _____
8 ☐ Are insects attracted to you? _____
9 ☐ Do you scar easily? _____
10 ☐ Do you have any pain or discomforts in or around any scars? _____
11 ☐ Do you have adhesions? Explain. _____
12 ☐ Do you have excess body perspiration? _____
13 ☐ Do you have excess body odor? _____
14 ☐ Do you have reactions to poison ivy, oak or sumac? _____

HEALTHY SKIN cont...

DESCRIBE

15 ☐ Do you have oily, dry or itchy skin? _____
16 ☐ Do you have eczema? _____
17 ☐ Do you have psoriasis or cracking skin? _____
18 ☐ Do you have cysts, warts, moles, liver spots, and/or fungus growths? _____
19 ☐ Do you have rashes or vesicles (small blisters)? _____
20 ☐ Do you have herpes or shingles? _____
21 ☐ Do you have cold sores, fever blisters or canker sores? _____
22 ☐ Are you troubled with boils? _____
23 ☐ Do you get sores that are slow to heal? _____
24 ☐ Do you have warts? _____
25 ☐ Are you troubled with corns? _____
26 ☐ Do you have any other skin disorders? Explain. _____

HEALTHY EYES

DESCRIBE

1 ☐ Do you wear corrective lenses? _____
2 ☐ Do you experience dry itchy, watery or red eyes? _____
3 ☐ Do you have eye discomforts associated with allergies and hay fever? _____
4 ☐ Are you troubled with conjunctivitis (pink eye)? _____
5 ☐ Do you have styes? _____
6 ☐ Do you have cataracts? _____
7 ☐ Do you have eye stress? _____
8 ☐ Do your eyes fatigue easily? _____
9 ☐ Do you have macular degeneration? _____
10 ☐ Do you have other eye conditions? Yes ___ No ___ Describe _____

HEALTHY PAIN RELIEF

DESCRIBE

1 ☐ Have you been diagnosed with rheumatoid arthritis? _____
2 ☐ Have you been diagnosed with osteo-arthritis? _____
3 ☐ Does any part of your body experience numbness/tingling? ___ Where? _____
4 ☐ Do you have back problems? ___ Where? _____
5 ☐ Do you have a spinal curvature? _____
6 ☐ Do you suffer from muscle cramps? _____
7 ☐ Do you suffer from muscle spasms? _____
8 ☐ Are your muscles frequently sore? _____
9 ☐ Do you have muscle weakness? _____
10 ☐ Are your joints stiff in the morning? _____
11 ☐ Do you suffer from painful feet? _____

HEALTHY PAIN RELIEF cont...

DESCRIBE

12 ☐ Have you been diagnosed with gout? _____

13 ☐ Do you have headaches? Yes ___ No ___ Explain. _____

14 ☐ Do you have migraine headaches? Yes ___ No ___ Explain. _____

15 ☐ Do you have sciatica? _____

16 ☐ Do you have teeth and/or gum problems? _____

17 ☐ Do you have amalgam/metal fillings? Yes ___ No ___ How many? _____

18 ☐ Do you have jaw problems? _____

19 ☐ Do you bruise easily? _____

20 ☐ Have you been diagnosed with neurological disease? _____

21 ☐ Do you have any other pain or injuries? ___ Explain. _____

HEALTHY WEIGHT

DESCRIBE

1 ☐ Are you overweight? _____ Estimated ___ lbs. overweight _____

2 ☐ Are you underweight? _____ Estimated ___ lbs underweight _____

3 ☐ How often do you exercise? _____
- Once a week ___
- Twice a week ___
- Three times a week ___
- Five times a week ___
- More than 5 times a week ___

4 ☐ What type of exercise do you do?
- Walking ___
- Running ___
- Jogging ___
- Aerobics ___
- Swimming ___
- Other _____

5 ☐ How much water do you drink daily?
- Less than 4 cups ___
- 4 – 8 cups ___
- More than 8 cups ___

6 ☐ Do you crave sweets? _____

7 ☐ Do you have an excessive appetite? _____

8 ☐ Do you have a poor appetite? _____

9 ☐ Do you desire to vomit after eating? _____

10 ☐ Do you have any obsessive dietary habits? Explain. _____

11 ☐ Do you have an eating disorder? _____

12 ☐ Do you eat when nervous? _____

13 ☐ Do you have edema or water retention? Where? _____

14 ☐ Do you have any other weight disorders? Explain. _____

HEALTHY CONTROL

DESCRIBE

1 ☐ Do you smoke tobacco?
How much do you smoke a day? _____

2 ☐ Do you chew tobacco?
How much do you chew a day? _____

HEALTHY IMMUNE

DESCRIBE

1 ☐ Are you bothered with viruses at various times during the year? _____
2 ☐ Do you have food allergies? _____
3 ☐ Are you sensitive to chemicals? Explain. _____
4 ☐ Are you oversensitive to the environment? _____
5 ☐ Do you have recurring infections, virus, bacteria, fungus or other? _____
6 ☐ Do you have colds or flu often? Yes ___ No ___ How often? _____
7 ☐ Do you cough frequently? _____
8 ☐ Do you have frequent earaches or discharges? _____
9 ☐ Do you have ringing in the ears or a loss of hearing? _____
10 ☐ Have you been diagnosed with Lyme disease? _____
11 ☐ Do you have frequent laryngitis or hoarseness? _____
12 ☐ Do you have fevers frequently? _____
13 ☐ Do you have frequent sinusitis? _____
14 ☐ Do you have frequent sore throats? _____
15 ☐ Are your glands often swollen? _____
16 ☐ Are your tonsils often swollen? _____
17 ☐ Do you have sinus headaches? _____
18 ☐ Do you have yeast or fungal overgrowths and/or candida albicans infections? _____
19 ☐ Do you have any other immune disorders? _____

HEALTHY DIGESTION

DESCRIBE

1 ☐ Do you have problems with constipation? _____
2 ☐ Do you use laxatives? _____
3 ☐ Do you have diarrhea? _____
4 ☐ Do you have colitis? _____
5 ☐ Have you been diagnosed with a gall bladder condition? _____
6 ☐ Do you have gall stones? _____
7 ☐ Do you have black stools? _____
8 ☐ Do you have red or bloody stools? _____
9 ☐ Do you have problems with heartburn? _____
10 ☐ Do you have problems with hemorrhoids? _____
11 ☐ Do you have problems with rectal fissures or polyps? _____
12 ☐ Do you have indigestion? ___ When? _____
13 ☐ Do you have problems with gas? _____
14 ☐ Do you have problems with bloating? _____
15 ☐ Do you experience any pain or tenderness in your abdomen? _____
16 ☐ Have you ever had intestinal worms, itchy nose or rectum? _____
17 ☐ Are you frequently nauseated or vomit easily? _____
18 ☐ Do you suffer from motion sickness? _____
19 ☐ Have you been diagnosed with stomach ulcers? _____
20 ☐ Do you have any other digestive disorders? _____

HEALTHY DIGESTION cont...

DESCRIBE

21 ☐ Do you have frequent foul smelling lower gas? _____

22 ☐ Do you have frequent foul smelling stools? _____

23 ☐ Do you have frequent problems with upper gas, such as belching? _____

HEALTHY URINARY

DESCRIBE

1 ☐ Do you have frequent urination? _____

2 ☐ Do you ever lose control of your bladder or dribble when sneezing or laughing? _____

3 ☐ Do you have painful urination? _____

4 ☐ Do you have difficulty in starting the stream? _____

5 ☐ Do you have frequent kidney or bladder infections? _____

6 ☐ Do you have or have you ever had kidney stones? _____

7 ☐ Do you have any other urinary tract disorders? _____

HEALTHY CIRCULATION

DESCRIBE

1 ☐ Do you have slurred or stuttered speech? _____

2 ☐ Do you have confusion? _____

3 ☐ Have you been diagnosed with a heart condition? _____

4 ☐ Do you have low blood pressure? _____

5 ☐ Do you have high blood pressure? _____

6 ☐ Do you have circulatory problems? _____

7 ☐ Are you often dizzy? _____

8 ☐ Do you get light headed when standing quickly? _____

9 ☐ Do you have cold hands or feet? _____

10 ☐ Do you experience spells of rapid heart beat? _____

11 ☐ Are you aware of your heart skipping beats? Yes ___ No ___
What is going on in your life when you notice this condition? _____

12 ☐ Do you have nosebleeds? _____

13 ☐ Do you have varicose or spider veins? _____

14 ☐ Have you been diagnosed with phlebitis? _____

15 ☐ Do you have any other circulatory disorders? Explain. _____

HEALTHY RESPIRATION

DESCRIBE

1 ☐ Do you have hay fever and/or allergies? _____

2 ☐ Is your nose frequently stuffy? _____

3 ☐ Have you been diagnosed with asthma? _____

4 ☐ Have you been diagnosed with emphysema? _____

5 ☐ Have you been diagnosed with bronchitis or pneumonia? _____

6 ☐ Do you have a chest pain or discomfort? _____

7 ☐ Do you have post-nasal drip? _____

8 ☐ Do you spit up phlegm? _____

9 ☐ Do you snore frequently or loudly? _____

10 ☐ Do you have any other respiratory disorders? Explain. _____

HEALTHY DETOXIFICATION

DESCRIBE

1 ☐ Does acid accumulate in your body? _____

2 ☐ Do you have any tumors or abnormal growths? _____

3 ☐ Have you been diagnosed with a liver condition? _____

4 ☐ Have you ever had chemotherapy or radiation treatment? _____

5 ☐ Do you have pain or sensitivity in the lower right portion of the abdomen? _____

6 ☐ Have you worked or lived in any toxic environments that you are aware of? Explain. _____

7 ☐ Do you have any other toxic condition? Explain.

_____

8 ☐ Have you been exposed to toxic metals (tooth fillings, old plumbing or paint, frequent seafood consumption, etc?)

_____

9 ☐ Do you live in an area of heavy outdoor pollution? _____

10 ☐ Does breathing the air in your house or workplace aggravate your symptoms? _____

11 ☐ Are you frequently in contact with household chemicals and /or topical cosmetics? _____

12 ☐ Are you aware of exposure to pesticides or herbacides? _____

13 ☐ Are you aware of any reactions to food additives or preservatives? _____

HEALTHY SPORTS ENHANCEMENT

DESCRIBE

1 ☐ Are you interested in increasing muscular strength or bodybuilding? _____

2 ☐ Do you have sports injuries? _____

3 ☐ Do you have soreness, bruises, tightness and stiffness after sports activities? _____

4 ☐ Are you interested in any sports enhancements? ___ Explain. _____

HEALTHY ALLERGY CORRECTION

DESCRIBE

1 ☐ Do you have any allergies? _____ If yes, please list. _____

2 ☐ Do you live/work in a moldy environment? _____

3 ☐ Are you sensitive to dairy products? _____

4 ☐ Are you sensitive to animal hair/dander? _____

5 ☐ Do you know of any food allergies? _____ If yes, please list: _____

_____

HEALTHY CANCER SUPPORT

DESCRIBE

1 ☐ Do or did any of your immediate family members have cancer? _____ If yes, describe in detail. _____

_____

_____

_____

2 ☐ Do have cancer or have you had it in the past? _____

ENVIRONMENTAL ADAPTATION

DESCRIBE

1 ☐ Do you have general symptoms that are created or aggravated by cold/dry environments? _____

2 ☐ Do you have general symptoms that are created or aggravated by cold/damp environments? _____

3 ☐ Do you have general symptoms that are created or aggravated by hot/humid environments? _____

4 ☐ Do you have general symptoms that are created or aggravated by hot/dry environments? _____

5 ☐ Do you have general symptoms that are created or aggravated due to changing of seasons? _____

HEALTHY MIND AND EMOTIONS

DESCRIBE

See our comprehensive Personal Health Appraisal for Healthy Mind & Body

1 ☐ Do you suffer from or have you suffered from any mental or emotional traumas? _____

2 ☐ Do you have agoraphobia: fear of crowds or going out of the house? _____

3 ☐ Are you usually jumpy? _____

4 ☐ Do you suffer from nervousness? _____

5 ☐ Do you have claustrophobia: a fear of closed spaces? _____

6 ☐ Do you have signs of depression? _____

7 ☐ Do you portray signs of manic depression or personality shifts? _____

8 ☐ Do you have feelings of grief or guilt? _____

9 ☐ Do you have recurring fears or nightmares? _____

10 ☐ Do you have recurring fears or phobias? _____

11 ☐ Do you feel you are under considerable emotional stress? Yes ___ No ___ Please describe: _____

_____

12 ☐ Do you have any obsessive behaviors? _____

13 ☐ Have you been diagnosed with epilepsy? _____

14 ☐ Do you suffer from poor concentration? _____

15 ☐ Do you suffer from loss of memory? _____

16 ☐ Do you suffer from confusion? _____

17 ☐ Do you have any other mental or emotional disorders? Explain. _____

1 ☐ **List all nutritional supplements, home remedies, etc. you have tried and their results. Mark what you are now taking.**

2 ☐ **Have you taken a lot of over the counter (OTC) medicines over the years?**

3 ☐ **List any prescription drugs you have taken in the past:**

4 ☐ **List any prescription drug(s) you are taking now, how long you've taken them, and the condition you are taking them for.**

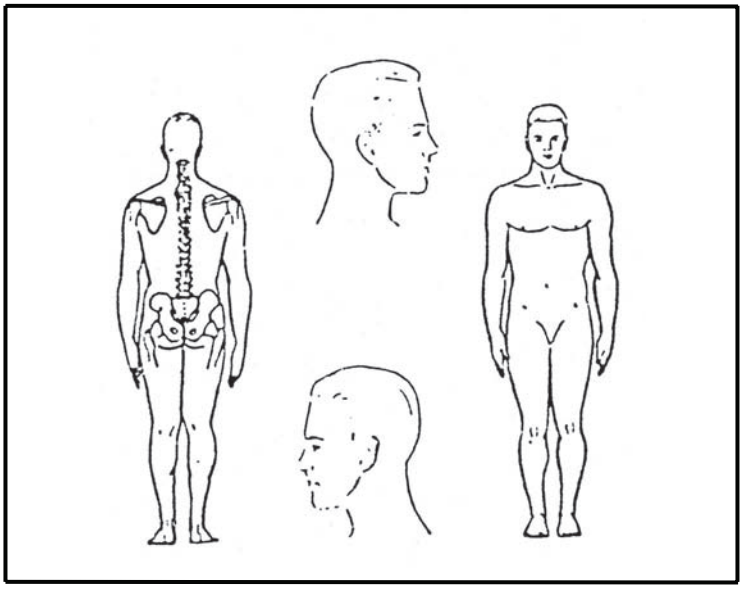
5 ☐ **Please feel free to write any personal information that you feel to be important to your health and well-being. This information is necessary for us to provide you with the highest quality health care possible:**

The major health problems of your immediate family will assist us in understanding your health pattern. Report all diseases, sicknesses, reasons for hospitalization, cause and age of death, etc.

NAME	RELATION	HEALTH PROBLEMS

Please mark your areas of pain on the figures at right.

Describe the pain:



The information I have provided is to the best of my knowledge, accurate and true.

Signature of Patient or Guardian: **Date:**

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.