

**HEALTH PROFILE QUESTIONAIRE**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Date:** |  |

**Please place a check mark next to any symptoms you are CURRENTLY experiencing:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **HEAD** | Headaches  Faintness  Dizziness | | Difficulty falling asleep  Difficulty staying asleep | | | |
| **EYES** | Watery, dry or itchy  Swollen, reddened or sticky eyelids | | Bags or dark circles  Blurred or tunnel vision | | | |
| **EARS** | Itchy  Drainage from ear  Earaches | | Ear infections  Ringing in ears  Hearing loss | | | |
| **NOSE** | Itchy nose  Stuffy nose  Sneezing attacks | | Sinus problems  Hay fever/ allergies  Excessive mucus | | | |
| **MOUTH/**  **THROAT** | Sore throat  Hoarseness  Loss of voice  Chronic coughing  Bleeding gums  Chapped lips  Bad breath | | Mouth sores, ulcers  Excessive mucus  Swollen or discolored tongue, gums, lips  Frequent throat clearing  Teeth grinding/clenching  Cracks in mouth corners | | | |
| **HEART** | Heart palpitations  Chest pain | | Tight feeling in chest  Rapid/pounding heartbeat | | | |
| **LUNGS** | Asthma  Bronchitis  Chest congestion | | Smoker  Difficulty breathing  Shortness of breath | | | |
| **DIGESTIVe**  **TRACT** | Nausea  Vomiting  Bloated feeling  Belching  Passing gas  Diarrhea | | Constipation  Irritable bowel  Heartburn  Acid reflux  Intestinal pain  Stomach pain | |
| **SKIN,**  **HAIR,**  **AND**  **HAIR** | Acne  Hives  Rashes  Hair loss | Dry skin  Eczema  Psoriasis  Hot flashes | | Excessive sweating  Thin, peeling nails  Ridges on nails  White spots on nails | |
| **EMOTION** | Anger  Anxiety  PMS | Panic  OCD  Fear | | Irritability/Aggression  Mood swings  Depression | |
| **JOINTS/**  **MUSCLE** | | Stiffness  Arthritis  Muscle weakness  Muscle pain/aches | | Joint pain or aches  Limitation of movement  Overall feeling of weakness or tiredness | | |
| **WEIGHT** | | Excessive weight  Underweight  Emotional eating/drinking  Binge eating/drinking  Water retention | | Craving certain foods:  Sugar  Caffeine  Salt  Alcohol  Chocolate | | |
| **ENERGY/**  **ACTIVITY** | | Interrupted sleep  Insomnia  Hyperactivity  Restlessness | | Apathy, lethargy  Fatigue, sluggishness  Frequent illness | | |
| **MIND** | | Poor memory  Confusion  Poor comprehension  Stuttering/stammering | | Difficulty with focus or concentration  Trouble making decisions  Poor physical coordination | | |
| **URO-GENITAL SYSTEM** | | Vaginal dryness  Erectile dysfunction  Disinterest in sex  Frequent urination | | Urgent urination  Genital itch  Genital discharge  Bed wetting | | |
|  | |  |  |  | | |
| **Additional information:** | | | | | | |
| **Please describe any recent illness (e.g., flu, cold, infection) or injury**. **List all prescription medicines you are CURRENTLY taking.**    **List any food (e.g., shellfish, citrus…) or drug allergies you have:**  **List recent vaccinations, type and date received.** | | | | | | |