Carolina Center *for* Restorative Medicine

Restoring Hope and Health with Heart

Adult Intake Questionnaire

809 Spring Forest Road, Suite 100
Raleigh, NC 27609
www.ccrmraleigh.com
info@ccrmraleigh.com
P 919-803-4268 | F 919-977-1381

General Information

Name: ______________________________ Today's Date: ____________

Age: __________ Date of Birth: ____________ Email: ______________________

Address: ____

City: ______________________________ State: ______ Zip: ____________

Phone (Home:______________________ Cell: ______________ Work: ______________

Genetic Background: ◯ African American ◯ Hispanic ◯ Asian ◯ Mediterranean ◯ Native American ◯ Caucasian ◯ Northern European ◯ Other:

When, where and from whom did you last receive medical or health care? ______________________

____

How did you hear about our practice? ◯ Clinical Website ◯ Other website ◯ Referral from doctor ◯ Referral from family/friend member ◯ Social Media ◯ Other: ______________________

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem	Severity			Prior Treatment/Approach	Success		
	mild	moderate	severe		Excellent	Good	Fair
Example: Post Nasal Drip	X			Elimination Diet	X		
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

History

Patient's Birth/Childhood History

You were born: ◯ Term ◯ Premature ◯ Don't Know

Were there any pregnancy complications? ◯ Yes ◯ No

If yes, explain: ______________________________

As a child, were there any food that were avoided because they gave you symptoms? ◯ Yes ◯ No

If yes, what symptoms? (Example: milk – gas and diarrhea)______________________________

____

Dental History

Check if you have any of the following, and provide number if applicable:

◯ Silver mercury fillings _____ ◯ Gold Fillings ____ ◯ Root Canal ____ ◯ Implants ____

◯ Caps/Crowns _____ ◯ Tooth pain _____ ◯ Bleeding gums ____ ◯ Gingivitis _____

◯ Problems with chewing ____ ◯ Other dental concerns? ______________________________

Have you had any mercury fillings removed? ◯ Yes ◯ No If yes, when ______________________________

How many fillings did you have as a kid? ______

Do you brush regularly? ◯ Yes ◯ No

Do you floss regularly? ◯ Yes ◯ No

Environmental/Detoxification History

Do any of these significantly affect you?

◯ Cigarette smoke ◯ Perfume/ colognes ◯ Auto exhaust fumes

◯ Other ______________________________

In your work or home environment are you regularly expose to: (Check all that apply)

◯ Mold ◯ Water leaks ◯ Renovations ◯ Chemicals ◯ Exectromagnetic radiation

◯ Damp environments ◯ Carpets or rugs ◯ Old paint ◯ Stagnant or stuffy air ◯ Smokers ◯ Pesticides

◯ Herbicides ◯ Harsh chemicals (solvents, glue, gas, acids, etc) ◯ Cleaning chemicals

◯ Heavy metals (lead, mercury, etc.) ◯ Paint ◯ Airplane travel ◯ Other: ______________________________

____

Have you had a significant exposure to any harmful chemical? ◯ Yes ◯ No

If yes, Chemical name: ______________________ length of exposure: _____________ date:______________________

Do you have any pets or farm animals? ◯ Yes ◯ N

If yes, do they live: ◯ Inside ◯ Outside ◯ Both inside and outside

Men's History

(Check box if applicable)

◯ Testicular mass ◯ Testicular pain ◯ Prostate enlargement ◯ Prostate infection ◯ Change in sex drive

◯ Impotence ◯ Premature ejaculation ◯ Difficulty obtaining erection ◯ Difficulty maintaining an erection

◯ Loss of control of urine ◯ Urinary urgency/hesitancy/change in stream ◯ Vasectomy

◯ Nocturia (urination at night) # of times per night ______

◯ Sexually transimitted diseases (describe): ______
Screening/Procedures: (If applicable for prostate testing, provide date)
PSA Level: ◯ 0-2 ◯ 2-4 ◯ 4-10 ◯ >10 Date: ______

Women's History

Obstetric History: (Check box and provide number if applicable)
◯ Pregnancies ______ ◯ Miscarriages ______ ◯ Abortions ______ ◯ Living children ______
◯ Vaginal deliveries ______ ◯ Cesarean ______ ◯ Term births ______ ◯ Premature birth ______
Birth weight of largest baby ______ Birth weight of smallest baby ______
Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure, diabetes, post-partum depression, issues with breast feeding, etc.? ◯ Yes ◯ No
If yes, please describe: ______

Menstrual History: Age at first period: ______ Date of last menstrual period: ______ Length of cycle: ______
Time between cycles ______ Cramping? ◯ Yes ◯ No Pain? ◯ Yes ◯ No
If yes, please describe: ______
Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? ◯ Yes ◯ No
Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ◯ Yes ◯ No
If yes, please describe ______

Use of hormonal birth control: ◯ Birth control pills ◯ Patch ◯ Nuvaring ◯ Other ______
How Long? ______
Any problems with hormonal birth control? ◯ Yes ◯ No
If yes, explain: ______
Use of other contraception? ◯ Yes ◯ No
Condoms: ◯ Yes ◯ No Diaphram ◯ Yes ◯ No IUD ◯ Yes ◯ No Partner vasectomy ◯ Yes ◯ No

Are you in menopause ◯ Yes ◯ No If yes, age at last period ______
Was it surgical menopause? ◯ Yes ◯ No If yes, explain surgery______
Do you currently have symptomatic problems with menopause? (Check all that apply)
◯ Hot flashes ◯ Mood swings ◯ Concentration/memory problems ◯ Headaches ◯ Joint Pain
◯ Vaginal dryness ◯ Weight gain ◯ Decreased libido ◯ Loss of control of urine ◯ Palpatations
Are you on hormone replacement therapy? ◯ Yes ◯ No
If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)? ______
______

Other Gynecological Symptoms: (Check all that apply)
◯ Endometriosis ◯ Infertility ◯ Fibrocystic breasts ◯ Fibroids ◯ Vaginal Infection ◯ Ovarian Cysts
◯ Pelvic inflammatory disease ◯ Reproductive Cancer ◯ Sexually trasmitted disease
Please describe: ______

Gynecological Screening/Procedures: (If applicable, provide date)
Last Pap test: ______ ◯ Normal ◯ Abnormal
Last mammogram: ______ ◯ Normal ◯ Abnormal
Last bone denisity: ______ Results: ◯ High ◯ Low ◯ Within normal range

Medical History: Illness/Conditions

Check **YES** for a condition you currently have. Check **PAST** for a condition you've had in the past.

GASTROINTESTINAL	YES	PAST
Irritable bowel syndrome	◯	◯
GERD (reflux)	◯	◯
Crohn's disease/Ulcerative colitis	◯	◯
Peptic ulcer disease	◯	◯
Celiac disease	◯	◯
Gallstones	◯	◯
Other: ______________________	◯	◯

RESPIRATORY	YES	PAST
Bronchitis	◯	◯
Asthma	◯	◯
Emphysema	◯	◯
Pneumonia	◯	◯
Sinusitis	◯	◯
Sleep apnea	◯	◯
Other: ______________________	◯	◯

URINARY/GENITAL	YES	PAST
Kidney stones	◯	◯
Gout	◯	◯
Intestitial cystitis	◯	◯
Frequent yeast infections	◯	◯
Frequent urinary tract Infections	◯	◯
Sexual dysfunction	◯	◯
Sexually transmitted diseases	◯	◯
Other: ______________________	◯	◯

ENDOCRINE/METABOLIC	YES	PAST
Diabetes	◯	◯
Hypothyroidism (low thyroid)	◯	◯
Hyperthyroidism (overactive thyroid)	◯	◯
Infertility	◯	◯
Metabolic syndrome/Insulin resistance	◯	◯
Eating disorder	◯	◯
Hypoglycemia	◯	◯
Other: ______________________	◯	◯

MUSCULOSKELETAL	YES	PAST
Fibromyalgia	◯	◯
Osteoarthritis	◯	◯
Chronic Pain	◯	◯
Other: ______________________	◯	◯

SKIN	YES	PAST
Eczema	◯	◯
Psoriasis	◯	◯
Acne	◯	◯
Skin Cancer	◯	◯
Other: ______________________	◯	◯

CARDIOVASCULAR	YES	PAST
Angina	◯	◯
Heart attack	◯	◯
Heart failure	◯	◯
Hypertension	◯	◯
Stroke	◯	◯
High blood fats (cholesterol, triglycerides)	◯	◯
Rheumatic Fever	◯	◯
Arrythmia (irregular heart rate)	◯	◯
Murmur	◯	◯
Mitral valve prolapse	◯	◯
Other: ______________________	◯	◯

NEUROLOGICAL/EMOTIONAL	YES	PAST
Epilepsy/Seizures	◯	◯
ADD/ADHD	◯	◯
Headaches	◯	◯
Migraines	◯	◯
Depression	◯	◯
Anxiety	◯	◯
Autism	◯	◯
Multiple sclerosis	◯	◯
Parkinson's disease	◯	◯
Dementia	◯	◯
Other: ______________________	◯	◯

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INFLAMMATORY/IMMUNE	YES	PAST
Rheumatoid arthritis	◯	◯
Chronic fatigue syndrome	◯	◯
Food allergies	◯	◯
Environmental allergies	◯	◯
Multiple chemical sensitivities	◯	◯
Autoimmune disease	◯	◯
Immune deficiency	◯	◯
Mononucleosis	◯	◯
Hepatitis	◯	◯
Other: ______________________	◯	◯

CANCER	YES	PAST
Lung	◯	◯
Breast	◯	◯
Colon	◯	◯
Prostate	◯	◯
Skin	◯	◯
Other: ______________________	◯	◯

DIAGNOSTIC STUDIES	DATE	COMMENTS
Bone density		
CT scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Barium enema		
Other:		
INJURIES	**DATE**	**COMMENTS**
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
SURGERIES	**DATE**	**COMMENTS**
Appendectomy		
Dental		
Gall bladder		
Hernia		
Tonsillectomy		
Joint replacement		

SURGERIES (continued)	DATE	COMMENTS
Heart surgery		
Other:		
HOSPITALIZATIONS	**DATE**	**REASON**

Medications/Supplements

Current medications (include prescription and over-the-counter)

MEDICATION	DOSAGE	START DATE	REASON FOR USE

Nutritional supplements (vitamin/minerals/herbs etc.)

MEDICATION	DOSAGE	START DATE	REASON FOR USE

Have medications or supplements ever caused unusual side effects or problems? ◯ Yes ◯ No

If yes, describe:____

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? ◯ Yes ◯ No

Tylenol (acetaminophen)? ◯ Yes ◯ No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? ◯ Yes ◯ No

HOW MANY TIMES HAVE YOU TAKEN ANTIBIOTICS?	≤5	>5	REASON FOR USE
Infancy/Childhood			
Teen Years			
Adulthood			

Have you ever taken long term antibiotics ◯ Yes ◯ No

If yes, explain: ____________________

HOW MANY TIMES HAVE YOU TAKEN ORAL STEROIDS? (e.g. cortisone, prednisone, etc.)?	≤5	>5	REASON FOR USE
Infancy/Childhood			
Teen Years			
Adulthood			

Allergies

NAME OF MEDICATION/SUPPLEMENT/FOOD	REACTION

Family History

Check family members that have had any of the following

Condition	Mother	Father	Sister(s)	Brother(s)	Child	Child	Child	Child	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer													
Heart disease													
Hypertension													
Obesity													
Diabetes													
Stroke													
Autoimmune disease													
Arthritis													
Kidney disease													
Thyroid problems													
Seizure/epilepsy													
Psychiatric disorders													
Anxiety													
Depression													
Asthma													
Allergies													
Eczema													
ADHD													
Autism													
Irritable bowel syndrome													
Dementia													
Substance abuse													
Genetic disorder													
Other:													
Other:													
Other:													

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Lifestyle Review

ACTIVITY TYPE	# OF TIMES PER WEEK	TIME/DURATION (MINUTES)
Cardio/Aerobic		
Strength/Resistance		
Flexibility/Stretching		
Balance		
Sports/Leisure (e.g., golf)		
Other:		
Other:		
Other:		

Sleep

How many hours of sleep do you get each night on average? _____

Do you have problems falling asleep? ◯ Yes ◯ No Staying asleep? ◯ Yes ◯ No

Do you have problems with insomnia? ◯ Yes ◯ No Do you snore? ◯ Yes ◯ No

Do you feel rested upon awakening? ◯ Yes ◯ No

Nutrition

Do you currently follow any of the following special diets or nutritional programs? (Check all that apply)

◯ Vegetarian ◯ Vegan ◯ Allergy ◯ Elimination ◯ Low Fat ◯ Low Carb ◯ High Protein

◯ Blood Type ◯ Low Sodium ◯ No Dairy ◯ No Wheat ◯ Gluten Free

◯ Other:____

Do you have sensitivities to certain foods? ◯ Yes ◯ No

If yes, list food and symptoms: ____

____

Do you have an aversion to certain foods? ◯ Yes ◯ No

If yes, explain: ____

Do you adversely react to: (Check all that apply)

◯ Monosodium glutamate (MSG) ◯ Artificial Sweeteners ◯ Garlic/onion ◯ Cheese ◯ Citrus foods

◯ Chocolate ◯ Alcohol ◯ Red Wine ◯ Sulfite-containing foods (wine, dried fruit, salad bars)

◯ Preservatives ◯ Food colorings ◯ Other food substances: ______________________________

Are there any foods that you crave or binge on? ◯ Yes ◯ No

If yes, what foods?____

Do you eat 3 meals a day? ◯ Yes ◯ No If no, how many? _______

Does skipping a meal greatly affect you? ◯ Yes ◯ No

How many meals do you eat out per week? ◯ 0-1 ◯ 1-3 ◯ 3-5 ◯ >5 meals per week

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Check the factors that apply to your current lifestyle and eating habits:

◯ Fast eater
◯ Eat too much
◯ Late-night eating
◯ Dislike healthy foods
◯ Time constraints
◯ Travel frequently
◯ Eat more than 50% of meals away from home
◯ Healthy foods not readily available
◯ Poor snack choices
◯ Significant other or family members don't like health foods
◯ Significant other or family members have special dietary needs
◯ Love to eat
◯ Eat because I have to
◯ Have negative relationship to food
◯ Struggle with eating issues
◯ Emotional eater (eat when sad, lonely, bored, etc.)
◯ Eat too much under stress
◯ Eat too little under stress
◯ Don't care to cook

Diet

Please record what you eat in a typical day:

Breakfast: ____

____

Lunch: ____

____

Dinner: ____

____

Snacks: ____

____

Fluids: ____

____

How many servings do you eat in a typical week of these foods:

_____ Fruits (not juice)   _____ Vegetables (not including white potatoes
_____ Legumes (beans, peas, etcl)   _____ Red meat   _____ Fish
_____ Nuts & Seeds   _____ Fats & Oils   _____ Cans of soda (regular or diet)
_____ Dairy/Alternatives   _____ Sweets (candy, cookies, cake, ice cream, etc.)

Do you drink caffeinated beverages? ◯ Yes ◯ No If yes, check amounts:
Coffee (cups per day): ____ 1 ____ 2-4 ____ >4   Tea (cups per day): ____ 1 ____ 2-4 ____ >4
Caffeinated sodas-regular or diet (cans per day): ____ 1 ____ 2-4 ____ >4
Do you have adverse reactions to caffeine? ◯ Yes ◯ No If yes, explain: ______________________________

____

When you drink caffeine, do you feel: ◯ Irritable or wired ◯ Aches and pains

Smoking

Do you smoke currently? ◯ Yes ◯ No If yes, packs per day: _____ Number of years _____
What type? ◯ Cigarettes ◯ Smokeless ◯ Pipe ◯ Cigar ◯ E-Cig

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Have you attempted to quit? ◯ Yes ◯ No If yes, what methods:______________________________________

____

If you smoked previously: Packs per day ______ Number of years ______
Are you regularly exposed to second-hand smoke? ◯ Yes ◯ No

Alcohol

How many alcoholic beverages do you drink a week? (1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)
◯ 1-3 ◯ 4-6 ◯ 7-10 ◯ >10 ◯ None
Have you ever had a problem with alcohol? ◯ Yes ◯ No If yes, explain:______________________________

____

Have you ever though about getting help to control or stop your drinking? ◯ Yes ◯ No

Other Substances

Are you currently using any recreational drugs? ◯ Yes ◯ No If yes, type:______________________________

____

Have you ever used IV or inhaled recreational drugs? ◯ Yes ◯ No

Stress

Do you feel you have an excessive amount of stress in your life? ◯ Yes ◯ No
Do you feel you can easily handle the stress in your life? ◯ Yes ◯ No
How much stress does each of the following cause on a daily basis (Rate on a scale of 1-10, 10 being highest)
Work _____ Family _____ Social _____ Finances _____ Health _____ Other ______________________
Do you use relaxation techniques? ◯ Yes ◯ No If yes, how often?

____

Which techniques do you use? (Check all that apply)
◯ Meditation ◯ Breathing ◯ Tai Chi ◯ Yoga ◯ Prayer ◯ Other: ______________________
Have you ever sought counseling? ◯ Yes ◯ No
Are you currently in therapy? ◯ Yes ◯ No If yes, describe: ______________________________

____

Have you ever been abused, a victim of crime, or experienced a significant trauma? ◯ Yes ◯ No
What are your hobbies or leisure activities? ____

____

Relationships

Marital status: ◯ Single ◯ Married ◯ Divorced ◯ Long-Term Partner ◯ Widow(er)

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months.

GENERAL	Mild	Moderate	Severe
Cold hands and feet	◯	◯	◯
Cold intolerance	◯	◯	◯
Daytime sleepiness	◯	◯	◯
Difficulty falling asleep	◯	◯	◯
Early waking	◯	◯	◯
Fatigue	◯	◯	◯
Fever	◯	◯	◯
Flushing	◯	◯	◯
Heat intolerance	◯	◯	◯
Night waking	◯	◯	◯
Nightmares	◯	◯	◯
Can't remember dreams	◯	◯	◯
Low body temperature	◯	◯	◯

HEAD / EYES / EARS	Mild	Moderate	Severe
Conjunctivitis	◯	◯	◯
Distorted sense of smell	◯	◯	◯
Distorted taste	◯	◯	◯
Ear fullness	◯	◯	◯
Ear ringing/buzzing	◯	◯	◯
Eye crusting	◯	◯	◯
Eyelid margin redness	◯	◯	◯
Headache	◯	◯	◯
Hearing loss	◯	◯	◯
Hearing problems	◯	◯	◯
Migraines	◯	◯	◯
Sensitivity to loud noises	◯	◯	◯
Vision problems	◯	◯	◯

MUSCUSKELETAL (cont.)	Mild	Moderate	Severe
Back muscle spasm	◯	◯	◯
Calf cramps	◯	◯	◯
Chest tightness	◯	◯	◯
Foot cramps	◯	◯	◯
Joint deformity	◯	◯	◯
Joint pain	◯	◯	◯
Joint redness	◯	◯	◯
Joint stiffness	◯	◯	◯
Muscle pain	◯	◯	◯
Muscle spasms	◯	◯	◯
Muscle stiffness	◯	◯	◯
Muscle twitches:			
Around eyes	◯	◯	◯
Arms or legs	◯	◯	◯
Muscle weakness	◯	◯	◯

MUSCUSKELETAL (cont.)	Mild	Moderate	Severe
Neck muscle spasm	◯	◯	◯
Tendonitis	◯	◯	◯
Tension headache	◯	◯	◯
TMJ problems	◯	◯	◯

MOOD / NERVES	Mild	Moderate	Severe
Agoraphobia	◯	◯	◯
Anxiety	◯	◯	◯
Auditory hallucinations	◯	◯	◯
Blackouts	◯	◯	◯
Depression	◯	◯	◯
Difficulty:			
Concentrating	◯	◯	◯
With balance	◯	◯	◯
With thinking	◯	◯	◯
With judgment	◯	◯	◯
With speech	◯	◯	◯
With memory	◯	◯	◯
Dizziness (spinning)	◯	◯	◯
Fainting	◯	◯	◯
Fearfulness	◯	◯	◯
Irritability	◯	◯	◯
Light-headedness	◯	◯	◯
Numbness	◯	◯	◯
Other phobias	◯	◯	◯
Panic attacks	◯	◯	◯
Paranoia	◯	◯	◯
Seizures	◯	◯	◯
Suicidal thoughts	◯	◯	◯
Tingling	◯	◯	◯
Tremor/trembling	◯	◯	◯
Visual hallucinations	◯	◯	◯

CARDIOVASCULAR	Mild	Moderate	Severe
Angina/chest pain	◯	◯	◯
Breathlessness	◯	◯	◯
Heart attack	◯	◯	◯
High blood pressure	◯	◯	◯
Heart murmur	◯	◯	◯
Irregular pulse	◯	◯	◯
Mitral valve prolapse	◯	◯	◯
Palpitations	◯	◯	◯
Phlebitis	◯	◯	◯
Swollen ankles/feet	◯	◯	◯
Varicose veins	◯	◯	◯

Symptom Review (cont.)

Please check if these symptoms occur presently or have occurred in the last 6 months.

URINARY	Mild	Moderate	Severe
Bed wetting	○	○	○
Hesitancy	○	○	○
Infection	○	○	○
Kidney disease	○	○	○
Kidney stone	○	○	○
Leaking/incontinence	○	○	○
Pain/burning	○	○	○
Prostate enlargement	○	○	○
Prostate infection	○	○	○

DIGESTION	Mild	Moderate	Severe
Anal spasm	○	○	○
Bad teeth	○	○	○
Bleeding gums	○	○	○
Bloating of:			
Lower abdomen	○	○	○
Whole abdomen	○	○	○
Bloating after meals	○	○	○
Blood in stools	○	○	○
Burping	○	○	○
Canker sores	○	○	○
Cold sores	○	○	○
Constipation	○	○	○
Cracking at corner of lips	○	○	○
Dentures w/ poor chewing	○	○	○
Diarrhea	○	○	○
Difficulty swallowing	○	○	○
Dry mouth	○	○	○
Farting	○	○	○
Fissures	○	○	○
Foods "repeat" (reflux)	○	○	○
Heartburn	○	○	○
Hemorrhoids	○	○	○
Intolerance to:			
Lactose	○	○	○
All dairy products	○	○	○
Gluten	○	○	○
Corn	○	○	○
Eggs	○	○	○
Fatty foods	○	○	○
Wheat	○	○	○
Yeast	○	○	○
Liver disease/Jaundice (yellow eyes or skin)	○	○	○

DIGESTION (cont.)	Mild	Moderate	Severe
Lower abdominal pain	○	○	○
Mucus in stools	○	○	○
Nausea	○	○	○
Periodontal disease	○	○	○
Sore tongue	○	○	○
Strong stool odor	○	○	○
Undigested food in stool	○	○	○
Upper abdominal pain	○	○	○
Vomiting	○	○	○

EATING	Mild	Moderate	Severe
Binge eating	○	○	○
Bulimia	○	○	○
Can't gain weight	○	○	○
Can't lose weight	○	○	○
Carbohydrate craving	○	○	○
Carbohydrate intolerance	○	○	○
Poor appetite	○	○	○
Salt craving	○	○	○
Frequent dieting	○	○	○
Sweet cravings	○	○	○
Caffeine dependency	○	○	○

RESPIRATORY	Mild	Moderate	Severe
Bad Breath	○	○	○
Bad odor in nose	○	○	○
Cough – dry	○	○	○
Cough – productive	○	○	○
Hayfever:	○	○	○
Spring	○	○	○
Summer	○	○	○
Fall	○	○	○
Change of seasons	○	○	○
Hoarseness	○	○	○
Nasal stuffiness	○	○	○
Nose bleeds	○	○	○
Post nasal drip	○	○	○
Sinus fullness	○	○	○
Sinus infection	○	○	○
Snoring	○	○	○
Sore throat	○	○	○
Wheezing	○	○	○

Carolina Center *for* Restorative Medicine
Restoring Hope and Health with Heart

Symptom Review (cont.)

Please check if these symptoms occur presently or have occurred in the last 6 months.

NAILS	Mild	Moderate	Severe
Bitten			
Brittle			
Curve up			
Frayed			
Fungus – fingers			
Fungus – toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of:			
Fingernails			
Toenails			
White spots/lines			

NAILS	Mild	Moderate	Severe
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			

SKIN DRYNESS OF	Mild	Moderate	Severe
Eyes			
Feet:			
Any cracking?			
Any peeling?			
Hair: Any unmanageable			
Hands:			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			

SKIN PROBLEMS	Mild	Moderate	Severe
Acne on back			
Acne of chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of arms			
Cellulite			
Dark circles-eyes			
Ears get red			

SKIN CONDITIONS (cont.)	Mild	Moderate	Severe
Easy bruising			
Eczema			
Herpes – genital			
Hives			
Jock itch			
Lackluster skin			
Moles w/ color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Sensitivities to bites			
Sensitivity to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			

ITCHING SKIN	Mild	Moderate	Severe
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Genitals			
Roof of mouth			
Scalp			
Skin in general			
Throat			

MALE REPRODUCTION	Mild	Moderate	Severe
Discharge from penis			
Ejaculation problems			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (low sex drive)			