



## Body Systems Assessment

Check only those items with which you're currently experiencing or have in the recent past. Skip any that do not apply to you.

### General

<input type="checkbox"/> Fever	<input type="checkbox"/> Swollen glands	<input type="checkbox"/> No dream recall
<input type="checkbox"/> Chills/cold all over	<input type="checkbox"/> Cold hands & feet	<input type="checkbox"/> Early waking
<input type="checkbox"/> Aches/pains	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Daytime sleepiness
<input type="checkbox"/> General weakness	<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Distorted vision
<input type="checkbox"/> Difficulty sweating	<input type="checkbox"/> Night walker	<input type="checkbox"/> Thin or emaciated body
<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Nightmares	

### Skin

<input type="checkbox"/> Cuts heal slowly	<input type="checkbox"/> Fungus on nails	<input type="checkbox"/> Have bumps on the back of arms and front of thighs
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Peeling skin	<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Rash	<input type="checkbox"/> Cracking skin	<input type="checkbox"/> Strong body odor
<input type="checkbox"/> Pigmentation	<input type="checkbox"/> Shingles	<input type="checkbox"/> Skin is sensitive to sun
<input type="checkbox"/> Changing moles	<input type="checkbox"/> Nails split	<input type="checkbox"/> Skin is sensitive to fabrics
<input type="checkbox"/> Calluses	<input type="checkbox"/> White spots/lines on nails	<input type="checkbox"/> Skin is sensitive to detergents
<input type="checkbox"/> Eczema	<input type="checkbox"/> Crawling sensation	<input type="checkbox"/> Skin color: red face
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Burning on bottom of feet	<input type="checkbox"/> Skin color: pale face
<input type="checkbox"/> Dryness	<input type="checkbox"/> Athlete's foot	
<input type="checkbox"/> Oiliness	<input type="checkbox"/> Cellulite	
<input type="checkbox"/> Itching	<input type="checkbox"/> Bugs love to bite you	
<input type="checkbox"/> Acne		
<input type="checkbox"/> Boils		
<input type="checkbox"/> Hives		



## Head

<input type="checkbox"/> Poor concentration	<input type="checkbox"/> Headaches (cont.)	<input type="checkbox"/> Concussion/whiplash
<input type="checkbox"/> Confusion	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Mental sluggishness
<input type="checkbox"/> Headaches: <ul style="list-style-type: none"><li><input type="checkbox"/> After meals</li><li><input type="checkbox"/> Severe</li><li><input type="checkbox"/> Migraine</li><li><input type="checkbox"/> Frontal</li></ul>	<input type="checkbox"/> Occipital	<input type="checkbox"/> Forgetfulness
	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Indecisive
	<input type="checkbox"/> Daytime	<input type="checkbox"/> Face twitch
	<input type="checkbox"/> Relieved by eating sweets	<input type="checkbox"/> Poor memory
		<input type="checkbox"/> Hair loss

## Eyes

<input type="checkbox"/> Sand in eyes	<input type="checkbox"/> Halo around lights	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Double vision	<input type="checkbox"/> Eye pains	<input type="checkbox"/> Floaters in eyes
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Dark circles under eyes	<input type="checkbox"/> Visual hallucinations
<input type="checkbox"/> Poor night vision	<input type="checkbox"/> Red eyes	
<input type="checkbox"/> Bright flashes	<input type="checkbox"/> Strong light irritates	

## Ears

<input type="checkbox"/> Aches	<input type="checkbox"/> Deafness/hearing loss	<input type="checkbox"/> Frequent infections
<input type="checkbox"/> Discharge/conjunctivitis	<input type="checkbox"/> Itching	<input type="checkbox"/> Tubes in ears
<input type="checkbox"/> Pains	<input type="checkbox"/> Pressure	<input type="checkbox"/> Sensitive to loud noises
<input type="checkbox"/> Ringing	<input type="checkbox"/> Wear a hearing aid	<input type="checkbox"/> Hearing hallucinations

## Nose / Sinuses

<input type="checkbox"/> Stuffy	<input type="checkbox"/> Acute smell	-- If checked, are symptoms worse in the:
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Drainage	<input type="checkbox"/> Spring
<input type="checkbox"/> Running	<input type="checkbox"/> Sneezing spells	<input type="checkbox"/> Summer
<input type="checkbox"/> Discharge	<input type="checkbox"/> Post nasal drip	<input type="checkbox"/> Fall
<input type="checkbox"/> Watery nose	<input type="checkbox"/> No sense of smell	<input type="checkbox"/> Winter
<input type="checkbox"/> Congested	<input type="checkbox"/> The change of seasons	
<input type="checkbox"/> Infection	tends to make your	
<input type="checkbox"/> Polyps	symptoms worse	



## Mouth

- Coated tongue
- Sore tongue
- Teeth problems
- Bleeding gums
- Canker sores
- TMJ  
(Temporomandibular joint disorder)
- Cracked lips/corners
- Chapped lips
- Fever blisters
- Wear dentures
- Grind teeth when sleeping
- Bad breath
- Dry mouth

## Tongue

- Bright red tongue
- Yellow coating on tongue

## Throat

- Mucus
- Mucus: thick and yellow
- Mucus: green
- Difficulty swallowing
- Frequent hoarseness
- Tonsillitis
- Enlarged glands
- Constant clearing of throat
- Throat closes up

## Neck

- Stiffness
- Swelling
- Lumps
- Neck glands swell

## Kidney / Urinary Tract

- Burning
- Frequent urination
- Blood in urine
- Night time urination
- Problem passing urine
- Kidney pain
- Kidney stones
- Painful urination
- Bladder infections
- Kidney infections
- Syphilis
- Bedwetting
- Have trichomonas
- Dark yellow urine
- Red urine



## Circulation / Respiration

<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Bronchitis/pneumonia
<input type="checkbox"/> Sensitive to hot	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Sensitive to cold	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Croup
<input type="checkbox"/> Extremities cold or clammy	<input type="checkbox"/> Low exercise tolerance	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Hands/feet go to sleep/numb	<input type="checkbox"/> Frequent coughs	<input type="checkbox"/> Heavy/tight chest
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Breathing heavily	<input type="checkbox"/> Past heart attack?
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Frequently sighing	When _____
<input type="checkbox"/> Pain between shoulders	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Dizziness upon standing	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Spider veins
<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Fast and full wrist pulse
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Fast and thin wrist pulse
<input type="checkbox"/> High triglycerides	<input type="checkbox"/> Murmurs	
	<input type="checkbox"/> Skipped heartbeat	
	<input type="checkbox"/> Heart enlargement	
	<input type="checkbox"/> Angina pain	

## Gastrointestinal / Digestion

<input type="checkbox"/> Peptic/duodenal ulcer	<input type="checkbox"/> Nausea	<input type="checkbox"/> Rectal itching
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Use laxatives
<input type="checkbox"/> Excessive appetite	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Bloating
<input type="checkbox"/> Gallstones	<input type="checkbox"/> Abdominal pains/cramps	<input type="checkbox"/> Belch frequently
<input type="checkbox"/> Gallbladder pain	<input type="checkbox"/> Gas	<input type="checkbox"/> Anal itching
<input type="checkbox"/> Nervous stomach	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Anal fissures
<input type="checkbox"/> Full feeling after meal	<input type="checkbox"/> Constipation	<input type="checkbox"/> Bloody stools
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Changes in bowels	<input type="checkbox"/> Undigested food in stools
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Rectal bleeding	
<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Tarry stools	
<input type="checkbox"/> Hiatal hernia		



## Joint / Muscles / Tendons

- Pain wakes me up
- Head injury
- Spasms
- Weakness in legs and arms
- Muscle stiffness in morning
- Pains that move
- Balance problems
- Damp weather bothers you

## Women's History (For Women Only)

- Fibrocystic breasts
- Non-period bleeding
- Breast cancer
- Lumps in breast
- Breast soreness during period
- Ovarian cysts
- Fibroid tumors/breast
- Vaginal dryness
- Pregnant
- Spotting
- Vaginal discharge
- Infertility
- Heavy periods
- Had partial/total hysterectomy
- Decreased libido
- Fibroid tumors/uterus
- Hot flashes
- Heavy bleeding
- Painful periods
- Mood swings
- Joint pains
- Change in period
- Concentration/memory problems
- Headaches
- Breast soreness before period
- Weight gain
- Endometriosis
- Loss of control of urine
- Palpitations

## Men's History (For Men Only)

- Have you had a PSA done?
  - Yes
  - No
- Change in libido
- Difficulty obtaining erection
- PSA Level:
  - 0 – 2
  - 2 – 4
  - 4 – 10
  - >10
- Impotence
- Difficulty maintaining an erection
- Diminished libido
- Nocturia (urination at night)
  - How many times at night? \_\_\_\_\_
- Poor libido
- Prostate enlargement
- Genital pain
- Hernia
- Prostate infection
- Sore on penis
- Urgency/hesitancy/change in urinary stream
- Prostate cancer
- Low sperm count
- Loss of control of urine



## Emotional

- Convulsions
- Dizziness
- Fainting spells
- Blackouts
- Amnesia
- Had shock therapy
- Frequently keyed up and jittery
- Shaky
- Startled by sudden noises
- Often feel suddenly scared
- Go to pieces easily
- Forgetful
- Listless
- Withdrawn feeling
- Feel "lost" in time
- Had nervous breakdown
- Had "burnout"
- Feel groggy
- Unable to concentrate
- Short attention span
- Vision changes
- Unable to reason
- Considered a nervous person
- Worried over little things
- Anxiety
- Unusual tension
- Frustration
- Numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Been admitted for psychiatric care
- Often awakened by frightening dreams
- Family member had nervous breakdown
- Use tranquilizers
- Aggressive
- Misunderstood by others
- Irritable
- Easily flare in anger
- Feeling of hostility
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness
- Am a workaholic
- Have had hallucinations
- Have considered suicide
- Have overused alcohol
- Family history of overused alcohol
- Cry often
- Feel insecure
- Have overused drugs
- Been addicted to drugs
- Extremely shy
- Inappropriate or incoherent speech
- Delirium