



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: | <input type="checkbox"/> Occipital | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> After meals | <input type="checkbox"/> Afternoon | <input type="checkbox"/> Indecisive |
| <input type="checkbox"/> Severe | <input type="checkbox"/> Daytime | <input type="checkbox"/> Face twitch |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Relieved by eating sweets | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Frontal | | <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"/> Running | <input type="checkbox"/> Sneezing spells | <input type="checkbox"/> Spring |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Summer |
| <input type="checkbox"/> Watery nose | <input type="checkbox"/> No sense of smell | <input type="checkbox"/> Fall |
| <input type="checkbox"/> Congested | <input type="checkbox"/> The change of seasons tends to make your symptoms worse | <input type="checkbox"/> Winter |
| <input type="checkbox"/> Infection | | |
| <input type="checkbox"/> Polyps | | |



Mouth

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

Tongue

- | | |
|--|---|
| <input type="checkbox"/> Bright red tongue | <input type="checkbox"/> Yellow coating on tongue |
|--|---|

Throat

- | | | |
|--|--|--|
| <input type="checkbox"/> Mucus | <input type="checkbox"/> Frequent hoarseness | <input type="checkbox"/> Constant clearing of throat |
| <input type="checkbox"/> Mucus: thick and yellow | <input type="checkbox"/> Tonsillitis | |
| <input type="checkbox"/> Mucus: green | <input type="checkbox"/> Enlarged glands | <input type="checkbox"/> Throat closes up |
| <input type="checkbox"/> Difficulty swallowing | | |

Neck

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Lumps |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Neck glands swell |

Kidney / Urinary Tract

- | | | |
|--|---|--|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Kidney pain | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Have trichomonas |
| <input type="checkbox"/> Night time urination | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Dark yellow urine |
| <input type="checkbox"/> Problem passing urine | <input type="checkbox"/> Kidney infections | <input type="checkbox"/> 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?
When _____ |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Frequently sighing | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Spider veins |
| <input type="checkbox"/> Dizziness upon standing | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Fast and full wrist pulse |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Fast and thin wrist pulse |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Mitral valve prolapse | |
| <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

- | | | |
|--|--|--|
| <input type="checkbox"/> Pain wakes me up | <input type="checkbox"/> Head injury | <input type="checkbox"/> Spasms |
| <input type="checkbox"/> Weakness in legs and arms | <input type="checkbox"/> Muscle stiffness in morning | <input type="checkbox"/> Pains that move |
| <input type="checkbox"/> Balance problems | <input type="checkbox"/> Damp weather bothers you | |
| <input type="checkbox"/> Muscle cramping | | |

Women's History (For Women Only)

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

Men's History (For Men Only)

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



Emotional

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