BioEnergetic Health Survey

Instructions: Indicate the symptoms which apply to you using the following scale
(**0**) if "never" (**1**) if "rarely" (**2**) if "time to time" (**3**) if "often"

Patient: _____Age: ____ M/F ____ Practitioner: _____

Date _____

SECTION A: DIGESTIVE

_____ 1. Lower bowel gas several hours after eating
_____ 2. Burning stomach sensation, eating relieves
_____ 3. Coated tongue
_____ 4. Indigestion 1/2-1 hr after eating: (may be up To 3/4 hrs)
_____ 5. Carbonated drinks 3+ per week?
_____ 6. Difficult bowel movements
_____ 7. Ulcers?/Colitis?/ Gastritis?
_____ 8. Stomach bloating after eating
_____ 9. Excessive belching/burping
_____ 10. Bad breath
_____ 11. Alternating diarrhea/constipation
_____ 12. Have pets eg. dogs, cats, farm animals, etc.
_____ 13. Rectal itching
_____ 14. Can't gain weight
_____ 15. International travel
_____ 16. Stomach/intestinal cramping/diarrhea

Total: _____

SECTION B: SUGAR HANDLING PROBLEMS

_____ 17. Afternoon headaches
_____ 18. Get "shaky" if hungry
_____ 19. Faintness if meals delayed
_____ 20. Heart palpitates if meals missed or delayed
_____ 21. Eat when nervous
_____ 22. Awaken after few hours of sleep
_____ 23. Hard to get back to sleep
_____ 24. Crave candy or coffee in afternoon
_____ 25. Abnormal craving for sweets or snacks
_____ 26. Thirsty much of the time
_____ 27. History of diabetes
_____ 28. Excessive frequent urination
_____ 29. Blurred vision/failing eyesight
_____ 30. Breath smells sweet
_____ 31. Tingling, numbness, prickling sensation in extremities.

Total: _____

SECTION C: CARDIAC

_____ 32. Bruise easily, "black & blue spots"
_____ 33. Sigh frequently
_____ 34. Aware of "breathing heavily"
_____ 35. Open window in closed room
_____ 36. Susceptible to colds & fevers
_____ 37. Swollen ankles, worse at night
_____ 38. Muscle cramps, worse during night
_____ 39. Shortness of breath on exertion
_____ 40. Nosebleeds
_____ 41. Ringing in the ears
_____ 42. Heart palpitations
_____ 43. Dull pain in chest or radiating into left arm, worse on exertion
_____ 44. Hands & feet go to sleep easily
_____ 45. Numbness in extremities
_____ 46. Tendency to anemia
_____ 47. Tension under breastbone or feeling of tightness, worse in exertion
_____ 48. Blushing with no apparent cause
_____ 49. Black stool (no iron supplementation)
_____ 50. Poor concentration
_____ 51. Slurred speech
_____ 52. Headaches
_____ 53. Weakness/fatigue
_____ 54. Out of breath frequently e.g., going up stairs
_____ 55. Nervousness

Total: _____

SECTION D: LIVER & GALL BLADDER

_____ 56. Pain under right side of rib cage
_____ 57. Frequent skin rashes
_____ 58. Bitter metallic taste in mouth in morning
_____ 59. Bowel movements painful and difficult
_____ 60. Low energy, weakness, exhaustion
_____ 61. Upset from greasy/fatty foods
_____ 62. Bruises easily
_____ 63. Frequent headaches
_____ 64. Stools light coloured
_____ 65. Pain between shoulder blades
_____ 66. Laxatives used often
_____ 67. History of gall bladder attacks or gallstones
_____ 68. History of hepatitis
_____ 69. History of jaundice
_____ 70. Sneezing attacks
_____ 71. Itchy skin, worse at night
_____ 72. Dry flaky skin, hair
_____ 73. General feeling of poor health
_____ 74. Aching muscles
_____ 75. Swollen feet and/or legs

Total: _____

SECTION E: THYROID

_____ 76. Impaired hearing
_____ 77. Decrease in appetite
_____ 78. Ringing in ears
_____ 79. Constipation
_____ 80. Puffy hands/face
_____ 81. Tired/sluggish
_____ 82. Miscarriages
_____ 83. Infertility
_____ 84. Mental sluggishness/forgetfulness
_____ 85. Headache upon rising; wears off during day
_____ 86. Slow pulse, below 65
_____ 87. Cold hands and feet
_____ 88. Gains weight easily
_____ 89. Weight gain around hips
_____ 90. Outer third eyebrow thinning
_____ 91. "Emotional"
_____ 92. Flush easily
_____ 93. Night sweats
_____ 94.Hair loss

Total: _____

SECTION F: BONE DEVELOPMENT/MINERALS, ETC.

_____ 95. Hip and joint pain
_____ 96. Receding gums and/or dental cavities
_____ 97. Tendency towards slouching/weak
_____ 98. Bone loss/osteoporosis in family
_____ 99. Crunching, creaking joints

Total: _____

SECTION G: ENVIRONMENTAL

_____ 100. Exposure to fumes e.g., paint, salon, car
_____ 101. Use pesticides on garden
_____ 102. Live near power lines/high tension wires
_____ 103. Have mercury amalgams (silver) in mouth
_____ 104. Skin disorders e.g., psoriasis, eczema etc.
_____ 105. Loss of hair
_____ 106. Hormone disorders
_____ 107. History of cancer/personal or familial

Total: _____

SECTION H: MUSCLE AND LIGAMENT

_____ 108. Muscle aches, stiffness, cramping and pains
_____ 109. Chiropractic adjustments don't hold
_____ 110. Whiplash and/or ligamental trauma/strain
_____ 111. Fatigue, sluggishness
_____ 112. Upper or lower back pain
_____ 113. Stiff neck and shoulders

Total: _____

SECTION I: ADRENAL

_____ 114. Low blood pressure
_____ 115. Chronic fatigue
_____ 116. Low energy, lack of stamina
_____ 117. General malaise, unhappiness
_____ 118. Tendency to hives
_____ 119. Arthritic tendency
_____ 120. Excessive perspiration
_____ 121. Colds/flu often
_____ 122. Weakness after illness
_____ 123. Dark circles under the eyes
_____ 124. Crave salty foods
_____ 125. Feeling unrefreshed upon awakening
_____ 126. Allergies
_____ 127. Exhaustion—muscular & nervous
_____ 128. Respiratory disorders
_____ 129. Swollen ankles
_____ 130. Dizzy when stand up "too fast"
_____ 131. Decreasing appetite
_____ 132. Irritable
_____ 133. Bright lights irritate

Total: _____

SECTION J: FEMALE & MALE

Female Only

_____ 134. Painful menses
_____ 135. Premenstrual tension
_____ 136. Very easily fatigued
_____ 137. Depressed feeling
_____ 138. Menstruation excessive and prolonged
_____ 139. Painful breasts (monthly)
_____ 140. Lumpy breasts/worst at menses
_____ 141. Have taken birth control pills
_____ 142. Menopause, hot flashes, etc.
_____ 143. Menses scanty or irregular
_____ 144. Acne, worse at menses
_____ 145. Vaginal discharge/yeast, etc.

Male Only

_____ 146. Tired too easily
_____ 147. Urination difficult
_____ 148. Night urination frequent
_____ 149.Pain on inside of legs or heel
_____ 150. Feeling of incomplete bowel evacuation
_____ 151. Prostrate trouble
_____ 152. Leg nervous at night
_____ 153. Diminished sex drive

Female Total_____

Male Total _____

SECTION K: LUNG

_____ 154. Chronic cough
_____ 155. Pain around ribs
_____ 156. Shortness of breath
_____ 157. Chest pain
_____ 158. Difficulty breathing
_____ 159. Post nasal drip
_____ 160. Sinus and nasal congestion
_____ 161. Coughing up phlegm
_____ 162. Coughing up blood
_____ 163. Bronchitis (frequent)
_____ 164. Infections settle in lungs
_____ 165. Sensitive to smog
_____ 166. Asthma
_____ 167. Wheezing
_____ 168. Smoker
_____ 169. Chronic lung congestions
_____ 170. Breathes through mouth
_____ 171. Shallow breather

Total _____

SECTION L: IMMUNE

_____ 172. Throat infections
_____ 173. Poor wound healing
_____ 174. Slow to recover from colds or flu
_____ 175. Gets boils or sties
_____ 176. Swollen lymph glands
_____ 177. Catch colds or flu easily
_____ 178. Bumpy skin on arms
_____ 179. Inflamed or bleeding gums
_____ 180. Cough with mucus
_____ 181. Swollen tongue
_____ 182. Dark areas under the eyes/cheeks
_____ 183. Sore throat
_____ 184. Post nasal drip
_____ 185. Ear aches and infections
_____ 186. Herpes/cold sores

Total: _____

SECTION M: KIDNEYS

_____ 187. Frequent urination	_____ 196. Strong smelling urine
_____ 188. Rose-coloured (bloody) urine	_____ 197. Mild back pain
_____ 189. Dripping after urination	_____ 198. Interrupted urine stream
_____ 190. Difficulty passing urine	_____ 199. Tingling in joints
_____ 191. Cloudy urine	_____ 200. Joint and muscle pain/cramping
_____ 192. Rarely need to urinate	_____ 201. Can't hold urine
_____ 193. Frequent bladder infections	_____ 202. Dark circles under eyes
_____ 194. Painful/burning when urinating	_____ 203. Frequent urge to urinate but passes only small amounts
_____ 195. Urination when cough or sneeze	

Total: _____

SECTION N:

Medications you are currently taking:

_____

_____

205. How often do you take (or have taken) antibiotics? #____ Y / N

206. Reactions to vaccinations? Y / N

207. How many silver amalgams do you have in your mouth?_____ Root canals? _____ Crowns/bridges? Y / N

208. Were your wisdom teeth impacted? Y / N Other Dental Problems? Y / N

209. Allergies? Y / N (List main)

210. Are you experiencing bone loss or osteoporosis? Y / N

211. Do you smoke? Y / N

212. Diagnosed for parasites? Y / N

213. Diagnosed or history of Candida? Y / N

214. Exposure to pesticides Y / N

215. Drink 6-8 glasses of water daily? Y / N

216. Hormone replacement medications? Y / N

IMPORTANT: Please list your five main health complaints in the *order of importance:*

1. _____

2. _____

3. _____

4. _____

5. _____