

Client Re-evaluation

The Spring, Center for Natural Medicine

2416 S Lamar Blvd, Ste B, Austin TX 78704 512-445-7373

Today's Date: _____

Name: _____ M F Birthdate: _____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Daytime phone: _____ Evening phone: _____

Email address: _____

Marital Status: S M D W Spouse's Name: _____

Emergency Contact- Name _____ Phone: _____

Chief complaints. Please tell us the main reason you are here- _____

Secondary Complaints. Please tell us about other health concerns you may have- _____

Previous Treatments for these Complaints - _____

Are you currently under the care of a physician or health care professional? If yes, please give name and date of last visit- _____

Major Illness- Please list all major illness and approximate dates- _____

Surgeries - Please list all surgeries and approximate dates- _____

Injuries- Please list all injuries and traumas and approximate dates- _____

Current Medication(drugs) and dosage (use separate sheet if needed)- _____

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Current nutritional supplements and dosage (use separate sheet if needed)- _____

Please list any allergies (including food)- _____

Weight: _____ Height: _____

Describe health of spouse/partner- _____

No. of Children(if any): _____

Name of child	Age	Sex	Health or health concerns
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you drink coffee? Y N How much per day? _____

Do you drink alcohol? Y N Type and quantity- _____

Do you smoke? Y N Type and quantity- _____

Do you exercise? Y N Type and duration- _____

Do you have any trouble with sleep? Y N Please explain- _____

Do you have pets? Y N What Kind and how many- _____

What can we do to make you happier? _____

WOMEN ONLY

Are you pregnant? Y N Are you trying to conceive? Y N Are you nursing? Y N

Do you have regular monthly periods? _____

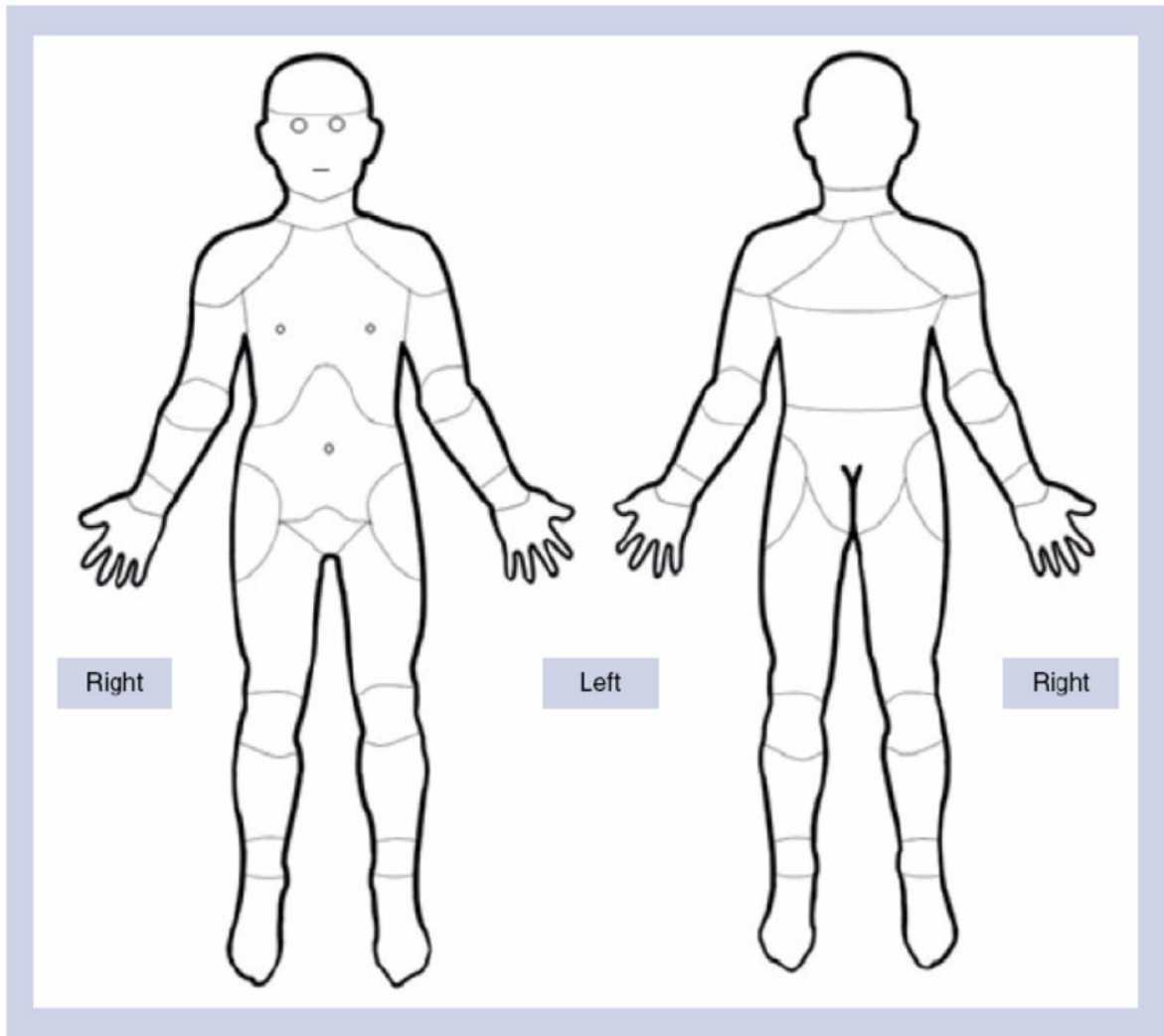
Circle any of the following symptoms you experience associated with your period:

Cramping Bloating Moodiness Heavy bleeding Back pain Headaches Clots

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Scars, Surgeries, Piercings, Tattoos and Metal Implants

On the diagram above please indicate where you have any scars, piercings, tattoos and metal implants.

Don't forget about C-sections, episiotomies, cosmetic surgery, vasectomies, laparoscopic surgeries, metal pins, trauma scars, joint replacements and vaccination scars

Office use only

Scars

Piercings

Tattoos

Surgery

Trauma

Implants

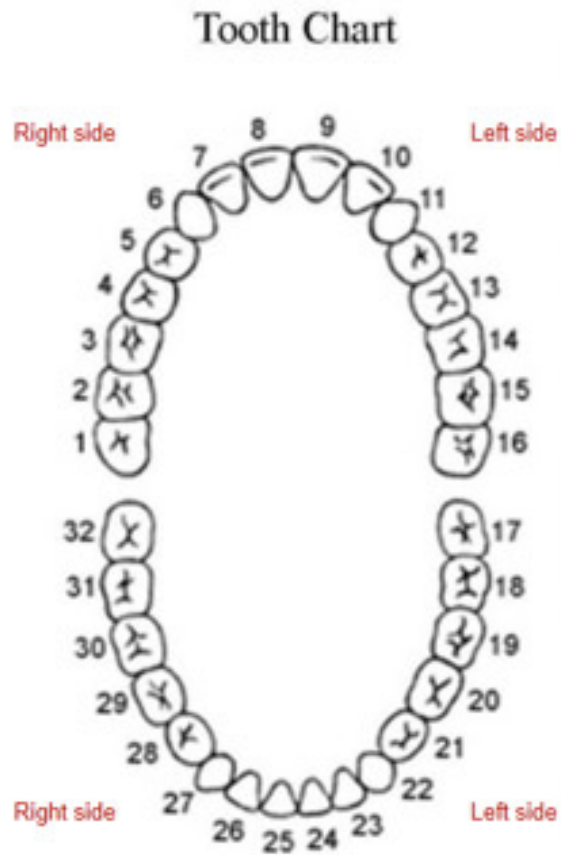
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Dental Chart

On the chart below please indicate the following:

- Silver fillings
- Composite or porcelain fillings
- Gold Fillings
- Crowns
- Root canals
- Veneers
- Bridges
- Dentures
- Extracted teeth (don't forget about the wisdom teeth)



SYMPTOM SURVEY FORM



Patient _____ Doctor _____ Date _____
 Birth Date ____ / ____ / ____ Approx Weight _____ Sex: Male Female
 Pulse: Recumbent _____ Standing _____ Vegetarian: Yes No
 Blood pressure: Recumbent ____ / ____ Standing ____ / ____ Ragland's Test is Positive

INSTRUCTIONS: Fill in only the circles which apply to you.

- ○ ○ MILD symptoms (occurred once or twice last 6 months).
- ● ○ MODERATE symptoms (occurred once or twice last month).
- ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
- ○ ○ Leave circles **BLANK** if they don't apply to you!

1 2 3

- 52 ○ ○ ○ Awaken after few hours sleep - hard to get back to sleep
- 53 ○ ○ ○ Crave candy or coffee in afternoons
- 54 ○ ○ ○ Moods of depression - "blues" or melancholy
- 55 ○ ○ ○ Abnormal craving for sweets or snacks

1 2 3 GROUP 1

- 1 ○ ○ ○ Acid foods upset
- 2 ○ ○ ○ Get chilled often
- 3 ○ ○ ○ "Lump" in throat
- 4 ○ ○ ○ Dry mouth-eyes-nose
- 5 ○ ○ ○ Pulse speeds after meal
- 6 ○ ○ ○ Keyed up - fail to calm
- 7 ○ ○ ○ Cut heals slowly
- 8 ○ ○ ○ Gag easily
- 9 ○ ○ ○ Unable to relax; startles easily
- 10 ○ ○ ○ Extremities cold, clammy
- 11 ○ ○ ○ Strong light irritates
- 12 ○ ○ ○ Urine amount reduced
- 13 ○ ○ ○ Heart pounds after retiring
- 14 ○ ○ ○ "Nervous" stomach
- 15 ○ ○ ○ Appetite reduced
- 16 ○ ○ ○ Cold sweats often
- 17 ○ ○ ○ Fever easily raised
- 18 ○ ○ ○ Neuralgia-like pains
- 19 ○ ○ ○ Staring, blinks little
- 20 ○ ○ ○ Sour stomach often

GROUP 2

- 21 ○ ○ ○ Joint stiffness on arising
- 22 ○ ○ ○ Muscle-leg-toe cramps at night
- 23 ○ ○ ○ "Butterfly" stomach, cramps
- 24 ○ ○ ○ Eyes or nose watery
- 25 ○ ○ ○ Eyes blink often
- 26 ○ ○ ○ Eyelids swollen, puffy
- 27 ○ ○ ○ Indigestion soon after meals
- 28 ○ ○ ○ Always seems hungry; feels "lightheaded" often
- 29 ○ ○ ○ Digestion rapid
- 30 ○ ○ ○ Vomiting frequent
- 31 ○ ○ ○ Hoarseness frequent
- 32 ○ ○ ○ Breathing irregular
- 33 ○ ○ ○ Pulse slow; feels "irregular"
- 34 ○ ○ ○ Gagging reflex slow
- 35 ○ ○ ○ Difficulty swallowing
- 36 ○ ○ ○ Constipation, diarrhea alternating
- 37 ○ ○ ○ "Slow starter"
- 38 ○ ○ ○ Get "chilled" infrequently
- 39 ○ ○ ○ Perspire easily
- 40 ○ ○ ○ Circulation poor, sensitive to cold
- 41 ○ ○ ○ Subject to colds, asthma, bronchitis

GROUP 3

- 42 ○ ○ ○ Eat when nervous
- 43 ○ ○ ○ Excessive appetite
- 44 ○ ○ ○ Hungry between meals
- 45 ○ ○ ○ Irritable before meals
- 46 ○ ○ ○ Get "shaky" if hungry
- 47 ○ ○ ○ Fatigue, eating relieves
- 48 ○ ○ ○ "Lightheaded" if meals delayed
- 49 ○ ○ ○ Heart palpitates if meals missed or delayed
- 50 ○ ○ ○ Afternoon headaches
- 51 ○ ○ ○ Overeating sweets upsets

GROUP 4

- 56 ○ ○ ○ Hands and feet go to sleep easily, numbness
- 57 ○ ○ ○ Sigh frequently, "air hunger"
- 58 ○ ○ ○ Aware of "breathing heavily"
- 59 ○ ○ ○ High altitude discomfort
- 60 ○ ○ ○ Opens windows in closed rooms
- 61 ○ ○ ○ Susceptible to colds and fevers
- 62 ○ ○ ○ Afternoon "yawner"
- 63 ○ ○ ○ Get "drowsy" often
- 64 ○ ○ ○ Swollen ankles, worse at night
- 65 ○ ○ ○ Muscle cramps, worse during exercise; get "charley horses"
- 66 ○ ○ ○ Shortness of breath on exertion
- 67 ○ ○ ○ Dull pain in chest or radiating into left arm, worse on exertion
- 68 ○ ○ ○ Bruise easily, "black and blue" spots
- 69 ○ ○ ○ Tendency to anemia
- 70 ○ ○ ○ "Nose bleeds" frequent
- 71 ○ ○ ○ Noises in head, or "ringing in ears"
- 72 ○ ○ ○ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

- 73 ○ ○ ○ Dizziness
- 74 ○ ○ ○ Dry skin
- 75 ○ ○ ○ Burning feet
- 76 ○ ○ ○ Blurred vision
- 77 ○ ○ ○ Itching skin and feet
- 78 ○ ○ ○ Excessive falling hair
- 79 ○ ○ ○ Frequent skin rashes
- 80 ○ ○ ○ Bitter, metallic taste in mouth in mornings
- 81 ○ ○ ○ Bowel movements painful or difficult
- 82 ○ ○ ○ Worrier, feels insecure
- 83 ○ ○ ○ Feeling queasy; headache over eyes
- 84 ○ ○ ○ Greasy foods upset
- 85 ○ ○ ○ Stools light colored
- 86 ○ ○ ○ Skin peels on foot soles
- 87 ○ ○ ○ Pain between shoulder blades
- 88 ○ ○ ○ Use laxatives
- 89 ○ ○ ○ Stools alternate from soft to watery
- 90 ○ ○ ○ History of gallbladder attacks or gallstones
- 91 ○ ○ ○ Sneezing attacks
- 92 ○ ○ ○ Dreaming, nightmare type bad dreams
- 93 ○ ○ ○ Bad breath (halitosis)
- 94 ○ ○ ○ Milk products cause distress
- 95 ○ ○ ○ Sensitive to hot weather
- 96 ○ ○ ○ Burning or itching anus
- 97 ○ ○ ○ Crave sweets

GROUP 6

- 98 ○ ○ ○ Loss of taste for meat
- 99 ○ ○ ○ Lower bowel gas several hours after eating
- 100 ○ ○ ○ Burning stomach sensations, eating relieves
- 101 ○ ○ ○ Coated tongue
- 102 ○ ○ ○ Pass large amounts of foul-smelling gas
- 103 ○ ○ ○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 ○ ○ ○ Mucous colitis or "irritable bowel"
- 105 ○ ○ ○ Gas shortly after eating
- 106 ○ ○ ○ Stomach "bloating" after eating

1 2 3 GROUP 7A

- 107 ○ ○ ○ Insomnia
- 108 ○ ○ ○ Nervousness
- 109 ○ ○ ○ Can't gain weight
- 110 ○ ○ ○ Intolerance to heat
- 111 ○ ○ ○ Highly emotional
- 112 ○ ○ ○ Flush easily
- 113 ○ ○ ○ Night sweats
- 114 ○ ○ ○ Thin, moist skin
- 115 ○ ○ ○ Inward trembling
- 116 ○ ○ ○ Heart palpitates
- 117 ○ ○ ○ Increased appetite without weight gain
- 118 ○ ○ ○ Pulse fast at rest
- 119 ○ ○ ○ Eyelids and face twitch
- 120 ○ ○ ○ Irritable and restless
- 121 ○ ○ ○ Can't work under pressure

GROUP 7B

- 122 ○ ○ ○ Increase in weight
- 123 ○ ○ ○ Decrease in appetite
- 124 ○ ○ ○ Fatigue easily
- 125 ○ ○ ○ Ringing in ears
- 126 ○ ○ ○ Sleepy during day
- 127 ○ ○ ○ Sensitive to cold
- 128 ○ ○ ○ Dry or scaly skin
- 129 ○ ○ ○ Constipation
- 130 ○ ○ ○ Mental sluggishness
- 131 ○ ○ ○ Hair coarse, falls out
- 132 ○ ○ ○ Headaches upon arising, wear off during day
- 133 ○ ○ ○ Slow pulse, below 65
- 134 ○ ○ ○ Frequency of urination
- 135 ○ ○ ○ Impaired hearing
- 136 ○ ○ ○ Reduced initiative

GROUP 7C

- 137 ○ ○ ○ Failing memory
- 138 ○ ○ ○ Low blood pressure
- 139 ○ ○ ○ Increased sex drive
- 140 ○ ○ ○ Headaches, "splitting or rending" type
- 141 ○ ○ ○ Decreased sugar tolerance

GROUP 7D

- 142 ○ ○ ○ Abnormal thirst
- 143 ○ ○ ○ Bloating of abdomen
- 144 ○ ○ ○ Weight gain around hips or waist
- 145 ○ ○ ○ Sex drive reduced or lacking
- 146 ○ ○ ○ Tendency to ulcers, colitis
- 147 ○ ○ ○ Increased sugar tolerance
- 148 ○ ○ ○ Women: menstrual disorders
- 149 ○ ○ ○ Young girls: lack of menstrual function

GROUP 7E

- 150 ○ ○ ○ Dizziness
- 151 ○ ○ ○ Headaches
- 152 ○ ○ ○ Hot flashes
- 153 ○ ○ ○ Increased blood pressure
- 154 ○ ○ ○ Hair growth on face or body (female)
- 155 ○ ○ ○ Sugar in urine (not diabetes)
- 156 ○ ○ ○ Masculine tendencies (female)

GROUP 7F

- 157 ○ ○ ○ Weakness, dizziness
- 158 ○ ○ ○ Chronic fatigue
- 159 ○ ○ ○ Low blood pressure
- 160 ○ ○ ○ Nails weak, ridged
- 161 ○ ○ ○ Tendency to hives
- 162 ○ ○ ○ Arthritic tendencies
- 163 ○ ○ ○ Perspiration increase
- 164 ○ ○ ○ Bowel disorders
- 165 ○ ○ ○ Poor circulation
- 166 ○ ○ ○ Swollen ankles
- 167 ○ ○ ○ Crave salt
- 168 ○ ○ ○ Brown spots or bronzing of skin
- 169 ○ ○ ○ Allergies - tendency to asthma

1 2 3

- 170 ○ ○ ○ Weakness after colds, influenza
- 171 ○ ○ ○ Exhaustion - muscular and nervous
- 172 ○ ○ ○ Respiratory disorders

GROUP 8

- 173 ○ ○ ○ Apprehension
- 174 ○ ○ ○ Irritability
- 175 ○ ○ ○ Morbid fears
- 176 ○ ○ ○ Never seems to get well
- 177 ○ ○ ○ Forgetfulness
- 178 ○ ○ ○ Indigestion
- 179 ○ ○ ○ Poor appetite
- 180 ○ ○ ○ Craving for sweets
- 181 ○ ○ ○ Muscular soreness
- 182 ○ ○ ○ Depression; feelings of dread
- 183 ○ ○ ○ Noise sensitivity
- 184 ○ ○ ○ Acoustic hallucinations
- 185 ○ ○ ○ Tendency to cry without reason
- 186 ○ ○ ○ Hair is coarse and/or thinning
- 187 ○ ○ ○ Weakness
- 188 ○ ○ ○ Fatigue
- 189 ○ ○ ○ Skin sensitive to touch
- 190 ○ ○ ○ Tendency toward hives
- 191 ○ ○ ○ Nervousness
- 192 ○ ○ ○ Headache
- 193 ○ ○ ○ Insomnia
- 194 ○ ○ ○ Anxiety
- 195 ○ ○ ○ Anorexia
- 196 ○ ○ ○ Inability to concentrate; confusion
- 197 ○ ○ ○ Frequent stuffy nose; sinus infections
- 198 ○ ○ ○ Allergy to some foods
- 199 ○ ○ ○ Loose joints

FEMALE ONLY

- 200 ○ ○ ○ Very easily fatigued
- 201 ○ ○ ○ Premenstrual tension
- 202 ○ ○ ○ Painful menses
- 203 ○ ○ ○ Depressed feelings before menstruation
- 204 ○ ○ ○ Menstruation excessive and prolonged
- 205 ○ ○ ○ Painful breasts
- 206 ○ ○ ○ Menstruate too frequently
- 207 ○ ○ ○ Vaginal discharge
- 208 ○ ○ ○ Hysterectomy / ovaries removed
- 209 ○ ○ ○ Menopausal hot flashes
- 210 ○ ○ ○ Menses scanty or missed
- 211 ○ ○ ○ Acne, worse at menses
- 212 ○ ○ ○ Depression of long standing

MALE ONLY

- 213 ○ ○ ○ Prostate trouble
- 214 ○ ○ ○ Urination difficult or dribbling
- 215 ○ ○ ○ Night urination frequent
- 216 ○ ○ ○ Depression
- 217 ○ ○ ○ Pain on inside of legs or heels
- 218 ○ ○ ○ Feeling of incomplete bowel evacuation
- 219 ○ ○ ○ Lack of energy
- 220 ○ ○ ○ Migrating aches and pains
- 221 ○ ○ ○ Tire too easily
- 222 ○ ○ ○ Avoids activity
- 223 ○ ○ ○ Leg nervousness at night
- 224 ○ ○ ○ Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____