

BALANCING BODY CHEMISTRY HEALTH ASSESSMENT Balancing Body Chemistry



Name: _____ Sex: _____ Age: _____ Date: _____

Patient's Health Professional: _____

PART I

Circle any of the following medications you are taking:

- | | | | |
|-------------------------|---------------------------------|-----------------------|----------------------------|
| • Antacids | • Chemotherapy | • Hormones | • Relaxants/Sleeping Pills |
| • Antibiotic/Antifungal | • Cortisone Anti-Inflammatories | • Laxatives | • Recreational Drugs |
| • Antidepressants | • Diuretics | • Lithium | Specify _____ |
| • Antidiabetic/Insulin | • Heart Medications | • Oral Contraceptives | • Thyroid |
| • Aspirin/Tylenol | • High Blood Pressure | • Radiation | • Ulcer Medications |
| | | | • Other _____ |

Circle if you eat, drink, or use:

- | | | | |
|------------------------|--------------------------------------|-------------------------|-----------------------|
| • Alcohol | • Distilled Water | • Luncheon Meats | • Non-Herbal Teas |
| • Candy | • Fluoridated/Chlorinated Water | • Margarine | • Chew Tobacco |
| • Carbonated Beverages | • At fast food restaurants regularly | • Refined Sugars | • Vitamins & Minerals |
| • Cigarettes | • Fried Foods | • Milk Products | Specify _____ |
| • Coffee | • Refined (White) Flour Products | • Artificial Sweeteners | |

Circle if you:

- | | | |
|-----------------------------|-------------------------------------|------------------------------------|
| • Diet often | • Exercise less than 3 times weekly | • Are exposed to chemicals at work |
| • Salt food without tasting | • Are under excessive stress | • Are exposed to cigarette smoke |

DIRECTIONS:

Please read each description and darken the number which best describes the frequency of your symptoms within the past year. If you do not understand a symptom, put a ? before the symptom's number.

KEY:

0 = Never 1 = Mild 2 = Moderate 3 = Severe
(Occurs once a month or less) (Occurs several times monthly) (Aware of it almost constantly)

PART II

IMPORTANT

Dear Patient, Please list your five major health concerns in order of importance:

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

Section C:

- | | | | | |
|--|---|---|---|---|
| 24. Coated tongue or "fuzzy" debris on tongue | 0 | 1 | 2 | 3 |
| 25. Pass large amounts of foul smelling gas | 0 | 1 | 2 | 3 |
| 26. Irritable bowel or mucous colitis | 0 | 1 | 2 | 3 |
| 27. Constipation, diarrhea alternating or stools alternate from soft to watery | 0 | 1 | 2 | 3 |
| 28. Bowel movements painful or difficult, constipation, and/or laxatives used | 0 | 1 | 2 | 3 |
| 29. Burning or itching anus | 0 | 1 | 2 | 3 |

CATEGORY II

- | | | | | |
|---|---|---|---|---|
| 30. Head congestion/sinus fullness" | 0 | 1 | 2 | 3 |
| 31. Sneezing attacks | 0 | 1 | 2 | 3 |
| 32. Dreaming, nightmare-like bad dreams | 0 | 1 | 2 | 3 |
| 33. Milk products and/or wheat products cause distress | 0 | 1 | 2 | 3 |
| 34. Eyes and nose watery | 0 | 1 | 2 | 3 |
| 35. Eyes swollen and puffy | 0 | 1 | 2 | 3 |
| 36. Pulse speeds after meals and/or heart pounds after retiring | 0 | 1 | 2 | 3 |

PART III

CATEGORY I

Section A:

- | | | | | |
|--|---|---|---|---|
| 1. Bad breath, halitosis | 0 | 1 | 2 | 3 |
| 2. Loss of taste for high protein foods (meat, etc.) | 0 | 1 | 2 | 3 |
| 3. Burning ("acid") or nervous stomach, eating relieves | 0 | 1 | 2 | 3 |
| 4. Gas shortly after eating | 0 | 1 | 2 | 3 |
| 5. Indigestion 1/2 to 1 hour after eating, may last 3-4 hours | 0 | 1 | 2 | 3 |
| 6. Difficulty digesting fruits or vegetables; undigested foods found in stools | 0 | 1 | 2 | 3 |
| 7. Acid or spicy foods upset stomach | 0 | 1 | 2 | 3 |

Section B:

- | | | | | |
|---|---|---|---|---|
| 8. Lower bowel gas and or bloating several hours after eating | 0 | 1 | 2 | 3 |
| 9. Feet burn | 0 | 1 | 2 | 3 |
| 10. "Whites" of eyes (sclera) yellow | 0 | 1 | 2 | 3 |
| 11. Dry skin, itchy feet and/or skin peels on feet | 0 | 1 | 2 | 3 |
| 12. Brown spots or bronzing of skin | 0 | 1 | 2 | 3 |
| 13. Bitter metallic taste in mouth | 0 | 1 | 2 | 3 |
| 14. Blurred vision | 0 | 1 | 2 | 3 |
| 15. Headache over eyes | 0 | 1 | 2 | 3 |
| 16. Feel nauseous, queasy or gag easily | 0 | 1 | 2 | 3 |
| 17. Color of stools light brown or yellow | 0 | 1 | 2 | 3 |
| 18. Greasy or high fat foods cause distress | 0 | 1 | 2 | 3 |
| 19. Pain between shoulder blades | 0 | 1 | 2 | 3 |
| 20. Dark circles under eyes | 0 | 1 | 2 | 3 |
| 21. "Acid" breath | 0 | 1 | 2 | 3 |
| 22. History of gallbladder attacks or gallstones OR gallbladder removed | 0 | 1 | 2 | 3 |
| 23. Appetite reduced | 0 | 1 | 2 | 3 |

CATEGORY III

Section A:

- | | | | | |
|---|---|---|---|---|
| 37. Crave sweets or coffee in afternoon or mid-morning | 0 | 1 | 2 | 3 |
| 38. Hungry between meals or excessive appetite | 0 | 1 | 2 | 3 |
| 39. Overeating sweets upsets | 0 | 1 | 2 | 3 |
| 40. Eat when nervous | 0 | 1 | 2 | 3 |
| 41. Irritable before meals | 0 | 1 | 2 | 3 |
| 42. Get "shaky" or light-headed if meals delay | 0 | 1 | 2 | 3 |
| 43. Fatigue, eating relieves | 0 | 1 | 2 | 3 |
| 44. Heart palpitates if meals missed or delayed | 0 | 1 | 2 | 3 |
| 45. Awaken a few hours after sleep, hard to get back to sleep | 0 | 1 | 2 | 3 |

Section B:

- | | | | | |
|---|-----|----|---|---|
| 46. Muscle soreness after moderate exercise | 0 | 1 | 2 | 3 |
| 47. Vulnerability to insect bites (especially fleas and mosquitoes) | 0 | 1 | 2 | 3 |
| 48. Loss of muscle tone or "heaviness" in arms or legs | 0 | 1 | 2 | 3 |
| 49. Enlarged heart and/or heart failure | 0 | 1 | 2 | 3 |
| 50. Worrier, feel insecure and/or highly emotional | 0 | 1 | 2 | 3 |
| 51. Pulse slow/below 65 or irregular pulse | Yes | No | | |