Adult Re-Exam Form

Name: _____ Date: _____

What has improved? _____

_____

Has anything gotten worse? _____

_____

Any new complaints? _____

_____

Any change in medications? _____

Current weight? _____ Change? _____

Consistency in taking supplements ____ %

LIST YOUR PRIMARY CONCERNS / GOALS IN ORDER OF IMPORTANCE:

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

Please describe progress or concern in the following areas:

Digestion/Elimination: _____

Diet: _____

Immune/Allergy: _____

Sleep: _____

Pain or Headache: _____

Exercise: _____

PAIN/STIFFNESS/SWELLING/NUMBNESS/TINGLING

____ TMJ (☐R ☐L)
____ Upper Neck (☐R ☐L)
____ Lower Neck (☐R ☐L)
____ Upper Back (☐R ☐L)
____ Shoulders (☐R ☐L)
____ Elbows (☐R ☐L)
____ Wrist (☐R ☐L)
____ Hand (☐R ☐L)
____ Mid Back (☐R ☐L)
____ Low Back (☐R ☐L)
____ SI Joint (☐R ☐L)
____ Hips (☐R ☐L)
____ Sciatica (☐R ☐L)
____ Legs (☐R ☐L)
____ Knees (☐R ☐L)
____ Ankles (☐R ☐L)
____ Feet (☐R ☐L)
____ Other _____

CRAMPS/ACHES/RESTLESS

____ Cramps *(☐legs ☐feet ☐arms ☐hands)*
____ Aches *(☐legs ☐feet ☐arms ☐hands)*
____ Restless *(☐legs ☐feet ☐arms ☐hands)*
____ Other: _____

OFFICE USE ONLY

pH: _____ Ear Crease: _____ R _____ L
Zinc test: _____ Nails: _____
Weight: _____ Tongue: _____
Resist: _____ React: _____

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Adult Case History

_____ Stress : scale 1-10
_____ Bowel Movement: /wk
_____ Water: oz / day
_____ Juice: glasses/day

_____ Coffee: cups / day
_____ Soda: oz /day
_____ Alcohol: glasses /wk
_____ Tobacco: /day

_____ Soy Use: _____
_____ Artificial Sweetener Use:
- Equal (Aspartame)
- Splenda (Sucralose)

_____ Cardio: x/wk
_____ Weight Train: x/wk
_____ Yoga / Pilates: x/wk
_____ Sports: hrs/wk

Rank any symptoms you are currently having 1 - 10 or check applicable boxes.

EARS
___ Noise (Ring/Hiss/Pound)
___ Plugged
___ Popping
___ Ache / Infection
___ Draining
___ Itchy
___ Hearing Loss
___ Dizziness/Vertigo
___ Excessive Ear Wax
___ Other: _____

EYES
___ Burn / Tear / Itchy
___ Ache / Dry / Red
___ Crust in am / Film
___ Bouts of Blurriness
___ Floaters / Spots
___ Tired / Puffy
___ Stye
___ Twitching around eye
___ Dark circles
___ Light sensitive
___ Other: _____

SINUS
___ Nosebleeds
___ Dry
___ Drain
___ Stuffy/plugged
___ Sneeze frequently
___ Taste / Smell loss
___ Post nasal drip

SKIN / HAIR / NAILS
___ Skin Rash: _____
___ Acne: _____
___ Butt Acne
___ Dry skin
___ Eczema / Psoriasis
___ Nails (white spots/ridges)
___ Nails (weak/ peeling)
___ Hair loss
___ Limp Hair
___ Varicose / Spider veins
___ Damp hands / feet
___ Dandruff
___ Red dots
___ Bruise easily
___ Bumps on Back of Arms
___ Missing outer 1/3 of eyebrow
___ Cold hands / feet
___ Ingrown toenails
___ Other: _____

STOMACH
___ Heartburn
___ Indigestion
___ Stomach Ache / Cramps
___ Nausea/Vomiting
___ Bloat After Eat
___ Gas / Flatulence
___ Belching
___ Ulcer
___ Other: _____

BOWELS
___ Diarrhea
___ Constipation
___ Incomplete
___ Bulky
___ Cramps in Abdomen
___ Pain w/ Bowel Movement
___ Laxative / Suppository Use
___ Colonics / Enemas
___ Anal Itching
___ Hemorrhoids:
___ Swollen / Achy
___ Burning / Itchy
___ Blood
___ Other: _____

STOOL CONSISTENCY
☐ Normal
___ Light colored feces
___ Soft
___ Fluffy
___ Hard
___ Pebbles
___ Ribbon-like
___ Mucous
___ Contain string-like
___ Black / White specks
___ Contain undigested food

APPETITE / DIET
☐ Low ☐ Norm ☐ High appetite
___ Crave Starch / Sweets
___ Crave Salt
___ Crave Chocolate / Ice Cream
___ Eat lots of spicy foods
☐ Nighttime snack: _____
If meals are missed:
___ Nausea
___ Extreme hunger
___ Cold / Clammy
___ Rapid heartbeat
___ Irritability
___ Light headed

LIBIDO / SEXUALITY
☐ Low ☐ Normal ☐ High
Orgasm:
☐ none ☐ poor ☐ good ☐ great

CHEST
___ Tension / Tight
___ Pressure / Heaviness
___ Congestion
___ Chest / Sternal Pain
___ Palpitations-Heart Skip
___ Heart Racing / Slowing
___ Other: _____

RESPIRATORY
___ Short of breath - Constant
___ Short of breath - Exertion
___ Wheeze
___ Air hunger / yawn
___ Frequent Sighs
___ Upper Resp Infx
___ Asthma
___ Other: _____

SLEEP
Quality of Sleep:
☐ Poor ☐ Fair ☐ Good ☐ Great
Hours in bed _____
Hours asleep _____
Interrupted ____ x per night
Waking at ____ am
___ Difficulty falling asleep
___ Difficulty staying asleep
___ Crave sleep during day
___ Awaken Suddenly (Jolt)
___ Don't dream
___ Nightmares / Epic dreams
___ Night sweats
___ Restlessness
___ Restless Leg Syndrome

EMOTIONS
___ Sadness / Depression
___ Moodiness / Irritable
___ Frustrated / Angry
___ Nervous / Anxiety
___ Grief
___ Panic / Fear
___ Cry
___ S.A.D.
___ OCD
___ Other: _____

HEADACHES
___ Base of Skull (back)
___ Side of Head (temples)
___ Frontal (above eyes)
___ Top of Head
___ Entire Head
___ Migraines

COGNITION
___ Forget Names
___ Forget Numbers
___ Forget Words
___ Forget Actions
___ Difficulty Concentrating
___ Other: _____

ENERGY
☐ Normal ☐ Low ☐ Variable ☐ High
___ Slow to start in am
___ Low energy after meals
___ Energy crash at ☐ am ☐ pm
___ Other: _____

URINATION
Times during the night _____
___ Urgency
___ Burning/Pain
___ Odor/Foamy
___ Dark color
___ Incontinence
___ Urinary tract infection
___ Kidney troubles
___ Other: _____

MALE ONLY
___ Erectile Dysfunction
___ Prostate Problems
____ Burn
____ Achy / Pain
____ Restriction / Swelling
___ Other: _____

FEMALE ONLY:
Date Last Period: _____
Cycle Length (28-30 days): _____
Days of Flow _____
Cramps: ☐ mild ☐ mod ☐ severe
PMS: ☐ mild ☐ mod ☐ severe
___ Vaginal Itching / Discharge
___ Heavy flow
___ Large clots
___ Yeast Infection
___ Menopause
___ Hot Flashes
___ Vaginal Drynes
___ Painful Intercourse
___ Other: _____

OTHER HEALTH EVENTS/ ISSUES: