



What type of care do you desire?

- _____ temporary relief of symptoms/pain control.
- _____ eradication of tendencies causing your condition.
- _____ balanced optimum healthcare, elimination of root cause of problem, if possible.
- _____ maintenance care/balance to stay in good health.

How would you classify your condition?

- _____ minor _____ severe/worsening
- _____ involved _____ serious

On a scale of 1-10, how would you rate how your health problem affects your life?
(1 is no problem, 10 is major problem) _____

What other therapies have you tried for this condition?

_____.

Lab results: (please include copies, if available) _____

_____.

List one adjective/word to describe your life _____.

Please indicate the use and frequency of the following?

- tobacco _____
- coffee/black tea _____
- alcohol _____
- non-medical drugs _____
- exercise _____

How do you feel about the following areas of your life?

Please check appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Comments
Spouse						
Family						
Diet						
Sex						
Self						
Work						
Exercise						
Spiritually						