Name_____ DOB:_____Age:_____ Date:_____

HPI: please complete the symptom sheet section below by making on x on yes or no. if yes please explain.

SYMPTOMS	YES	NO	Please Explain.
Fever			
Sweats			
Chills			
Flushing			
Fatigue, tiredness, poor stamina			
Unexplained hair loss			
Swollen Glands			
Sore throat			
Testicular pain			
Pelvic Pain			
Unexp. Menstrual irregularity			
Breast pain			
Bladder irritability/ dysfunction			
Sexual dysfunction/ Loss of labido			
Nausea			
Constipation			
Diarrhea			
Chest Pain			
Rib soreness			
Shortness of breath			
Cough			
Heart palpitations, pulse skips			
Neck stiffness/ Back stiffness			
Neck cracks			
Neck pain			
Joint stiffness			
Joint swelling			
Joint pain			
Muscle pain			
Twitching of the muscle			
Headache			
Numbness/ Tingling			
Facial paralysis			
Blurry vision			
floaters			
Light sensitivity			
Ear buzzing/ringing			
Ear pain			

Sound sensitivity			
Poor balance			
SYMPTOMS	**YES**	**NO**	**EXPLAIN..**
Lightheadedness, wooziness			
Tremor			
confusion			
Difficulty in thinking			
Forgetfulness			
Poor short term memory			
Disorientation/getting lost/ Going to wrong places			
Difficulty with speech			
Word finding problem			
Reversing numbers/ letters			
Difficulty with writing			
Mood swings			
Depression/ anxiety			
Disturbance sleep(too much/ too little)			

What is your current percentage of normal(0%feeling absolute worst-100% feeling the best)?

Are you having any current yeast problems?

Are you having any current diarrhea symptoms?

What are the worst symptoms?

What medicines and supplements are you taking now?

Do you have specific questions for this visit?