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BALANCING BODY CHEMISTRY *HEALTH ASSESSMENT*

Name: _____Sex: _____Age: ____ Birth date:_____
Occupation:_____ Height:_____Weight: _____Date:_____
Blood Type:_____ # Bowel Movements per day/week: _____ Any Major Surgeries_____

Part I

Circle any of the following medications you are taking:

Antacids	Cortisone/Anti-Inflammatories	Lithium	Ulcer Medications
Chemotherapy	Laxatives	Thyroid Meds	Aspirin/Tylenol
Hormones	Recreational Drugs	Anti-diabetic/Insulin	High Blood Pressure
Sleeping Pills	Antidepressants	Heart Medications	Radiation
Antibiotics	Anti-fungal	Oral Contraceptives	Diuretics Other:

Circle or darken if you eat, drink, or use:

Alcohol	Fluoridated/Chlorinated Water	Refined Sugars	Milk Products
Distilled Water	Margarine /Vegetable oil	Coffee	Artificial Sweeteners
Luncheon Meats	Chewing Tobacco /Cigarettes	Wheat Flour Products	Fried Foods
Non-Herbal Teas	Carbonated Beverages	Candy / Soda	Eat Fast Foods Regularly

Vitamins & Minerals: Please Specify:

Circle if you:

Diet Often	Exposed to chemicals at work	Under excessive stress
Salt food w/o tasting	Exercise less than 3 times wkly	Exposed to smoke

Directions: Please read each description, put a number from 0-3 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. **Answer all questions.**

ANSWER KEY: 0 = Never (or leave blank)
1 = Mild (Occurs once or twice a month)
2 = Moderate (Occurs several times monthly)
3 = Severe (aware of it almost constantly)

___ A-1 History of constipation?
___ A-2. Bad Breath/Halitosis?
___ A-3 Loss of Taste for meat?
___ A-4 Belching shortly after meals?
___ A-5 Bloating or gas shortly after meals?
_____**Total for Section A**

___B-1 Burning or gnawing stomach pain?
___B-2 Heartburn or indigestion after meals?
___B-3 Stomach pain from stress or spicy foods?
___B-4 Been told you have Ulcers?
___B-5 Use antacids or aspirin?
___B-6 Use milk or carbonated drinks to relieve stomach pain?
_____ **Total for Section B**

___C-1 Remnants of food or fibers in stool?
___C-2 Nausea or diarrhea?
___C-3 Mucous in stools?
___C-4 Pass gas frequently?
_____**Total for Section C**

___D-1 Pain or discomfort in abdomen area?
___D-2 Have allergies?
___D-3 Family History of autoimmune disease?
___D-4 Drink Alcohol?
___D-5 Drink milk or eat dairy products?
___D-6 Often have constipation or diarrhea?
___D-7 Frequently have gas?
_____**Total for Section D**

___E-1 Coated or fuzzy debris on tongue?
___E-2 Bowel movements painful or difficult?
___E-3 Irritable Bowel or Colitis?
___E-4 Have Bad Breath often?
_____**Total for Section E**

___F-1 Burning or itching anus?
___F-2 Frequently get skin eruptions or bumps?
___F-3 History of Yeast infections?
___F-4 Use or have Estrogen compounds?
___F-5 Have intestinal pain for no reason?
___F-6 Have diarrhea?
___F-7 Have allergies or sensitivities?
___F-8 Get sick often or stay sick?
___F-9 Feel tired all the time?
_____**Total for Section F**

___G-1 Discomfort on right side under ribcage?
___G-2 Blurred vision?
___G-3 Intolerance of greasy foods?
___G-4 Eat fast food?
___G-5 Tightness/pain between shoulder blades?
___G-6 Light colored or foul smelling stools?

___G-7 Feel queasy after eating fatty foods?
___G-8 Drink coffee?
___G-9 Dry skin, itchy or peeling feet?
___G-10 Retaining water?
___G-11 Gag easily?
___G-12 Sour or metallic taste in mouth?
_____**Total for Section G**

___H-1 Feet burn?
___H-2 Noises in head or ringing in ears?
___H-3 Strong light irritates eyes?
___H-4 Drink alcohol?
___H-5 Sensitive to fumes, smells, Smoke, or chemicals?
___H-6 Thick mucous or swollen lymph nodes?
___H-7 Have allergies?
___H-8 Eat luncheon meat?
___H-9 Bronzing of skin or brown spots?
_____**Total for Section H**

___I-1 Head congestion or sinus fullness?
___I-2 Frequent sneezing?
___I-3 Eyes and nose watery, swollen, or puffy?
___I-4 Nightmare like dreams?
___I-5 Dark circles under eyes?
___I-6 Dairy, Corn, Wheat cause distress?
___I-7 Sensitive to fumes smoke, or chemicals?
___I-8 Thick mucous or swollen lymph nodes?
___I-9 Chronic sinus infections?
_____**Total for Section I**

___J-1 Crave sweets/coffee between meals?
___J-2 Hungry between meals/excessive appetite?
___J-3 Irritable before meals if delayed?
___J-4 Get shaky or light-headed if meals delayed?
___J-5 Wake in night and can't go back to sleep?
___J-6 Problems with memory between meals?
___J-7 Eat sweets, refined foods, or fast foods?
_____**Total for Section J**

___K-1 Family history of diabetes?
___K-2 Excessive thirst?
___K-3 Excessive urination?
___K-4 Fasting glucose greater than 120 mg/dl?
___K-5 Overweight by 50 lbs. or more?
_____**Total for Section K**

___L-1 Difficulty maintaining Chiropractic adjustments?
___L-2 Crave salt?
___L-3 Low Blood pressure?
___L-4 Weakness after colds or slow recovery?
___L-5 Headaches in afternoon?
___L-6 Muscular or nervous exhaustion?
___L-7 Chronic fatigue or slow starter in morning?
___L-8 Have allergies or sensitivities?
_____**Total for Section L**

___M-1 Have anxiety?
___M-2 Problems sleeping or insomnia?
___M-3 Crave sweets or coffee to keep going?
___M-4 Get shaky if meals delayed?
___M-5 Retain water?
___M-6 Are you under a lot of stress?
___M-7 Feel tired or sleepy in afternoon?
___M-8 Eat refined flour, sugar, coffee?
_____**Total for Section M**

___N-1 Hair and skin dry but not coarse?
___N-2 Weight gain around hips and waist?
___N-3 Sex drive reduced or absent?
___N-4 Males - Impotent or decrease in size of testes?
___N-5 Females - Infertile or decrease in size of breasts?
___N-6 Abnormal thirst?
___N-7 Lack of menstruation (females)?
_____**Total for Section N**

___O-1 Feel worse after Chiropractic adjustment?
___O-2 Forgetful, mental sluggishness, or reduced initiative?
___O-3 Skin course and dry?
___O-4 Cold hands and feet?
___O-5 Frequent constipation?
___O-6 Headaches upon wakening?
___O-7 Gain weight easily?
___O-8 Cry easily, worse with change in season?
___O-9 Hair thin or falling out?
___O-10 Feel depressed?
_____**Total for Section O**

Females only – section P
___P-1 Menstruates too frequently?
___P-2 Acne worse at menses?
___P-3 Scanty or missed periods?
___P-4 Painful or tender breasts?
___P-5 Have had hysterectomy?
___P-6 Mood changes or irritable before menses?
___P-7 Painful or cramping during menses?
___P-8 Menses excessive or prolonged?
___P-9 Menopausal depression?
___P-10 Have hot flashes or night sweats?
___P-11 Depression before menses?
_____**Total for Section P**

Males Only – section Q
___Q-1 History of prostate problems?
___Q-2 Decreased size and force of urinary stream?
___Q-3 Reduced sex drive?
___Q-4 Dribbling after urination?
___Q-5 Frequent night urination?
___Q-6 Feeling incomplete bowel evacuation?
___Q-7 Difficulty stopping urinary flow?
___Q-8 Leg nervousness at night?
___Q-9 Pain on side of legs or inside of heels?
_____**Total for Section Q**

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___R-1 Chest pain or shortness of breath?
___R-2 Swollen ankles, worse at night?
___R-3 Personal/family history of heart disease?
___R-4 High cholesterol or triglycerides?
___R-5 Pain under sternum that goes to left shoulder?
___R-6 Air hunger, sigh frequently, or labored breathing?
___R-7 Irregular heartbeat?
___R-8 Snores while sleeping?
___R-9 Pain, cramp or tired feeling in foot, calf, and hip?
_____**Total for Section R**

___S-1 Have bronchial asthma or bronchitis?
___S-2 Frequent lung congestion?
___S-3 Live or work around people who smoke?
___S-4 Recurrent sinus or upper-respiratory infections?
___S-5 Chronic cough?
_____**Total for Section S**

___T-1 Recurrent bladder or kidney infections?
___T-2 Painful burning when passing urine?
___T-3 Cloudy, rosey, or strong smelling urine?
___T-4 Difficulty urinating?
___T-5 Urinary leakage or bedwetting?
___T-6 Back pain or aching in kidney area?
___T-7 History of kidney problems?
___T-8 Have skin eruptions, psoriasis or eczema?
_____**Total for Section T**

___U-1 Pain in neck or shoulder?
___U-2 Tightness in shoulder muscles?
___U-3 Muscle cramps or spasms?
___U-4 Muscles and joints sore all over?
_____**Total for Section U**

___V-1 Joint pain in hands or fingers?
___V-2 Told you have arthritis?
___V-3 joint stiffness?
___V-4 Told you have herniated/slipped disc?
_____**Total for Section V**

___W-1 Bones are sore or pain in fingers?
___W-2 Cavities or dentures?
___W-3 Gums bleed easily?
___W-4 Have muscle cramps?
___W-5 Told you have bone loss or Osteoporosis?
_____**Total for Section W**

___X-1 Uncoordinated or unsteady walk?
___X-2 Pins and needles, burning in hands or feet?
___X-3 Muscle weakness or reflex loss?
___X-4 Loss of sense of vibration in legs?
___X-5 Memory Loss?
___X-6 Restless legs?
___X-7 Dizziness?
___X-8 Irritable or moody?
_____**Total for Section X**

___Y-1 Chronic infections?
___Y-2 Wounds heal slowly?
___Y-3 Loss of sense of taste and smell?
___Y-4 Fatigued?
___Y-5 White spots under fingernails?
_____**Total for Section Y**

___ZA-1 Night vision poor?
___ZA-2 Strong light irritates eyes?
___ZA-3 Noises in head or ringing in ears?
_____**Total for Section ZA**

___ZB-1 Vulnerable to insect bites?
___ZB-2 Loss of muscle tone or heaviness in arms and legs?
___ZB-3 Worrier, feel insecure, or emotional?
___ZB-4 Slow pulse or irregular heartbeat?
___ZB-5 Poor appetite?
_____**Total for Section ZB**

___ZC-1 Burning sensation in mouth?
___ZC-2 Cannot recall dreams?
___ZC-3 Numbness in hands and/or feet?
___ZC-4 Intolerance to MSG?
_____**Total for Section ZC**

___ZD-1 Intolerance to sulfites (found in wine)?
___ZD-2 Sensitive to perfumes or smells?
_____**Total for Section ZD**

___ZE-1 Frequently irritable?
___ZE-2 Easily startled or nervous?
___ZE-3 Muscle, leg, or toe cramping at rest?
___ZE-4 Body odor or foot odor?
___ZE-5 Crave chocolate?
_____**Total for Section ZE**

___ZF-1 'Lump' in throat?
___ZF-2 Dry mouth, eyes, or nose?
___ZF-3 Gag easily?
_____**Total for Section ZF**

___ZG-1 Fatigued all the time?
___ZG-2 Nails weak or ridged?
___ZG-3 History of anemia?
___ZG-4 Hands or feet often cold?
___ZG-5 Crave ice?
___ZG-6 'Whites' of eyes blue tinted?
_____**Total for Section ZG**

___ZH-1 Gums bleed easily?
___ZH-2 Bruise easily?
_____**Total for Section ZH**

___ZI-1 Poor wound healing?
___ZI-2 Dry skin?
___ZI-3 Vision blurred or impaired?
___ZI-4 Chronic infections?
___ZI-5 Frequent skin problems?
_____**Total for Section ZI**

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CLIENT INFORMED CONSENT & STATEMENT OF INTENT

I, Jane Smolnik, am a Traditional Naturopath. I hold a doctorate in Natural Medicine and am also board certified in Holistic Iridology, and a Certified Holistic Therapist. I have worked in the field of nutrition and natural health education since 1991. I am a health educator, NOT A PHYSICIAN. As such, I do not diagnose or treat disease, rather I help support the innate healing response of the body through food, nutritional supplements, relaxation & visualization, energy therapies, and exercise programs.

I, the Client, understand that information provided on the relationship between nutrition and health is NOT meant to replace competent medical care or treatment for any health problem or condition. I understand that a Nutritional Assessment and Health Evaluation are not done to define health as it relates to disease, but as it relates to wellness.

I fully understand that the attending practitioner does not offer allopathic drugs, surgery, chemical stimulants, radiation therapy or any other conventional treatments. In addition, he/she does not diagnose, treat or otherwise prescribe for my disease, conditions or illness. I am advised to see my licensed healthcare provider for medical care.

I, the Client, choose to improve my health by assuming greater self-responsibility to reduce or eliminate unhealthy behaviors that are contrary to my well-being. I am here to educate myself on how to take better care of my body naturally for greater health.

I certify that I am here solely on my own behalf. I am not representing any other person, company, association, and/or on the behalf of any governmental agency.

I currently am___ /am not____ under the care of a physician for a health problem or medical condition.

If so, for what problem or condition?

Jane Smolnik, ND, does___/does not___ have my permission to contact and consult with my physician about the work we are doing and to obtain client/patient records if necessary.

My physician is: _____

_____

Client signature Print Name

_____

Address, City, State, Zip

_____ _____

Date Phone number:

Thank you. Our work together is completely confidential at all times. I look forward to working with you and supporting you in your journey to improved health and well-being!