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

Circle if you eat, drink, or use:

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

Specify _____

Circle if you:

- Diet often
- Salt food without tasting
- Exercise less than 3 times weekly
- Are under excessive stress
- Are exposed to chemicals at work
- 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** (Occurs once a month or less) **2 = Moderate** (Occurs several times monthly) **3 = Severe** (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._____

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
	Yes		No	
23. Appetite reduced	0	1	2	3

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

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	

PART III (Continued)

CATEGORY IV

Section A:

52. Sex drive increased 0 1 2 3
53. "Splitting" type headaches 0 1 2 3
54. Memory failing 0 1 2 3
55. Tolerance for sugar reduced 0 1 2 3

Section B:

56. Sex drive reduced or absent 0 1 2 3
57. Abnormal thirst 0 1 2 3
58. Weight gain around hips or waist 0 1 2 3
59. Tendency to ulcers or colitis 0 1 2 3
60. Increased ability to eat sugar without symptoms ... 0 1 2 3
61. Menstrual disorders (women) 0 1 2 3
62. Lack of menstruation (young girls) 0 1 2 3

Section C:

63. Difficulty gaining weight, even if large appetite 0 1 2 3
64. Heart palpitations 0 1 2 3
65. Nervous, emotional, and/or can't work under pressure 0 1 2 3
66. Insomnia 0 1 2 3
67. Inward Trembling 0 1 2 3
68. Night Sweats 0 1 2 3
69. Fast pulse at rest 0 1 2 3
70. Intolerant to high temperatures 0 1 2 3
71. Easily flushed 0 1 2 3

Section D:

72. Difficulty losing weight 0 1 2 3
73. Reduced initiative and/or mental sluggishness 0 1 2 3
74. Easily fatigued, sleepy during the day 0 1 2 3
75. Sensitive to cold, poor circulation (cold hands and feet) 0 1 2 3
76. Dry or scaly skin 0 1 2 3
77. "Ringing" in ears/noises in head 0 1 2 3
78. Hearing impaired 0 1 2 3
79. Constipation 0 1 2 3
80. Excessive falling hair and/or coarse hair 0 1 2 3
81. Headaches when awaken/wear off during day 0 1 2 3

Section E:

82. Blood pressure increased 0 1 2 3
83. Headaches 0 1 2 3
84. Hot flashes 0 1 2 3
85. Hair growth on face or body (Question to females) 0 1 2 3
86. Masculine tendencies (Question to females) 0 1 2 3

Section F:

87. Blood pressure low 0 1 2 3
88. Crave salt 0 1 2 3
89. Chronic fatigue/get drowsy 0 1 2 3
90. Afternoon yawning 0 1 2 3
91. Weakness/dizziness 0 1 2 3
92. Weakness after colds/slow recovery 0 1 2 3
93. Circulation poor 0 1 2 3
94. Muscular and nervous exhaustion 0 1 2 3
95. Subject to colds, asthma, bronchitis (respiratory disorders) 0 1 2 3
96. Allergies and/or hives 0 1 2 3
97. Difficulty maintaining manipulative correction 0 1 2 3
98. Arthritic tendencies 0 1 2 3
99. Nails weak, ridged 0 1 2 3
100. Perspire easily 0 1 2 3
101. Slow starter in morning 0 1 2 3
102. Afternoon headaches 0 1 2 3

CATEGORY V

Section A:

103. Frequent skin rashes and/or hives 0 1 2 3
104. Muscle-leg-toe cramping at rest and/or while sleeping 0 1 2 3
105. Fever easily raised/fevers common 0 1 2 3
106. Crave Chocolate 0 1 2 3
107. Feet have bad odor 0 1 2 3
106. Hoarseness frequent 0 1 2 3
109. Difficulty swallowing 0 1 2 3
110. Joint stiffness after rising 0 1 2 3
111. Vomiting frequent 0 1 2 3
112. Tendency to anemia 0 1 2 3
113. "Whites" of eyes (sclera) blue 0 1 2 3
114. "Lump" in throat 0 1 2 3
115. Dry mouth-eyes-nose 0 1 2 3
116. White spots on finger nails 0 1 2 3
117. Cuts heal slowly and/or scar easily 0 1 2 3
118. Reduced or "lost" sense of taste and/or smell 0 1 2 3
119. Susceptible to colds, fevers, and/or infections 0 1 2 3
120. Strong light irritates eyes 0 1 2 3
121. Noises in head or ringing in ears 0 1 2 3
122. Burning sensations in mouth 0 1 2 3
123. Numbness in hands and feet (extremities "go to sleep") 0 1 2 3
124. Intolerant to monosodium glutamate (MSG) ..... Yes No
125. Cannot recall dreams 0 1 2 3
126. Nose bleeds frequent 0 1 2 3
127. Bruise easily, "black and blue" spots 0 1 2 3
128. Muscle cramps, worse with exercise ("charley horses") 0 1 2 3

CATEGORY VI

129. Aware of heavy and/or irregular breathing 0 1 2 3
130. Discomfort in high altitudes 0 1 2 3
131. "Air hunger"/ sigh frequently 0 1 2 3
132. Swollen ankles/worse at night 0 1 2 3
133. Shortness of breath with exertion 0 1 2 3
134. Dull pain in chest and/or pain radiating into left arm, worse on exertion 0 1 2 3

CATEGORY VII

Female Only

135. Premenstrual tension 0 1 2 3
136. Painful menses (cramping, etc.) 0 1 2 3
137. Menstruation excessive or prolonged 0 1 2 3
138. Painful/tender breasts 0 1 2 3
139. Menstruate too frequently 0 1 2 3
140. Acne, worse at menses 0 1 2 3
141. Depressed feelings before menstruation 0 1 2 3
142. Vaginal discharge 0 1 2 3
143. Menses scanty or missed 0 1 2 3
144. Hysterectomy/ovaries removed ..... Yes No
145. Menopausal hot flashes 0 1 2 3
146. Depression 0 1 2 3

CATEGORY VIII

Male Only

147. Prostate trouble 0 1 2 3
148. Urination difficult or dribbling 0 1 2 3
149. Night urination frequent 0 1 2 3
150. Pain on inside of legs or heels 0 1 2 3
151. Feeling of incomplete bowel evacuation 0 1 2 3
152. Leg nervousness at night 0 1 2 3
153. Tire easily/avoid activity 0 1 2 3
154. Reduced sex drive 0 1 2 3
155. Depression 0 1 2 3
156. Migrating aches and pains 0 1 2 3

HEALTH APPRAISAL INDICATOR

NAME _____ DATE _____

INSTRUCTIONS: Use Figures (1) Mild (2) Moderate and (3) Severe to show degree of severity. Check only those symptoms which apply to your case; do not write "No" where answers do not apply.

1. ___ Abnormal craving for sweets
2. ___ Afternoon headaches
3. ___ Alcohol consumption
4. ___ Allergies--tendency to asthma, hay fever, skin rash, etc.
5. ___ Awaken after few hours sleep--hard to get back to sleep
6. ___ Aware of breathing heavily
7. ___ Bad dreams
8. ___ Bleeding Gums
9. ___ Blurred Vision
10. ___ Brown spots or bronzing of skin
11. ___ Bruise easily "black and blue" spots
12. ___ "Butterfly" stomach, cramps
13. ___ Can't decide easily
14. ___ Can't start in A.M. before coffee
15. ___ Can't work under pressure
16. ___ Chronic fatigue
17. ___ Chronic nervous exhaustion
18. ___ Convulsions
19. ___ Crave candy or coffee in afternoons
20. ___ Cries easily for no reason
21. ___ Depressed
22. ___ Dizziness
23. ___ Drinks ___ cups of coffee daily
24. ___ Eat often or get hunger pains or faintness
25. ___ Eat when nervous
26. ___ Faintness if meals delayed
27. ___ Fatigue, eating relieves
28. ___ Fearful
29. ___ Get "shaky" if hungry
30. ___ Hallucinations
31. ___ Hand tremor
32. ___ Heart palpitates if meals missed or delayed
33. ___ Highly emotional
34. ___ Hunger between meals
35. ___ Insomnia
36. ___ Inward trembling
37. ___ Irritable before meals
38. ___ Lack energy
39. ___ Magnifies insignificant events
40. ___ Moods of depression "blues" or melancholy
41. ___ Poor memory
42. ___ Reduced intiative
43. ___ Sleepy after meals
44. Sleepy during day
45. ___ Weakness, dizziness
46. ___ Worrier, feel insecure
47. ___ Do your symptoms come before breakfast? Answer "Yes" or "No"
48. ___ Do you feel better after breakfast than before

CHIROPRACTIC ASSOCIATES

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Do you have chronic candidiasis (yeast sensitivity) ?

Please circle the best answer. If you are uncertain or need to explain your answer, please circle the number of the question and explain on the reverse side.

< means less than
> means greater than

1.	Have you taken antibiotics? Estimate.	infrequent	moderate	heavy
2.	Did you take antibiotics for acne?	no	< 3 mo.	> 3 mo.
3.	Have you ever taken cortisone (prednisone) ?	no	< 2 wk.	> 2 wk.
4.	Do you react poorly to sugar, alcohol, or cahbohydrates (starch) ?	no	sometimes	often
5.	Do you crave sugar and sweets?	no	sometimes	often
6.	Do you feel shaky or irritable when hungry?	no	sometimes	often
7.	Do you have allergies?	no	mild	severe
8.	Do odors (perfume, paint, etc.) bother you?	no	sometimes	often
9.	Do you have asthma?	no	mild	yes
10.	Have you had recurrent or chronic infections?	no	few	often
11.	Are you constipated?	no	sometimes	often
12.	Do you have diarrhea?	no	sometimes	often
13.	Is your memory or concentration impaired?	no	sometimes	often
14.	Do you have dry mouth?	no	sometimes	often
15.	Do you feel chilled?	no	sometimes	often
16.	Are you tired?	no	sometimes	often
17.	Do you have diminished sex drive?	no	sometimes	often
18.	Do you experience urinary frequency?	no	sometimes	often
19.	Are you depressed?	no	sometimes	often
20.	Do you have headaches?	no	sometimes	often
21.	Do you feel bloated or have excessive gas?	no	sometimes	often
22.	Do you have anal itching?	no	sometimes	often
Females only:				
23.	Have you ever taken birth control pills?	no	< 2 yr.	> 2 yr.
24.	Have you ever been pregnant?	no	< 1-3	> 3
25.	Have you had vaginal yeast infections?	no	once	> 1
26.	Do you have pre-menstrual depression or tension?	no	sometimes	often
27.	Do you have vaginal itching now?	no	mild	severe

Name_____ Date_____

4