

BioEnergetic Health Survey

Instructions: Indicate the symptoms which apply to you using the following scale
(0) if "never" **(1)** if "rarely" **(2)** if "time to time" **(3)** if "often"

Patient: _____ Age: ____ M/F ____ Practitioner: _____

Date _____

SECTION A:

<input type="checkbox"/> 1. Lower bowel gas several hours after eating	<input type="checkbox"/> 9. Excessive belching/burping
<input type="checkbox"/> 2. Burning stomach sensation, eating relieves	<input type="checkbox"/> 10. Bad breath
<input type="checkbox"/> 3. Coated tongue	<input type="checkbox"/> 11. Alternating diarrhea/constipation
<input type="checkbox"/> 4. Indigestion 1/2-1 hr after eating: (may be up To 3/4 hrs)	<input type="checkbox"/> 12. Have pets eg. dogs, cats, farm animals, etc.
<input type="checkbox"/> 5. Carbonated drinks 3+ per week?	<input type="checkbox"/> 13. Rectal itching
<input type="checkbox"/> 6. Difficult bowel movements	<input type="checkbox"/> 14. Can't gain weight
<input type="checkbox"/> 7. Ulcers?/Colitis?/ Gastritis?	<input type="checkbox"/> 15. International travel
<input type="checkbox"/> 8. Stomach bloating after eating	<input type="checkbox"/> 16. Stomach/intestinal cramping/diarrhea
Total: _____	

SECTION B:

<input type="checkbox"/> 17. Afternoon headaches	<input type="checkbox"/> 26. Thirsty much of the time
<input type="checkbox"/> 18. Get "shaky" if hungry	<input type="checkbox"/> 27. History of diabetes
<input type="checkbox"/> 19. Faintness if meals delayed	<input type="checkbox"/> 28. Excessive frequent urination
<input type="checkbox"/> 20. Heart palpitates if meals missed or delayed	<input type="checkbox"/> 29. Blurred vision/failing eyesight
<input type="checkbox"/> 21. Eat when nervous	<input type="checkbox"/> 30. Breath smells sweet
<input type="checkbox"/> 22. Awaken after few hours of sleep	<input type="checkbox"/> 31. Tingling, numbness, prickling sensation in extremities.
<input type="checkbox"/> 23. Hard to get back to sleep	
<input type="checkbox"/> 24. Crave candy or coffee in afternoon	
<input type="checkbox"/> 25. Abnormal craving for sweets or snacks	
Total: _____	

SECTION C:

<input type="checkbox"/> 32. Bruise easily, "black & blue spots"	<input type="checkbox"/> 44. Hands & feet go to sleep easily
<input type="checkbox"/> 33. Sigh frequently	<input type="checkbox"/> 45. Numbness in extremities
<input type="checkbox"/> 34. Aware of "breathing heavily"	<input type="checkbox"/> 46. Tendency to anemia
<input type="checkbox"/> 35. Open window in closed room	<input type="checkbox"/> 47. Tension under breastbone or feeling of tightness, worse in exertion
<input type="checkbox"/> 36. Susceptible to colds & fevers	<input type="checkbox"/> 48. Blushing with no apparent cause
<input type="checkbox"/> 37. Swollen ankles, worse at night	<input type="checkbox"/> 49. Black stool (no iron supplementation)
<input type="checkbox"/> 38. Muscle cramps, worse during night	<input type="checkbox"/> 50. Poor concentration
<input type="checkbox"/> 39. Shortness of breath on exertion	<input type="checkbox"/> 51. Slurred speech
<input type="checkbox"/> 40. Nosebleeds	<input type="checkbox"/> 52. Headaches
<input type="checkbox"/> 41. Ringing in the ears	<input type="checkbox"/> 53. Weakness/fatigue
<input type="checkbox"/> 42. Heart palpitations	<input type="checkbox"/> 54. Out of breath frequently e.g., going up stairs
<input type="checkbox"/> 43. Dull pain in chest or radiating into left arm, worse on exertion	<input type="checkbox"/> 55. Nervousness
Total: _____	

SECTION D:

<input type="checkbox"/> 56. Pain under right side of rib cage	<input type="checkbox"/> 66. Laxatives used often
<input type="checkbox"/> 57. Frequent skin rashes	<input type="checkbox"/> 67. History of gall bladder attacks or gallstones
<input type="checkbox"/> 58. Bitter metallic taste in mouth in morning	<input type="checkbox"/> 68. History of hepatitis
<input type="checkbox"/> 59. Bowel movements painful and difficult	<input type="checkbox"/> 69. History of jaundice
<input type="checkbox"/> 60. Low energy, weakness, exhaustion	<input type="checkbox"/> 70. Sneezing attacks
<input type="checkbox"/> 61. Upset from greasy/fatty foods	<input type="checkbox"/> 71. Itchy skin, worse at night
<input type="checkbox"/> 62. Bruises easily	<input type="checkbox"/> 72. Dry flaky skin, hair
<input type="checkbox"/> 63. Frequent headaches	<input type="checkbox"/> 73. General feeling of poor health
<input type="checkbox"/> 64. Stools light coloured	<input type="checkbox"/> 74. Aching muscles
<input type="checkbox"/> 65. Pain between shoulder blades	<input type="checkbox"/> 75. Swollen feet and/or legs
Total: _____	

SECTION E:

<input type="checkbox"/> 76. Impaired hearing	<input type="checkbox"/> 86. Slow pulse, below 65
<input type="checkbox"/> 77. Decrease in appetite	<input type="checkbox"/> 87. Cold hands and feet
<input type="checkbox"/> 78. Ringing in ears	<input type="checkbox"/> 88. Gains weight easily
<input type="checkbox"/> 79. Constipation	<input type="checkbox"/> 89. Weight gain around hips
<input type="checkbox"/> 80. Puffy hands/face	<input type="checkbox"/> 90. Outer third eyebrow thinning
<input type="checkbox"/> 81. Tired/sluggish	<input type="checkbox"/> 91. "Emotional"
<input type="checkbox"/> 82. Miscarriages	<input type="checkbox"/> 92. Flush easily
<input type="checkbox"/> 83. Infertility	<input type="checkbox"/> 93. Night sweats
<input type="checkbox"/> 84. Mental sluggishness/forgetfulness	<input type="checkbox"/> 94. Hair loss
<input type="checkbox"/> 85. Headache upon rising; wears off during day	
Total: _____	

SECTION F:

<input type="checkbox"/> 95. Hip and joint pain	<input type="checkbox"/> 98. Bone loss/osteoporosis in family
<input type="checkbox"/> 96. Receding gums and/or dental cavities	<input type="checkbox"/> 99. Crunching, creaking joints
<input type="checkbox"/> 97. Tendency towards slouching/weak	
Total: _____	

SECTION G:

<input type="checkbox"/> 100. Exposure to fumes e.g., paint, salon, car	<input type="checkbox"/> 104. Skin disorders e.g., psoriasis, eczema etc.
<input type="checkbox"/> 101. Use pesticides on garden	<input type="checkbox"/> 105. Loss of hair
<input type="checkbox"/> 102. Live near power lines/high tension wires	<input type="checkbox"/> 106. Hormone disorders
<input type="checkbox"/> 103. Have mercury amalgams (silver) in mouth	<input type="checkbox"/> 107. History of cancer/personal or familial
Total: _____	

SECTION H:

<input type="checkbox"/> 108. Muscle aches, stiffness, cramping and pains	<input type="checkbox"/> 111. Fatigue, sluggishness
<input type="checkbox"/> 109. Chiropractic adjustments don't hold	<input type="checkbox"/> 112. Upper or lower back pain
<input type="checkbox"/> 110. Whiplash and/or ligamental trauma/strain	<input type="checkbox"/> 113. Stiff neck and shoulders
Total: _____	

SECTION I:

<input type="checkbox"/> 114. Low blood pressure	<input type="checkbox"/> 125. Feeling unrefreshed upon awakening
<input type="checkbox"/> 115. Chronic fatigue	<input type="checkbox"/> 126. Allergies
<input type="checkbox"/> 116. Low energy, lack of stamina	<input type="checkbox"/> 127. Exhaustion—muscular & nervous
<input type="checkbox"/> 117. General malaise, unhappiness	<input type="checkbox"/> 128. Respiratory disorders
<input type="checkbox"/> 118. Tendency to hives	<input type="checkbox"/> 129. Swollen ankles
<input type="checkbox"/> 119. Arthritic tendency	<input type="checkbox"/> 130. Dizzy when stand up “too fast”
<input type="checkbox"/> 120. Excessive perspiration	<input type="checkbox"/> 131. Decreasing appetite
<input type="checkbox"/> 121. Colds/flu often	<input type="checkbox"/> 132. Irritable
<input type="checkbox"/> 122. Weakness after illness	<input type="checkbox"/> 133. Bright lights irritate
<input type="checkbox"/> 123. Dark circles under the eyes	
<input type="checkbox"/> 124. Crave salty foods	
Total: _____	

SECTION J:

Female Only	Male Only
<input type="checkbox"/> 134. Painful menses	<input type="checkbox"/> 146. Tired too easily
<input type="checkbox"/> 135. Premenstrual tension	<input type="checkbox"/> 147. Urination difficult
<input type="checkbox"/> 136. Very easily fatigued	<input type="checkbox"/> 148. Night urination frequent
<input type="checkbox"/> 137. Depressed feeling	<input type="checkbox"/> 149. Pain on inside of legs or heel
<input type="checkbox"/> 138. Menstruation excessive and prolonged	<input type="checkbox"/> 150. Feeling of incomplete bowel evacuation
<input type="checkbox"/> 139. Painful breasts (monthly)	<input type="checkbox"/> 151. Prostrate trouble
<input type="checkbox"/> 140. Lumpy breasts/worst at menses	<input type="checkbox"/> 152. Leg nervous at night
<input type="checkbox"/> 141. Have taken birth control pills	<input type="checkbox"/> 153. Diminished sex drive
<input type="checkbox"/> 142. Menopause, hot flashes, etc.	
<input type="checkbox"/> 143. Menses scanty or irregular	Female Total _____
<input type="checkbox"/> 144. Acne, worse at menses	
<input type="checkbox"/> 145. Vaginal discharge/yeast, etc.	Male Total _____

SECTION K:

<input type="checkbox"/> 154. Chronic cough	<input type="checkbox"/> 163. Bronchitis (frequent)
<input type="checkbox"/> 155. Pain around ribs	<input type="checkbox"/> 164. Infections settle in lungs
<input type="checkbox"/> 156. Shortness of breath	<input type="checkbox"/> 165. Sensitive to smog
<input type="checkbox"/> 157. Chest pain	<input type="checkbox"/> 166. Asthma
<input type="checkbox"/> 158. Difficulty breathing	<input type="checkbox"/> 167. Wheezing
<input type="checkbox"/> 159. Post nasal drip	<input type="checkbox"/> 168. Smoker
<input type="checkbox"/> 160. Sinus and nasal congestion	<input type="checkbox"/> 169. Chronic lung congestions
<input type="checkbox"/> 161. Coughing up phlegm	<input type="checkbox"/> 170. Breathes through mouth
<input type="checkbox"/> 162. Coughing up blood	<input type="checkbox"/> 171. Shallow breather
Total _____	

SECTION L:

<input type="checkbox"/> 172. Throat infections	<input type="checkbox"/> 180. Cough with mucus
<input type="checkbox"/> 173. Poor wound healing	<input type="checkbox"/> 181. Swollen tongue
<input type="checkbox"/> 174. Slow to recover from colds or flu	<input type="checkbox"/> 182. Dark areas under the eyes/cheeks
<input type="checkbox"/> 175. Gets boils or sties	<input type="checkbox"/> 183. Sore throat
<input type="checkbox"/> 176. Swollen lymph glands	<input type="checkbox"/> 184. Post nasal drip
<input type="checkbox"/> 177. Catch colds or flu easily	<input type="checkbox"/> 185. Ear aches and infections
<input type="checkbox"/> 178. Bumpy skin on arms	<input type="checkbox"/> 186. Herpes/cold sores
<input type="checkbox"/> 179. Inflamed or bleeding gums	
Total: _____	

SECTION M:

<input type="checkbox"/> 187. Frequent urination	<input type="checkbox"/> 196. Strong smelling urine
<input type="checkbox"/> 188. Rose-coloured (bloody) urine	<input type="checkbox"/> 197. Mild back pain
<input type="checkbox"/> 189. Dripping after urination	<input type="checkbox"/> 198. Interrupted urine stream
<input type="checkbox"/> 190. Difficulty passing urine	<input type="checkbox"/> 199. Tingling in joints
<input type="checkbox"/> 191. Cloudy urine	<input type="checkbox"/> 200. Joint and muscle pain/cramping
<input type="checkbox"/> 192. Rarely need to urinate	<input type="checkbox"/> 201. Can't hold urine
<input type="checkbox"/> 193. Frequent bladder infections	<input type="checkbox"/> 202. Dark circles under eyes
<input type="checkbox"/> 194. Painful/burning when urinating	<input type="checkbox"/> 203. Frequent urge to urinate but passes only small amounts
<input type="checkbox"/> 195. Urination when cough or sneeze	
Total: _____	

SECTION N:

Medications you are currently taking:

205. How often do you take (or have taken) antibiotics? #____ Y / N

206. Reactions to vaccinations? Y / N

207. How many silver amalgams do you have in your mouth? _____ Root canals? _____ Crowns/bridges? Y / N

208. Were your wisdom teeth impacted? Y / N Other Dental Problems? Y / N

209. Allergies? Y / N (List main)

210. Are you experiencing bone loss or osteoporosis? Y / N

211. Do you smoke? Y / N

212. Diagnosed for parasites? Y / N

213. Diagnosed or history of Candida? Y / N

214. Exposure to pesticides Y / N

215. Drink 6-8 glasses of water daily? Y / N

216. Hormone replacement medications? Y / N

IMPORTANT: Please list your five main health complaints in the order of importance:

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