HEALTH INVENTORY

Name _____Today's date_____

Address _____ Birth date _____

City_____State/Zip_____Age____Sex____Height____Weight____

Phone: W_____H:_____ Legal status: S M D Sep W Kid

E-mail (if you would like to be notified of upcoming classes)_____

Occupation_____

Referred by_____

Education (Years completed) Elem____HS_____Coll_____Voc_____Prof_____

Family Physician _____

External Factors That Affect You

Below are a list of things that you are exposed to. Each of these factors may affect you in a particular way . Please write in **what way you are affected** by each of the following . Do you feel worse or better in any way from each of the factors.

For instance take the factor "sun". Suppose by going in the sun you get a headache, then write "Headache " opposite to "sun".

If in hot weather you feel uneasy, then write "Uneasy" opposite to "Hot Weather " in the column.

Most importantly, write the effect each factor has on your main complaint. For instance if your main complaint is asthma and this is worse when lying on the back please write:
"Lying on the back " asthma becomes worse"

Sometimes one factor may make you feel worse in one way, and better in some other respect, For instance
Cold air " may cause headache but headache but make you feel better in general. If this is so, please mention this difference clearly.

This section is most important. Do not go through it hurriedly . Think carefully about the effect of each factor before you write.

Factors in life > > > > > > > Effect > >

Walking _____
Running _____
Climbing stairs _____
Going downstairs _____
Riding in bus, car etc. _____
Lying _____
Lying on back _____

Hot weather _____
Cold weather _____
Rainy weather _____
Cloudy weather _____
Change of season _____
Thunder storm _____
Covering _____

Lying on abdomen _____
Lying with head low_____
Drinking _____
Sitting _____
Dust _____
Standing _____
Smoke _____
Looking up _____
Touch _____
Looking down _____
Pressure _____
Looking from high places _____
Massage _____
Looking at moving object _____
Tight clothes _____
Noise _____
Before sleep _____
Sudden noise _____
During sleep _____
Music _____
After sleep _____
Light _____
After afternoon nap _____
Strong smells _____
Loss of sleep _____
When constipated _____
Before stools _____
Before urine _____
During stools _____
During urine_____
After stools _____
After urine _____
Coughing _____
Before menses _____
Sneezing _____
During menses _____
Laughing _____
After menses _____
Talking _____
After Sweating _____
Reading _____
When Fasting _____
Writing _____
After eating _____
Stooping _____
Before important engagement _____

Passing gas _____
Before exams _____
After hair cut _____
When angry _____
Combing hair _____
When worried _____
Brushing teeth _____
When sad _____
Moonlight _____
After weeping _____
Opening the mouth _____
Consolation /sympathy _____
Smoking _____
In a crowd _____
Limbs hanging down _____
In a closed room _____
Arms hanging down _____
When thinking of illness _____
Near sea _____
Full noon /new moon _____
Shaving _____
Morning _____
Stretching _____
Afternoon _____
Swallowing _____
Evening _____
Listening to others talk _____
Night _____
Vomiting _____
Bathing _____
Yawning _____
Drafts of air _____
Moving the eyes _____
Biting or chewing _____
Opening the eyes _____
Blowing nose _____
Closing the eyes _____
When alone _____
Getting feet wet _____
In company _____
Over eating _____
Physical exertion _____
Working in water _____
Belching_____
Fanning _____

Your childhood history

1) Check if you had any of the following:
Check twice (XX) if they were very intense.

- ☐ Obstinacy
- ☐ Unusual fears
- ☐ Temper tantrums
- ☐ Shyness
- ☐ Disobedience
- ☐ Unusual attachments (to whom)
- ☐ Aggression:
- ☐ Hyperactivity
- ☐ Biting nails
- ☐ Destructiveness
- ☐ Thumb –sucking
- ☐ Courageous
- ☐ Picking and playing with _____
- ☐ Possessiveness mother's body parts
- ☐ Competition-winning spirit
- ☐ Sibling jealousy
- ☐ Any special skills
- ☐ Religious
- ☐ Unusual desires (for what)
- ☐ Dullness of memory
- ☐ Boasting
- ☐ Slowness (in what)
- ☐ Stealing
- ☐ Laziness /Indolence
- ☐ Telling lies
- ☐ Sensitive/Emotional

2) Please write in detail, if your mother suffered from any emotional stress during pregnancy ._____
_____
_____

3) Please describe any other aspects you feel are striking about you as a child . _____
_____
_____

4) Describe one incident from your childhood when you became very upset. _____
_____
_____
_____
_____

Are you aware of any problems with your parents conceiving? _____
_____

Did your mother have any physical problem during pregnancy ? _____
_____
_____

Were any drugs taken during pregnancy ? ____
What were they? _____
_____

Was there any difficulty with your birth ? ___
_____
_____

At what age did you start:

Teething _____
Urine Control _____
Sitting up _____
Standing _____
Walking _____
Speaking _____
Did you eat indigestibles such as chalk , lime, dirt as a child? _____
Any problems with your growth & development? _____

Have you had any animal bites:

- ☐ Dog
- ☐ Rat
- ☐ Snake
- ☐ Scorpion

Did you take anti-rabies or anti –venom or any other treatment ?

APPETITE AND THIRST

How is your appetite ?

When are you hungry ?

What happens if you have to remain hungry for long ?

How fast do you eat ?

How much thirst do you have ?

Any particular time are you specially thirsty ?

Do you feel any change in your taste and feeling in your mouth ?

Please put one tick (✓) if you Like/ Dislike the food or if the food disagrees. Put two marks (✓✓) , if you strongly Like / Dislike the food or if the food strongly disagrees.

	Like	Dislike	Disagrees		Like	Dislike	Disagrees
Bitter				Eggs			
Salt extra				Spicy food			
Sweet				Meat			
Sour				Fish			
Bread				Cabbage			
Butter				Onions			
Fats				Warm food / drink			
Milk				Cold food / drink			
Coffee				Fruits			
Mud / Chalk				Anything else			

Physicals Page One

- ☐ Abdominal Bloating_____
- ☐ Abdominal pain _____
- ☐ Acne _____
- ☐ Allergies _____
- ☐ Arteriosclerosis _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Back pain/strain _____
- ☐ Balance problems _____
- ☐ Belching _____
- ☐ Bladder infection _____
- ☐ Bleeding or bruising_____
- ☐ Bleeding gums _____
- ☐ Blood clots _____
- ☐ Bowel Gas _____
- ☐ Breast fed _____
- ☐ Breast lumps _____
- ☐ Bronchitis _____
- ☐ Cancer _____
- ☐ Cataract _____
- ☐ Chest Pain or pressure_____
- ☐ " at rest _____
- ☐ " with exertion _____
- ☐ " with stress _____
- ☐ " with eating _____
- ☐ "down left arm,neck,back_____
- ☐ " w /nausea,sweat, anxiety_____
- ☐ " irregular heartbeat_____
- ☐ " Palpitations _____
- ☐ " Fast heartbeat _____
- ☐ " Heart murmur _____
- ☐ Cold hands/feet _____
- ☐ Constipation _____
- ☐ Convulsions _____
- ☐ Dizziness _____
- ☐ Hair loss / growth _____
- ☐ Change wart/mole _____
- ☐ Chemical sensitive. _____
- ☐ Chicken pox _____
- ☐ Chronic fatigue _____
- ☐ Chronic cough _____
- ☐ Colds, frequent _____
- ☐ Colitis _____
- ☐ Concentration difficult_____
- ☐ Congenital defects_____
- ☐ Dental problems _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Diarrhea _____
- ☐ Ear infections _____
- ☐ Eczema _____
- ☐ Endometriosis _____
- ☐ Epilepsy _____
- ☐ Eye pain _____
- ☐ Eyes tear or itch _____
- ☐ Fainting _____
- ☐ Fibrocystic breasts_____
- ☐ Fibroids _____
- ☐ Frequent infection_____
- ☐ Gallbladder disease _____
- ☐ Glaucoma _____
- ☐ Gout _____
- ☐ Halos around lights_____
- ☐ Hay fever _____
- ☐ Headaches _____
- ☐ Hemorrhoids _____
- ☐ Hearing Loss _____
- ☐ Hears ringing buzzing_____
- ☐ Heart attack _____
- ☐ Heart failure _____
- ☐ Hemorrhoids _____
- ☐ Hepatitis _____
- ☐ Herpes _____
- ☐ Hernia _____
- ☐ High blood pressure_____
- ☐ High cholesterol _____
- ☐ High triglycerides _____
- ☐ Hives _____
- ☐ Hypoglycemia _____
- ☐ Infectious mono. _____
- ☐ Insomnia _____
- ☐ Jaundice _____
- ☐ Joint pain _____
- ☐ " worse motion? _____
- ☐ " better motion _____
- ☐ " swollen joints _____
- ☐ " stiff joints _____
- ☐ Kidney infection _____
- ☐ Kidney stones _____
- ☐ Kidney problems _____
- ☐ Lightheadedness _____
- ☐ Liver disease _____
- ☐ Low back pain _____
- ☐ Malnutrition _____
- ☐ Measles _____
- ☐ Migraine _____
- ☐ Mood swings _____
- ☐ Mouth breather _____
- ☐ Mumps _____

- ☐ Muscle pain _____
- ☐ " weakness _____
- ☐ Nausea/vomiting _____
- ☐ Nervous cond. _____
- ☐ Neurological problems_____
- ☐ Nightmares _____
- ☐ Night sweats _____
- ☐ Nosebleeds _____
- ☐ Numbness/Tingling_____
- ☐ Overweight(20 lbs)_____
- ☐ Peptic ulcer _____
- ☐ Periodontal disease _____
- ☐ Phlebitis _____
- ☐ Pneumonia _____
- ☐ Polio _____
- ☐ Poor memory _____
- ☐ Premenstrual tension_____
- ☐ Rectal bleeding _____
- ☐ Restlessness _____
- ☐ Rheumatic fever _____
- ☐ Root canal _____
- ☐ Salivation excess _____
- ☐ Scarlet fever _____
- ☐ Seizure/Convulsion_____
- ☐ S.T.D's ._____
- ☐ Shortness of breath_____
- ☐ " with exertion _____
- ☐ " at night _____
- ☐ Sinusitis _____
- ☐ Skin problems _____
- ☐ Sleep disorders _____
- ☐ Sore throats _____
- ☐ Steroid use _____
- ☐ Stool is black _____
- ☐ " is clay colored _____
- ☐ " Mucousy _____
- ☐ Stroke _____
- ☐ Suicide attempt _____
- ☐ Swelling feet / legs _____
- ☐ Swollen glands _____
- ☐ Thyroid problems _____
- ☐ Tonsillitis _____
- ☐ Tooth problems _____
- ☐ Trembling episodes_____
- ☐ Tuberculosis _____
- ☐ Urine - frequent _____
- ☐ " Painful / burning_____
- ☐ " at night _____
- ☐ " blood in urine _____
- ☐ " foul odor to urine_____
- ☐ "loss of urine control_____

To control weight, I have

- ☐ Fasted longer than 1 day
- ☐ Diet pills
- ☐ Self-induced vomiting
- ☐ Laxatives / Enemas
- ☐ Diuretics (water pills)
- ☐ Health / diet
- ☐ Exercise

Surgeries or operations:

- ☐ Adenoids _____
- ☐ Appendix _____
- ☐ Eyes _____
- ☐ Gall Stones _____
- ☐ Hernia _____
- ☐ Piles _____
- ☐ Tonsils _____
- ☐ Uterine _____
- ☐ Renal _____

Anesthesia problems?

- ☐ General _____
- ☐ Local _____
- ☐ Lumbar _____

Mental / emotional injuries

- ☐ Shock _____
- ☐ Grief _____
- ☐ Frights _____
- ☐ Depression _____
- ☐ Nervous breakdowns_____

Drug use or stimulants:

_____

I estimate my use of:

coffee: _____cups / day

soda:_____cans / day

beer:_____cans / day

wine:____glasses per _____

hard liquor____oz per_____

marijuana: ___ per_____

I exercise! Yes No

I've been arrested Yes No

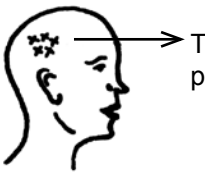
Have you been a victim of abuse?

- ☐ physical
- ☐ mental / emotional

I worry about

- ☐ money
- ☐ job
- ☐ family
- ☐ relationships
- ☐ world issues.

Please mark in the below figure, the locations of your trouble and write the exact sensation or type of pain you experience at those spots. For example if you have throbbing pain on the right side of you head please mark as shown →

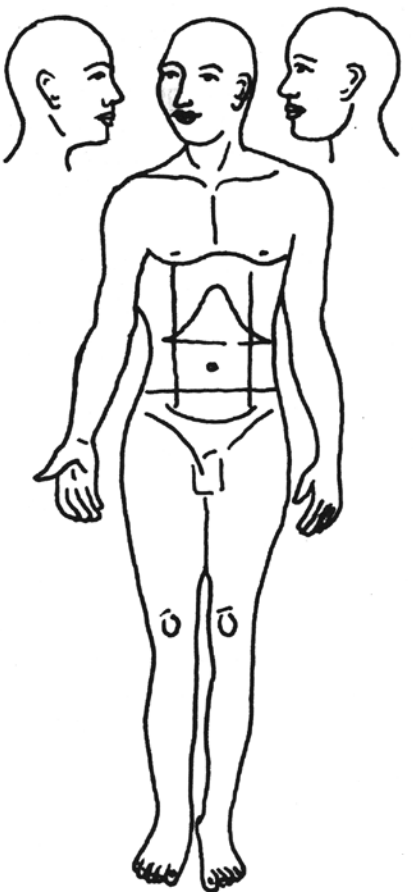


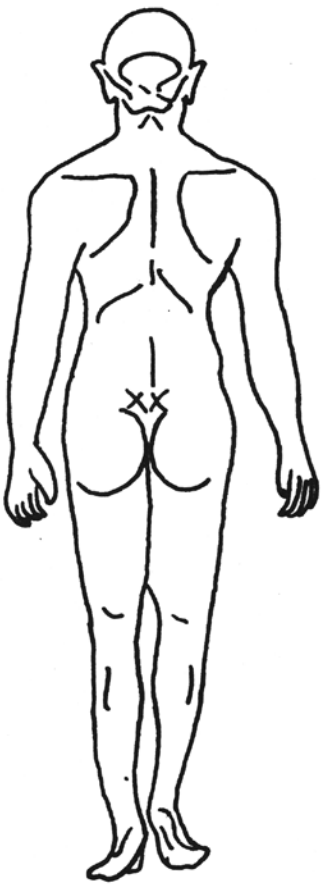
RIGHT FACE

FRONT

LEFT FACE

BACK





Mind / Emotions / Fears

It is now universally acknowledged that our mind has tremendous influence on your body . For optimum results, it's necessary to understand your nature. Answer these freely, carefully, and completely. This information is just as important as physical symptoms.

What are you anxious about? _____
_____
_____

Are you fearful of

- ☐ Animals
- ☐ people
- ☐ being alone
- ☐ darkness
- ☐ death
- ☐ diseases
- ☐ robbers
- ☐ sudden noises
- ☐ thunder
- ☐ of the future
- ☐ of something
- ☐ unknown
- ☐ high places
- ☐ other things _____

_____

What are you doubtful or suspicious of ? ____
_____

Who are you jealous / envious of? _____
_____

What symptoms occur when feeling this? ____
_____

In which matters are you impatient? _____
_____

In which matters are you hurried?_____
_____

How long do you remember hurts caused by others? _____
_____

How revengeful are you? _____
_____
_____

What are you proud of? _____
_____
_____

Does your pride get easily hurt? _____
_____
_____

Depressed, brooding, gloominess? _____
_____
_____

Do you ever become suicidal?_____
_____
_____

If so in what manner do you contemplate to end your life ? _____
_____
_____

Even so, are you afraid of dying ? _____
_____
_____

When are you cheerful? _____
_____
_____

Do you tend to think of sexual thoughts more than others appear to? _____
_____
_____

Mind / Emotions / Fears

Any unwanted thoughts any time ?_____

Have you any imaginary sensations or fears?

Do you hear voices , or hear your name being called , or something similar? _____

How is your short term & long term memory ?

For what is it poor? e.g. names, places , faces..

Do you weep easily? _____

What makes you weep? _____

How do you feel after weeping ? _____

How do you feel if someone offers sympathy and consolation? _____

Are you easily irritated? _____

What makes you angry? _____

What bodily symptoms do you develop When angry? e.g. trembling sweating etc.

Do you like company ? _____

Or rather remain alone? _____

How seriously are you affected by disorder and uncleanness in your surrounding ? _____

What is the greatest grief you have experienced in your life? _____

What is the greatest joy you have experienced in life? _____

What are your hobbies? _____

Are there any matters which you deeply dislike? _____

Are there any aspects of your mind / moods would you love to change. Yet, despite your desire, it seems you are unable to make those changes? _____

How does the future look to you? _____

What is your life's passion? _____

How would you like to be remembered after you leave this world?_____

Reproductive / Sexuality

SEXUAL SPHERE (GENERAL)

How do you feel after sexual intercourse? _____

Any particular feeling or symptoms appear before, during and after sexual intercourse? _____

Do you suffer from

- ☐ Syphilis ? _____
- ☐ Gonorrhoea ? _____
- ☐ Other? _____

Do you have increased desire or decreased desire for sex? _____

_____

What is the method you use for family planning? ____

_____

FOR MEN

Enlarged prostate? _____

Decreased urine stream? _____

Unable to interrupt stream? _____

Dribbiling after urination? _____

Problems with sexual function? _____

WOMEN

Is monthly cycle regular and predictable? _____

Usual length of entire cycle _____

Usual length of period _____

Age menstruation began _____

Number of pregnancies _____

Number of live births _____

# of abortions / miscarriages _____

Color of flow _____

Are the stains difficult to wash? _____

Spotting between periods? _____

PMS? (Anger or tears) _____

Describe any discomfort with periods _____

Do you suffer in any other way before, during or after menses? Please describe: _____

_____

Vaginal discharge _____

Painful intercourse _____

Itching _____

Problems w/ sexual function _____

Lump in breast _____

Abnormal pap smear _____

Infertility _____

Complications in pregnanacys _____

Have you ever used:

- ☐ the pill. Time used? _____
- ☐ IUD _____

MENOPAUSE

Age menopause started? _____

What were / are your symptoms during menopause ?

_____

_____

Is there any discharge? _____

_____

If there is discharge , mention the nature , colour , consistency and smell of discharge. _____

What can cause this to vary? _____

_____

What is the effect of this discharge on your general feeling ? _____

or any of your symptoms ? _____

Any itching , excoriation etc. due to discharge? _____

_____

Do you pass any gas from vagina ? _____

Dreams / Sleep

Check the dreams you have

- ◻ Cats-dogs
- ◻ Horse
- ◻ Wild animals
- ◻ Snakes
- ◻ Robbers
- ◻ Anxious
- ◻ Fearful
- ◻ Ghosts
- ◻ Travelling
- ◻ Riding
- ◻ Flying
- ◻ Swimming
- ◻ Drowning
- ◻ Houses
- ◻ Fruits
- ◻ Trees
- ◻ Water
- ◻ Snow
- ◻ Death, Whose?
- ◻ Dead bodies
- ◻ Dead person
- ◻ Parts of Body
- ◻ Suicide
- ◻ Being Hungry
- ◻ Being Thirsty
- ◻ Drinking
- ◻ Eating
- ◻ Fire
- ◻ Lightning
- ◻ Storm
- ◻ Rain
- ◻ Accidents
- ◻ Falling
- ◻ Shooting
- ◻ Wars
- ◻ Talking
- ◻ Singing
- ◻ Dancing
- ◻ Pleasant
- ◻ Business
- ◻ Money
- ◻ Day's work
- ◻ Forgotten work
- ◻ Vomiting
- ◻ Passing stool
- ◻ Urinating
- ◻ Blood – bleeding
- ◻ Excrements / soiling
- ◻ Romantic
- ◻ Sexual pleasure
- ◻ Rape
- ◻ Nakedness
- ◻ Pain
- ◻ Illness
- ◻ Mutilations
- ◻ Praying
- ◻ Religious
- ◻ God
- ◻ Failure /exams
- ◻ Unsuccessful efforts for what ? _____
- ◻ Missing the train or bus
- ◻ Being unprepared
- ◻ Grief
- ◻ Weeping
- ◻ Vexation
- ◻ Quarrels
- ◻ Jealousy
- ◻ Insults
- ◻ Police
- ◻ Imprisonment
- ◻ Crime
- ◻ Murder
- ◻ Killing
- ◻ Poison
- ◻ Misfortunes
- ◻ Insecurity
- ◻ Danger
- ◻ Being pursued
  By whom?_____
  Why? _____
- ◻ Of people
- ◻ Children
- ◻ Parties
- ◻ Feasts
- ◻ Marriage
- ◻ Of events
- ◻ Remote
- ◻ Recent
- ◻ Future
- ◻ Prophetic
- ◻ Physical Exertion
- ◻ Mental Exertion
- ◻ Fatigue
- ◻ Multi-Coloured
- ◻ If any other, specify_____

_____

Sleep

Posture in sleep.

- ◻ Back
- ◻ Side
- ◻ Abdomen

Which position are you unable to sleep? _____

During sleep do you:

- ◻ Snore
- ◻ Grind teeth
- ◻ Dribble saliva
- ◻ Sweat
- ◻ Keep eyes or mouth open
- ◻ Walk
- ◻ Talk
- ◻ Moan
- ◻ Weep
- ◻ Become restless
- ◻ Wake up with a jerk

Describe if anything else is unusual about your sleep: (sleepy, sleeplessness, etc._____

_____

If so when? _____

_____

How much do you cover up? ____

_____

Do you have to uncover any parts?

_____