



# Back To Life Natural Health Center

## Holistic Natural Health Care

2960 Winnetka Ave. N. #110 Crystal, MN 55427

763-546-3736, Fax 763-546-3807

[www.backtolifehealth.com](http://www.backtolifehealth.com)

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## Welcome to Back To Life Natural Health Center!

We are happy that you have chosen Back To Life for your health care needs.

Before your first visit, please fill out all of the enclosed forms. Take time to answer all the questions and be specific. This is very important in helping the doctor evaluate your current health status.

### Payment Policy

Please note that payment is due at the time of each visit. We regret that we are unable to make exceptions to this policy. However, we do accept Visa, MasterCard and Discover. If you wish to submit to insurance, we will give you a form to send in so that the insurance company can reimburse you. Our office will submit claims for auto accidents, Worker's Compensation, Personal Injury only. If you are covered under one of these please tell the receptionist.

### Cancellation Policy

Please let us know at least 24 hours in advance if you need to cancel your appointment. If sufficient notice is not provided, a missed appointment fee will be charged. This time has been reserved especially for you, and if you cannot use it, please give us the opportunity to offer someone else our care.

### What to Expect

The following paragraphs explain generally what you can expect in terms of treatment and cost. The treatment program does vary from person to person depending on the nature of the problem(s), so this is only an approximation of costs and frequency of treatment.

If you are coming in for treatment of muscular/skeletal problems only, the initial appointment will take about 30 minutes and will include an examination (usually \$45) and treatment (usually \$55-\$66). Additional treatments usually cost \$55-\$66 and vary in frequency depending on the severity of the problem (usually 1-2 times/week, initially).

If you are coming in for internal problems, the initial exam will take one hour. It will include a comprehensive examination (\$90) and occasionally a treatment (usually \$55-\$66). Treatments are often scheduled once or twice a week for the first few weeks, then once every other week or two for the next several weeks, and then continue to decrease as your health improves. Some patients will not need to come this frequently. If you schedule for the QFA (lab work), the cost is \$225 for the first time and \$175 for any re-testing at a later date. Please review the instructions for the fasting involved carefully. The doctor will often recommend specific supplements for you and these would involve additional charges. We will be happy to answer any questions you may have. Thank you!



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## **IF YOU ARE SCHEDULED FOR THE LABS, PLEASE FOLLOW THESE INSTRUCTIONS.**

### **Two Days Before Your Lab Test** **Collecting and Transporting Your Urine Sample**

The Urine contains a wealth of bio-chemical information. It is your metabolic diary. All bio-chemical processes of your body leave residues that eventually find their way to the urine. Thus, the urine specimen is ideal for measuring and monitoring your metabolic health.

#### **Diet Instructions:**

For my lab to obtain the clearest information from your urine specimen, follow these diet instructions for **2 full days prior to catching the urine specimen.**

- No nutritional supplements, unless prescribed by the doctor
- No gum, breath mints, or candy
- No eating your known allergenic foods
- No artificial food colorings
- No artificial sweeteners, sweets of all kinds or sugar
- No alcohol, coffee, black tea, soda or anything with caffeine.
- No laxatives & bulking agents, unless prescribed by the doctor
- No salt
- No beets, carrots or berries
- No processed or junk foods. Only natural foods!

**Eat meat or fish at two meals per day during these 2 days.**

**Drink a minimum of 48 oz of water daily.**

**12 hours before your appt. do not eat, drink or have anything in your mouth including toothpaste, lipstick or lip balms.**

#### **Collecting and Transporting Urine Specimen:**

Drink 48 oz (6, 8oz glasses) of water for 3 days prior to catching urine specimen (except for the 12 hours before)

Use the specimen cup provided by our office or any clean container with a good lid.

Catch only the first morning's voiding (after 3 am) the day of your appointment.

Wait until mid-stream to catch sample.

Fill specimen cup ½ full.

Screw the cap firmly in place to avoid leakage. Place in a baggie for protection.

Do not refrigerate the specimen. Keep it at room temperature.



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### PATIENT INFORMATION

PLEASE PRINT CLEARLY

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone number \_\_\_\_\_ Work phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_

Social Security number \_\_\_\_\_ Parents name (if pt. is a minor ) \_\_\_\_\_

Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated \_\_\_ Roommate \_\_\_ Ages of children \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's name \_\_\_\_\_ Employer \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

In case of emergency contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### ALL FEES ARE PAYABLE ON THE DAY SERVICES ARE RENDERED

I understand I am financially responsible for all charges whether or not paid by insurance. I understand that Back To Life will prepare any necessary reports and forms to assist me in making collection from the insurance company.

I hereby authorize the Doctor and staff to test and treat my condition as they deem appropriate as long as I am consulted before any test or treatment is implemented.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### PERMISSION TO TREAT A MINOR (to be completed if the patient is under age 18)

I, (parent/ guardian ) \_\_\_\_\_ give Back To Life Natural Health Center permission to examine, test and treat (child's name) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### INSURANCE INFORMATION (FILL OUT ONLY IF THIS VISIT IS DUE TO AN *AUTO ACCIDENT OR WORKMANS COMP. CLAIM*)

Insured's name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance company name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Claim number \_\_\_\_\_ Policy number \_\_\_\_\_

If Workers Compensation, was an accident report filed? \_\_\_\_\_ Date \_\_\_\_\_

I authorize payment of medical benefits to Back To Life Natural Health Center for all services provided.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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### Confidential Patient Case History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Print**

What is your major complaint? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other complaints: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past? \_\_\_\_\_

What activities aggravate the condition? \_\_\_\_\_

Is the condition getting worse? \_\_\_ Yes \_\_\_ No \_\_\_ Constant \_\_\_ Comes and goes

Is this condition interfering with your \_\_\_ Work \_\_\_ Sleep \_\_\_ Daily routine \_\_\_ Other \_\_\_\_\_

\*Please underline all of the following symptoms which you have now or have had previously. We want all the facts about your health before we treat you. Your health report is confidential and is treated as such by our staff.

#### General Symptoms

784.4- Headache  
346.2- Allergic  
346.9- Migraine  
307.81- Tension  
780.6- Fever  
780.9- Chills  
780.8- Sweats  
780.2- Fainting  
780.4- Dizziness  
780.3- Convulsions  
780.52- Loss of sleep  
780.7- Fatigue  
799.2- Nervousness  
783- Loss of weight  
278.0- Obesity  
782- Numbness/pain  
in arms, hands or legs  
995.3- Allergies  
785.09- Wheezing  
729.2- Neuralgia

#### E.E.N.T.

368.9- Failing vision  
367.1- Near sighted  
367.0- Far sighted  
378.9- Crossed eyes  
379.91- Eye pain  
389.9- Deafness  
388.70- Earache  
388.30- Ear noises  
388.6- Ear discharge  
784.7- Nose bleeds  
478.1- Nasal obstruction  
462- Sore throat  
784.49- Hoarseness  
477.9- Hay fever

493.9- Asthma  
521- Dental decay  
523.1- Gum trouble  
460- Frequent colds  
240.9- Enlarged thyroid  
463- Tonsillitis  
686.9- Sinus infection  
478.1- Nasal drainage  
785.6- Enlarged glands

#### Skin

782.1- Skin eruptions  
696.1- Psoriasis  
692.9- Eczema  
698.8- Itching  
287.8- Bruises easily  
701.1- Dryness  
454.9- Varicose veins  
782- Sensitive skin  
708.9- Hives or allergy

#### Respiratory

786.2- Chronic cough  
933.1- Spitting up phlegm  
786.3- Spitting up blood  
788.5- Chest pain  
786.09- Difficult breathing

#### Cardiovascular

785- Rapid heart beat  
427.89- Slow heart beat  
401.9- High blood pressure  
458.9- Low blood pressure  
786.51- Pain over heart  
438- Previous heart stroke  
440.9- Hardening of arteries  
719.07- Swelling of ankles

459.9- Poor circulation  
436- Paralytic stroke

#### Muscle & Joint Symptoms

716.9- Arthritis  
847- Stiff Neck  
722.10- Back ache  
719- Swollen Joints  
781- Tremors  
719.4- Painful joints  
724.79- Painful tailbone  
729.5- Foot trouble  
724.5- Pain between  
shoulders  
553.9- Hernia  
737.3- Spinal Curvature  
737.3- Faulty posture  
728.85- Muscle spasms  
724.8- Back spasms  
722.10- Sciatica

#### Genito-urinary Symptoms

788.3- Frequent urination  
788.1 Painful urination  
599.7- Blood in urine  
599- Pus in urine  
592- Kidney infection or  
stone  
788.3- Bed wetting  
788.1- Inability to control  
urine  
601.9- Prostate trouble

#### Gastro-intestinal Symptoms

783- Poor appetite  
536.8- Difficult digestion  
994.2- Excessive hunger  
787.3- Belching or gas  
787- Nausea  
787- Vomiting  
578- Vomiting blood  
536.8- Pain over Stomach  
787.3- Distention of  
abdomen  
564- Constipation  
558.9- Diarrhea  
789-Colon trouble  
455.6- Hemorrhoids  
785.1 Liver trouble  
575.9- Gallbladder trouble  
782.4- Jaundice  
558.9 Colitis

#### For Women Only

625.3- Painful menstrual  
periods  
626.2- Excessive flow  
627.2- Hot flashes  
626.4- Irregular cycle  
625.3- Cramps/backache  
634.9- Miscarriage  
623.5- Vaginal discharge  
611.79- Congested breast  
611.72- Lumps in breast  
627.2- Menopausal symptoms

Have you ever had previous chiropractic care? \_\_\_\_\_ If yes, date of last care \_\_\_\_\_

**(Please Complete Reverse Side)**

**Medical Attention for Chief Complaint:**

Name and address of doctor \_\_\_\_\_  
 When attended \_\_\_\_\_ How long \_\_\_\_\_ Hospitalization \_\_\_\_\_  
 Examination and x-rays made \_\_\_\_\_  
 Diagnosis \_\_\_\_\_  
 Type and duration of treatment \_\_\_\_\_  
 Results of treatment \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_\_\_

**Previous Chiropractic History:**

Name and address of doctor \_\_\_\_\_  
 What were you treated for \_\_\_\_\_  
 Examinations and x-rays made \_\_\_\_\_  
 Cause of problem as explained by doctor \_\_\_\_\_  
 Treatment type & duration \_\_\_\_\_  
 Results: \_\_\_good \_\_\_fair \_\_\_poor \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_  
 Drugs you now take: \_\_\_Blood pressure \_\_\_ Cholesterol \_\_\_ Pain killers \_\_\_ Muscle relaxants \_\_\_ Tranquilizers  
 \_\_\_ Insulin \_\_\_ Birth control \_\_\_ "Pep" pills \_\_\_ Allergy \_\_\_ others \_\_\_\_\_  
 Have you been in an auto accident? \_\_\_ Past year \_\_\_ Past 5 years \_\_\_ over 5 years \_\_\_ Never  
 Describe \_\_\_\_\_  
 Have you had any other personal injury or accident \_\_\_ Past year \_\_\_ Past 5 years \_\_\_ Over 5 years \_\_\_ Never  
 Describe \_\_\_\_\_  
 Were you ever knocked unconscious or stunned? \_\_\_ No \_\_\_ Yes When and how \_\_\_\_\_

**FAMILY HEALTH INFORMATION:** (Many health problems are hereditary; thus information about your family members will give us a better picture of your total health picture)

Relation	Name	Age	Present Symptoms	Previous Serious Illnesses
Mother				
Father				
Sisters				
Brothers				
Children				
Spouse				

**HAVE YOU EVER:**

	YES	NO	DESCRIBE BRIEFLY
Used a cane, crutch or other support?	___	___	_____
Been treated for a spine or nerve disorder?	___	___	_____
Had a fractured bone?	___	___	_____
Been hospitalized for other than surgery?	___	___	_____
Been diagnosed as having Hepatitis?	___	___	_____
Been diagnosed as having HIV or AIDS?	___	___	_____
Been diagnosed as having Mumps?	___	___	_____
Been diagnosed as having Measles?	___	___	_____
Been diagnosed as having Chicken Pox?	___	___	_____

**DO YOU:**

	YES	NO	
Currently take any vitamins or supplements?	___	___	_____
Think you may need vitamins or supplements?	___	___	_____
Have an allergy to any drug?	___	___	_____

**HABITS:**

	HEAVY	MODERATE	LIGHT	NONE	LIST ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE LAST TEN YEARS:
Alcohol	___	___	___	___	
Coffee	___	___	___	___	_____
Tobacco	___	___	___	___	_____
Drugs	___	___	___	___	_____
Exercise	___	___	___	___	_____
Sleep	___	___	___	___	_____
Appetite	___	___	___	___	_____

\_\_\_\_\_  
 Signature of patient

# Dysbiosis Questionnaire and score sheet

This questionnaire is designed for adults and the scoring system is not as appropriate for children. It lists factors in your medical history which are known to contribute to the disruption of normal healthy gastrointestinal bacteria, directly or indirectly promoting the overgrowth of yeast, fungi and other pathogens, (Section A), and symptoms commonly found in individuals with dysbiosis related illness (Section B and C).

By filling out and scoring this questionnaire you and your physician can evaluate if dysbiosis may be contributing to your health problems. Yet it will not provide an automatic “Yes” or “No” answer.

**Note:** *Dysbiosis refers to the condition where the normal healthy population of beneficial bacteria in the intestines has been disrupted, leaving it open to the overgrowth of yeast, fungi, parasites and potentially harmful strains of bacteria. This intestinal imbalance in turn adversely affects other important systems via toxic stress and interfering with nutrient absorption and utilization.*

## SECTION A: HISTORY

*For each “yes” answer in Section A, circle the point score for that question. Total your score and record it in the box at the end of the section. Then move to sections B and C and score them as directed.*

1. Have you taken tetracyclines (Sumycin, Panmycin, Vibramycin, etc.) or other antibiotics for skin acne or anything else for one month (or longer)? Yes= 25
  
2. Have you **at any time in your life**, taken other antibiotics for respiratory, urinary or other infections in shorter courses four or more times in a one year period? Yes = 20
  
3. Have you taken an antibiotic drug – even a single course? Yes = 6
  
4. Have you, at any time in your life, been bothered by recurrent or persistent prostatitis, vaginitis or other problems affecting your reproductive organs? Yes = 25
  
5. Have you taken birth control pills..... for more than 5 years? Yes = 25  
for more than 2 years? Yes = 15  
for 6 months to 2 years? Yes = 8
  
6. Have you been pregnant.....  
  
two or more times? Yes = 5  
one time? Yes = 3
  
7. Have you taken prednisone, Decadron or other cortisone type drugs.....  
  
For more than 6 months? Yes = 25  
For more than 2 weeks? Yes = 15  
For 2 weeks or less? Yes = 6
  
8. Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke...  
  
Moderate to severe symptoms? Yes = 20  
Mild symptoms? Yes = 5
  
9. Are your symptoms worse on damp, muggy days or in moldy places? Yes = 20
  
10. Have you had athlete’s foot, ring worm, “jock itch” or other chronic fungous infections of the skin or nails? (Y/N)  
Have such infections been.....  
  
Severe or persistent? Yes = 20  
Mild to moderate? Yes = 10
  
11. Do you crave sugar? Yes = 10

- |   |          |
|---|----------|
| 12. Do you crave breads?  | Yes = 10 |
| 13. Do you crave alcoholic beverages?   | Yes = 10 |
| 14. Does tobacco smoke really bother you?   | Yes = 10 |
| 15. Have you ever had a parasitic infection, dysentery, or unexplained episode of prolonged diarrhea and intestinal distress? | Yes = 15 |
| 16. Have you ever consumed chlorinated (tap) drinking water for more than 3 months?   | Yes = 15 |
| 17. Do you consume non-organic meat on a regular basis?   | Yes = 15 |
| 18. Do you eat processed/packaged food regularly?   | Yes = 20 |
| 19. Do you drink alcohol or coffee daily?   | Yes = 20 |
| 20. Do you have or have you ever had an ulcer, colitis, crohn's disease or diverticulitis?                                    | Yes = 35 |

**Total Score, Section A:** \_\_\_\_\_

**SECTION B: MAJOR SYMPTOMS**

For each of your symptoms, enter the appropriate figure on the line following the question:

If a symptom is occasional or mild = 3 points	If a symptom is frequent &/or moderate = 6 points
If a symptom is severe or disabling = 9 points	Add total score and record it in the box at the end of the section.

- |   |       |
|---|-------|
| 1. Fatigue or lethargy                            | _____ |
| 2. Feeling of being drained                       | _____ |
| 3. Poor memory                                    | _____ |
| 4. Feeling "spacey" or "unreal"                   | _____ |
| 5. Depression                                     | _____ |
| 6. Numbness, burning or tingling                  | _____ |
| 7. Muscle aches                                   | _____ |
| 8. Muscle weakness or paralysis                   | _____ |
| 9. Pain &/or swelling in joints                   | _____ |
| 10. Abdominal pain                                | _____ |
| 11. Constipation                                  | _____ |
| 12. Diarrhea                                      | _____ |
| 13. Bloating                                      | _____ |
| 14. Troublesome vaginal discharge                 | _____ |
| 15. Persistent vaginal burning or itching         | _____ |
| 16. Prostatitis                                   | _____ |
| 17. Impotence                                     | _____ |
| 18. Loss of sexual desire                         | _____ |
| 19. Endometriosis                                 | _____ |
| 20. Cramps and /or other menstrual irregularities | _____ |
| 21. Premenstrual tension                          | _____ |
| 22. Spots in front of eyes                        | _____ |
| 23. Erratic vision                                | _____ |
| 24. Eczema, dermatitis, psoriasis                 | _____ |

**Total Score, Section B** \_\_\_\_\_

**SECTION C: OTHER SYMPTOMS**

For each of your symptoms, enter the appropriate figure on the line following that question.  
 If the symptom is occasional or mild = 1pt      If the symptom is frequent &/or moderately severe = 2pt      If the symptom is sever &/or disabling = 3pt

- 
- 1. Drowsiness \_\_\_\_\_
  - 2. Irritability \_\_\_\_\_
  - 3. Poor coordination \_\_\_\_\_
  - 4. Inability to concentrate \_\_\_\_\_
  - 5. Frequent mood swings \_\_\_\_\_
  - 6. Headache \_\_\_\_\_
  - 7. Dizziness/loss of balance \_\_\_\_\_
  - 8. Pressure above ears, feeling of head swelling and tingling \_\_\_\_\_
  - 9. Itching \_\_\_\_\_
  - 10. Other rashes \_\_\_\_\_
  - 11. Heartburn \_\_\_\_\_
  - 12. Indigestion \_\_\_\_\_
  - 13. Belching & intestinal gas \_\_\_\_\_
  - 14. Mucus in stools \_\_\_\_\_
  - 15. Hemorrhoids \_\_\_\_\_
  - 16. Dry mouth \_\_\_\_\_
  - 17. Rash or blisters in mouth \_\_\_\_\_
  - 18. Bad Breath \_\_\_\_\_
  - 19. Nasal congestion or discharge \_\_\_\_\_
  - 20. Joint swelling or arthritis \_\_\_\_\_
  - 21. Postnasal drip \_\_\_\_\_
  - 22. Nasal itching \_\_\_\_\_
  - 23. Sore or dry throat \_\_\_\_\_
  - 24. Cough \_\_\_\_\_
  - 25. Pain or tightness in chest \_\_\_\_\_
  - 26. Wheezing or shortness of breath \_\_\_\_\_
  - 27. Urgency or urinary frequency \_\_\_\_\_
  - 28. Burning on urination \_\_\_\_\_
  - 29. Failing vision \_\_\_\_\_
  - 30. Burning or tearing of eyes \_\_\_\_\_
  - 31. Recurrent infection or fluid in ears \_\_\_\_\_
  - 32. Ear pain or hearing loss \_\_\_\_\_

**Total Score Section C:** \_\_\_\_\_

**Total Score Section A:** \_\_\_\_\_

**Total Score Section B:** \_\_\_\_\_

**Grand Total Score** 

The grand total score will help you and your physician decide if your health problems are dysbiosis related. Scores in women will run higher as 7 items in the questionnaire apply exclusively to women, while only 2 apply exclusively to men.

Dysbiosis related health problems are almost certainly present in women with scores over 180, and in men with scores over 140.

Dysbiosis related health problems are probably present in women with scores over 120 and in men with scores over 80.

With scores of less than 60 in women and 40 in men, dysbiosis is unlikely to be contributing to your health challenges.



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## MEDICAL SYMPTOMS QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

\*Rate each of the following symptoms based upon your typical health profile for the last 30 days.

### Point scale

- 0 – Never or almost never have the symptom
- 1 – Occasionally have it, effect is not severe
- 2 – Occasionally have it, effect is severe
- 3 – Frequently have it, effect is not severe
- 4 – Frequently have it, effect is severe

### HEAD

- \_\_\_ Headaches
  - \_\_\_ Faintness
  - \_\_\_ Dizziness
  - \_\_\_ Insomnia
- Total \_\_\_\_\_

### EYES

- \_\_\_ Watery or itchy eyes
  - \_\_\_ Swollen, reddened or sticky eyelids
  - \_\_\_ Bags or dark circles under eyes
  - \_\_\_ Blurred or tunnel vision
- (doesn't include near or far sightedness)
- Total \_\_\_\_\_

### EARS

- \_\_\_ Itchy ears
  - \_\_\_ Earaches, ear infections
  - \_\_\_ Drainage from ear
  - \_\_\_ Ringing in ears, hearing loss
- Total \_\_\_\_\_

### NOSE

- \_\_\_ Stuffy nose
  - \_\_\_ Sinus problems
  - \_\_\_ Hay fever
  - \_\_\_ Sneezing attacks
  - \_\_\_ Excessive mucus formation
- Total \_\_\_\_\_

### MOUTH/THROAT

- \_\_\_ Chronic coughing
  - \_\_\_ Gagging, frequent need to clear throat
  - \_\_\_ Soar throat, hoarseness, loss of voice
  - \_\_\_ Swollen or discolored tongue, gums, lips
  - \_\_\_ Canker sores
- Total \_\_\_\_\_

### SKIN

- \_\_\_ Acne
  - \_\_\_ Hives, rashes, dry skin
  - \_\_\_ Hair loss
  - \_\_\_ Flushing, hot flashes
  - \_\_\_ Excessive sweating
- Total \_\_\_\_\_

### HEART

- \_\_\_ Irregular or skipped heartbeat
  - \_\_\_ Rapid or pounding heartbeat
  - \_\_\_ Chest pain
- Total \_\_\_\_\_

LUNGS	<input type="checkbox"/> Chest congestion	
	<input type="checkbox"/> Asthma, bronchitis	
	<input type="checkbox"/> Shortness of breath	
	<input type="checkbox"/> Difficulty breathing	Total _____
DIGESTIVE TRACT	<input type="checkbox"/> Nausea, vomiting	
	<input type="checkbox"/> Diarrhea	
	<input type="checkbox"/> Constipation	
	<input type="checkbox"/> Bloating feeling	
	<input type="checkbox"/> Belching, passing gas	
	<input type="checkbox"/> Heartburn	
	<input type="checkbox"/> Intestinal/stomach pain	Total _____
JOINTS/ MUSCLE	<input type="checkbox"/> Pain or aches in joints	
	<input type="checkbox"/> Arthritis	
	<input type="checkbox"/> Stiffness or limitation of movement	
	<input type="checkbox"/> Pain or aches in muscles	
	<input type="checkbox"/> Feeling of weakness or tiredness	Total _____
WEIGHT	<input type="checkbox"/> Binge eating/ drinking	
	<input type="checkbox"/> Craving certain foods	
	<input type="checkbox"/> Excessive weight	
	<input type="checkbox"/> Compulsive eating	
	<input type="checkbox"/> Water retention	
	<input type="checkbox"/> Underweight	Total _____
ENERGY/ ACTIVITY	<input type="checkbox"/> Fatigue, sluggishness	
	<input type="checkbox"/> Apathy, lethargy	
	<input type="checkbox"/> Hyperactivity	
	<input type="checkbox"/> Restlessness	Total _____
MIND	<input type="checkbox"/> Poor memory	
	<input type="checkbox"/> Confusion, poor comprehension	
	<input type="checkbox"/> Poor Concentration	
	<input type="checkbox"/> Poor physical coordination	
	<input type="checkbox"/> Difficulty in making decisions	
	<input type="checkbox"/> Stuttering or stammering	
	<input type="checkbox"/> Slurred speech	
	<input type="checkbox"/> Learning disabilities	Total _____
EMOTIONS	<input type="checkbox"/> Mood swings	
	<input type="checkbox"/> Anxiety, fear, nervousness	
	<input type="checkbox"/> Anger, irritability, aggressiveness	
	<input type="checkbox"/> Depression	Total _____
OTHER	<input type="checkbox"/> Frequent illness	
	<input type="checkbox"/> Frequent or urgent urination	
	<input type="checkbox"/> Genital itch or discharge	Total _____
<b>GRAND TOTAL</b>		<b>TOTAL _____</b>

(NORTH)

HWY 694/94

Rockford Rd

42<sup>nd</sup> Ave

HWY 169

HWY 100

36<sup>th</sup> Ave

Back To Life Natural Health  
2960 Winnetka Ave N #110  
(763) 546-3736



30<sup>th</sup> Ave

Medicine Lake Rd

Winnetka Ave N

HWY 55

HWY 394