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| **Health Questionnaire Self Assessment****Craig P Kurtz LMHC, PA and Advanced Integrated Healing Therapies, ORG.****A Holistic Mental Health and Wellness Organization** **CLIENT HEALTH INFORMATION:**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_ Weight\_\_\_\_\_\_ Age\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number (optional)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FamilyPhysician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cardiologist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**HEALTH QUESTIONNAIRE****A SELF ASSESSMENT – Based on The Detox Miracle Source Book by Robert  Morse, N.D., D.Sc., I.D., M.H.**

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| --- |
| ***Thyroid/ Parathyroid (Glandular System)*** |
| Are you overweight? |
| Do you get cold hands and feet? |
| Do you have hair loss or are you going bald? |
| Is it easy to put on weight and hard to lose it? |
| Are your fingernails ridged, brittle or weak? |
| Do you have varicose or spider veins? |
| Do you, or have you had hemorrhoids? |
| Do you get cramping in your muscles? |
| Is your bladder strong or weak? |
| Do you have irregular heartbeat? |
| Do you have Mitral Valve Prolapse *(Heart Murmur)*? |
| Do you get headaches or migraines? |
| Do you now have, or have you ever had a hernia? |
| Have you ever had an aneurysm? |
| Do you have osteoporosis? |
| Do you have scoliosis? |
| Do you get irritable easily? |
| Do you have low energy levels? |
| Do you suffer from symptoms of depression? |
| Did you score low on your bone density tests? |
| Do your tests come back showing Low Calcium levels? |
| Do you have, or have you ever had a goiter? |
| Do you have spine deterioration or herniated discs? |
| Have you been diagnosed with Hashimoto or Reidel disease? *(Or any family member?)* |
| Do you sweat profusely or hardly at all? |
| ***Adrenal Glands (Glandular System)*** |
| **Medulla*(Adrenal)*** |
| Do you have M.S., Parkinson's or Palsy? |
| Do you have *anxiety attacks*, or feel *overly anxious*? |
| Do you feel excessive *shyness* or *inferior* to others? |
| Do you have low blood pressure *(below 118 systolic)*? |
| Do you have tremors, nervous legs, etc.? |
| Do you have tinnitus *(ringing in the ears)*? |
| Do you have S.O.B. *(shortness of breath)* or is it hard to take a deep breath? |
| Do you have arrthymias? |
| Do you have a hard time sleeping? |
| Do you have Chronic Fatigue Syndrome? |
| Do you get tired easily? |
| Have you been diagnosed with Addison's Disease or with Congenital Adrenal Hyperplasia? |
| ***Cortex (Adrenal)*** |
| Do you have elevated blood cholesterol levels? |
| Do you have lower back weakness? |
| Do you have, or have you had sciatica? |
| Do you have arthritis or bursitis? |
| Do you have and 'itis's' *(inflammatory conditions)*?  *Explain:* |
| ***Female Only*** |
| Are you menstruations irregular? |
| Do you get excessive bleeding during menstruation? |
| Do you have or have you had ovarian cysts? |
| Do you have or did you have fibroids? |
| Do you have or have you had endometriosis or A-typical cells? |
| Are you fibrocystic? |
| Do you have fibromyalgia or scleroderma? |
| Do you get sore breasts, especially during menstruation? |
| Do you have a low or excessive sex drive? |
| Have you had a hysterectomy?  When? \_\_\_\_\_\_        Partial\_\_\_\_\_   Complete\_\_\_\_\_\_ |
| Did they take any other organs out at the same time?*(c.a. gallbladder)* |
| Have you had a D & C? |
| Have you had a miscarriage? |
| Have you had difficulty in conceiving children? |
| Other: |
| ***Male Only*** |
| Do you have prostatitis *(frequent urination especially at night)*? If yes, how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have prostate cancer?  PSA count:\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have testicular hypertrophy *(enlargement)*? |
| Do you have low or excessive sex drive? |
| Do you have erection problems? |
| Do you have premature ejaculation? |
| Other: |
| ***Pancreas*** |
| Do you get gas after you eat? |
| Do you feel your foods just sitting in your stomach? |
| Do you have Acid Reflux? |
| Do you see any undigested food in your stools? |
| Do you have hypoglycemia *(Low Blood Sugar)*?  Type I\_\_\_\_\_\_ or  Type II\_\_\_\_\_\_\_ |
| Are you this and have a hard time putting on weight? |
| Do you have gastritis or enteritis? |
| Do your foods pass through you *(diarrhea)*? |
| Do you have moles on your body? |
| ***Gastro-Intestinal Tract*** |
| Is your tongue coated *(white, yellow, green or brown)*, especially in the morning? |
| Do you have a Hiatus Hernia? |
| Do you have Gastritis? |
| Do you have Colitis? |
| Do you have Diverticulitis? |
| Do you get or have Diarrhea? |
| Do you get or have Constipation? |
| How often do you have a Bowel Movement? |
| Have you ever had stomach or intestinal ulcers? |
| Do you or have you ever had any type of gastro-intestinal cancers: stomach, colon, rectal, etc. *Explain:* |
| Do you have Crohn's Disease? |
| Do you have 'gas' problems? |
| Other GI problems: |
| ***Liver/Gallbladder/Blood*** |
| Do you have a problem digesting fats? |
| Do fats or dairy foods cause bloating and/or pain in the stomach area? |
| Are your stools white or very light brown in color? |
| Do you get pain in the middle of your back *(especially after eating)*? |
| Do you get pain behind the right lower rib area? |
| Do you have 'liver' or brown spots on your skin?*(not freckles)* |
| Do you have any skin pigmentation changes? |
| Do you have skin problems?  If so what type? |
|  Are you anemic? |
| Do you have, or have you ever had hepatitis?  A\_\_\_\_ B\_\_\_\_ C\_\_\_\_ |
| ***Heart & Circulation*** |
| Do you have any gray hair? |
| Do you have a hard time remembering things? |
| Do you legs get tired or cramp after you walk? |
| Do you bruise easily? |
| Do you get chest pains or angina? |
| Have you ever had a heart attack *(Myocardial Infarction)*? |
| Have you ever had open-heart surgery? |
| Do you have heart arrhythmias?  What kind? |
| Do you have a heart murmur or Mitral Valve Prolapse? |
| Do you ever feel pressure on your chest? |
| Do you get 'prickly' pains anywhere, especially in the heart area?  Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have, or have you ever had High Blood Pressure? |
| Your average Blood Pressure is\_\_\_\_\_\_\_ over\_\_\_\_\_\_\_\_. |
| ***Skin*** |
| Do you get or have skin rashes? |
| Do you get skin blemishes? |
| Do you have Eczema or Dermatitis? |
| Do you have Psoriasis? |
| Do you itch anywhere?  Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is your skin dry? |
| Is your skin excessively oily? |
| Do you get or have dandruff? |
| ***Lymphatic System*** |
| Are you allergic to anything? |
| Do you ever get colds or flu-like symptoms? |
| Do you have sinus problems? |
| Do you have or get sore throats? |
| Do you have swollen lymph nodes? |
| Do you have or had tumors?  What type? Fatty\_\_\_\_ Benign\_\_\_ Cancerous\_\_\_  Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have a low platelet count *(blood)*? |
| Is your immune system low or sluggish? |
| Have you had appendicitis or an appendectomy?  When?\_\_\_\_\_\_\_\_\_\_\_ |
| Do you get boils, pimples, and the like? |
| Do you have allergies? |
| Have you ever had toxemia? |
| Do you have, or have you had cellulitis? |
| Have you ever had gout? |
| Do you get blurred vision? |
| Do you have mucus in your eyes when you wake up in the morning? |
| Do you snore? |
| Do you have sleep apnea? |
| Have you had y |
| our tonsils out?  What age?\_\_\_\_\_\_\_\_\_\_\_ |
| ***Kidneys & Bladder*** |
| Have you ever had a urinary tract infection*(UTI's)*? |
| Have you ever had 'burning' upon urination? |
| Do you have trouble holding your bladder *(para-thyroid)*? |
| Have you ever had kidney stones? |
| Do you have bags under your eyes *(especially in the morning)*? |
| Is your urine flow restricted? |
| Do you get cramping or pain on either side of your mid-to-lower back? |
| Do you or did you have nephritis? |
| Do you or did you ever have cystitis? |
| ***Lungs*** |
| Do you get or have (or have had) bronchitis? |
| Do you get or (or have had) emphysema? |
| Do you get or have (or have had) asthma? |
| Do you get or have (or have had) C.O.P.D.? |
| Are you on inhalers or nebulizers?  How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you know what your oxygen saturation is?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you get pain when you breathe? |
| Do you get pain when you take a deep breath? |
| Did you ever or do you have lung cancer? |
| Do you have a collapsed lung? |
| Are you a smoker?  How often? |
| Have you ever had pneumonia? |
| Have you worked around toxic chemicals, in coal mines or around asbestos? |
| Do you cough a lot? |
| Do you get any mucus when you cough? |
| What color is the mucus? |

**Other**

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| **What are your main health complaints or concerns? Elaborate on these conditions, symptoms.** |
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**Past Surgeries**

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| **Please list any past surgeries you have had *(e.g tonsil, hysterectomies,ETC open heart surgery)******Please include the year the surgery occurred.*** |
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**Chemical Medications: Please list any medications you are taking.**

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|   |
| **Medication** | **Reason** |
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**Natural Supplements:list any natural supplements you are taking.**

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| **Supplements** | **Vitamins & Minerals** |
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**Allergies: Please list anything you are allergic to.**

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| **Allergy** |
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**Genetic History**

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| **Mom:** |
| **Dad:** |
| **(Maternal) Grandfather:** |
| **(Maternal Grandmother:** |
| **(Fraternal) Grandfather:** |
| **(Fraternal) Grandmother:** |
| **Sister:** |
| **Sister:** |
| **Brother:** |
| **Brother:** |

Top of Form

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| \* Required fields |

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