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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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family  Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cardiologist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **HEALTH QUESTIONNAIRE**  **A SELF ASSESSMENT – Based on The Detox Miracle Source Book by Robert  Morse, N.D., D.Sc., I.D., M.H.**   |  | | --- | | ***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**   |  | | --- | |  | | **What are your main health complaints or concerns? Elaborate on these conditions, symptoms.** | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  |   **Past Surgeries**   |  | | --- | |  | | **Please list any past surgeries you have had *(e.g tonsil, hysterectomies,ETC open heart surgery)***  ***Please include the year the surgery occurred.*** | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  |   **Chemical Medications: Please list any medications you are taking.**   |  |  | | --- | --- | |  | | | **Medication** | **Reason** | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  |   **Natural Supplements:list any natural supplements you are taking.**   |  |  | | --- | --- | |  | | | **Supplements** | **Vitamins & Minerals** | |  |  | |  |  | |  |  | |  |  | |  |  |   **Allergies: Please list anything you are allergic to.**   |  | | --- | |  | | **Allergy** | |  | |  | |  | |  | |  | |  | |  | |  |   **Genetic History**   |  | | --- | |  | | **Mom:** | | **Dad:** | | **(Maternal) Grandfather:** | | **(Maternal Grandmother:** | | **(Fraternal) Grandfather:** | | **(Fraternal) Grandmother:** | | **Sister:** | | **Sister:** | | **Brother:** | | **Brother:** |   Top of Form   |  | | --- | | \* Required fields | | | | |