

**Body Symmetry**  
6604 Six Forks Rd., Ste 102, Raleigh, NC  
919-600-8840

**PLEASE PRINT LEGIBLY**

All information for office use only.

Date \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

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

Full Address \_\_\_\_\_

Email (for newsletters and special offers) \_\_\_\_\_

Occupation \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Emergency contact info \_\_\_\_\_

Personal goals relating to services \_\_\_\_\_

Military (past or present) or immediate family member \_\_\_\_\_

Colonic clients: Is this your first colonic? \_\_\_Y\_\_\_ N If not, when and where was the last one? \_\_\_\_\_

**GENERAL HEALTH**

Have you been hospitalized? \_\_\_\_\_ When? \_\_\_\_\_ Why? \_\_\_\_\_

Have you been diagnosed with a major illness/disease? \_\_\_\_\_ When? \_\_\_\_\_ What? \_\_\_\_\_

Please explain any kind of medical treatments you are currently receiving. \_\_\_\_\_

Please list any medications you are taking any why. \_\_\_\_\_

Please list any supplements you are taking and why. \_\_\_\_\_

Please list any kind of 'program' you are on. Ex: fasting, weight loss, nutrition, etc. \_\_\_\_\_

Please list all allergies. \_\_\_\_\_

Are you currently pregnant?  yes  no How many pregnancies? \_\_\_ full term \_\_\_ miscarriage \_\_\_ abortion \_\_\_

Did you gain additional weight with each pregnancy?  yes  no Did you lose your pregnancy weight with each child?  yes  no

How often are your bowel movements? \_\_\_\_\_ Constipation?  yes  no

Do you have any metal surgical parts in your body?  yes  no

Do you currently have, or have you had in the past, any of the following: **C** for Current, **P** for Past

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> abdominal gas/ <b>pain</b>      | <input type="checkbox"/> cramping                      | <input type="checkbox"/> loss of sleep                |
| <input type="checkbox"/> <b>abdominal hernia</b>         | <input type="checkbox"/> <b>Crohn's disease</b>        | <input type="checkbox"/> low libido                   |
| <input type="checkbox"/> acid reflux                     | <input type="checkbox"/> depression                    | <input type="checkbox"/> lung disorder                |
| <input type="checkbox"/> AIDS/HIV                        | <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Lupus                        |
| <input type="checkbox"/> anal bleeding                   | <input type="checkbox"/> dialysis                      | <input type="checkbox"/> Lyme disease                 |
| <input type="checkbox"/> anal discomfort/itching         | <input type="checkbox"/> diarrhea                      | <input type="checkbox"/> metal toxicity               |
| <input type="checkbox"/> anxiety                         | <input type="checkbox"/> Diverticulosis                | <input type="checkbox"/> menopause                    |
| <input type="checkbox"/> anemia                          | <input type="checkbox"/> <b>Diverticulitis</b>         | <input type="checkbox"/> mental disorder              |
| <input type="checkbox"/> <b>aneurysm</b>                 | <input type="checkbox"/> dizziness                     | <input type="checkbox"/> nausea                       |
| <input type="checkbox"/> anorexia                        | <input type="checkbox"/> eczema                        | <input type="checkbox"/> Osteopenia                   |
| <input type="checkbox"/> appendicitis                    | <input type="checkbox"/> edema                         | <input type="checkbox"/> Osteoporosis                 |
| <input type="checkbox"/> arthritis                       | <input type="checkbox"/> environmental allergies       | <input type="checkbox"/> pace maker                   |
| <input type="checkbox"/> asthma                          | <input type="checkbox"/> <b>Epilepsy</b>               | <input type="checkbox"/> parasites                    |
| <input type="checkbox"/> Atonic colon                    | <input type="checkbox"/> Epstein-Bar Virus             | <input type="checkbox"/> PMS                          |
| <input type="checkbox"/> auto immune disorder            | <input type="checkbox"/> extreme weight gain/loss      | <input type="checkbox"/> polyp                        |
| <input type="checkbox"/> bad breath                      | <input type="checkbox"/> fainting                      | <input type="checkbox"/> prolapsed colon              |
| <input type="checkbox"/> belching                        | <input type="checkbox"/> fatigue after eating          | <input type="checkbox"/> prostate disorder            |
| <input type="checkbox"/> bloating, general               | <input type="checkbox"/> fever/chills                  | <input type="checkbox"/> <b>recent surgery</b>        |
| <input type="checkbox"/> bloating, after eating          | <input type="checkbox"/> Fibromyalgia                  | <input type="checkbox"/> <b>rectal bleeding</b>       |
| <input type="checkbox"/> blood pressure high/low         | <input type="checkbox"/> fibroid cysts                 | <input type="checkbox"/> <b>renal insufficiencies</b> |
| <input type="checkbox"/> blood sugar high/low            | <input type="checkbox"/> <b>fissure/fistula</b>        | <input type="checkbox"/> <b>seizures</b>              |
| <input type="checkbox"/> Bulimia                         | <input type="checkbox"/> gallstones                    | <input type="checkbox"/> sinus condition              |
| <input type="checkbox"/> <b>Cancer:</b> type _____       | <input type="checkbox"/> headaches/migraines           | <input type="checkbox"/> skin condition               |
| <input type="checkbox"/> Candida                         | <input type="checkbox"/> ulcer                         | <input type="checkbox"/> spastic colon                |
| <input type="checkbox"/> Celiac disease                  | <input type="checkbox"/> <b>heart condition</b>        | <input type="checkbox"/> sweats                       |
| <input type="checkbox"/> cholesterol high/low            | <input type="checkbox"/> <b>hemorrhoids</b>            | <input type="checkbox"/> thyroid disorder             |
| <input type="checkbox"/> chronic fatigue                 | <input type="checkbox"/> IBS                           | <input type="checkbox"/> ulcer                        |
| <input type="checkbox"/> chronic pain                    | <input type="checkbox"/> indigestion                   | <input type="checkbox"/> urinary tract infection      |
| <input type="checkbox"/> <b>cirrhosis</b>                | <input type="checkbox"/> <b>intestinal perforation</b> | <input type="checkbox"/> vomiting                     |
| <input type="checkbox"/> <b>colitis</b>                  | <input type="checkbox"/> irregular period              | <input type="checkbox"/> other                        |
| <input type="checkbox"/> <b>congestive heart failure</b> | <input type="checkbox"/> kidney disorder               |   |
| <input type="checkbox"/> <b>contagious disease</b>       | <input type="checkbox"/> kidney stones                 |   |
| <input type="checkbox"/> constipation                    | <input type="checkbox"/> liver disorder                |   |

### DIETARY

Are you: Vegan? \_\_\_\_\_ Vegetarian? \_\_\_\_\_ Omnivorous?(eat animal protein) \_\_\_\_\_

Do you want to change? \_\_\_\_\_ To which group? \_\_\_\_\_ Why? \_\_\_\_\_

Usual breakfast \_\_\_\_\_

Usual lunch \_\_\_\_\_

Usual dinner \_\_\_\_\_

Usual snack \_\_\_\_\_

List any cravings you have on a regular basis \_\_\_\_\_

Do you have sensitivities to any of the following? \_\_\_\_\_ Lactose \_\_\_\_\_ casein \_\_\_\_\_ wheat \_\_\_\_\_ gluten

\_\_\_\_\_ night shade foods \_\_\_\_\_ additives \_\_\_\_\_ dyes \_\_\_\_\_ MSG \_\_\_\_\_ preservatives \_\_\_\_\_ latex



# Initial Symptom Survey

Date:	Patient Name:	Practitioner:
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**INSTRUCTIONS:** Score every symptom based on your experience **OVER THE PAST MONTH**. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score to the left of EVERY symptom listed. Write the "Grand Total" at the top. Also note the number of missed work days you have had in the last month due to illness.

<b>SCALE OF SYMPTOM POINTS</b>	<b>Grand Total:</b>	<b># Missed Work Days</b>
<b>IF you did not suffer from the symptom ever or almost never, leave it blank.</b> 1 = <b>OCCASIONALLY</b> (less than 2 times per week) and symptom <b>was MILD</b> 2 = <b>FREQUENTLY</b> (2 or more times per week) and symptom <b>was MILD</b> 3 = <b>OCCASIONALLY</b> (less than 2 times per week) and symptom <b>was SEVERE</b> 4 = <b>FREQUENTLY</b> (2 or more times per week) and symptom <b>was SEVERE</b>		

CONSTITUTIONAL	NASAL/SINUS	MUSCULOSKELETAL
Fatigue (sluggish, tired)	Post nasal drip	Joint pains
Hyperactive (nervous energy)	Sinus pain	Stiff joints
Restless (can't relax/sit still)	Runny nose	Muscle aches
Daytime sleepiness	Stuffy nose	Stiff muscles
Insomnia at night	Sneezing	Tics (facial or otherwise)
Malaise (feeling lousy)	TOTAL (0-20)	Muscle spasms
Seizures	<b>MOUTH/THROAT</b>	Muscle cramps
TOTAL (0-28)	Sore throat	TOTAL (0-28)
<b>EMOTIONAL/MENTAL</b>	Swollen throat	<b>CARDIOVASCULAR</b>
Depression	Swelling/burning lips/tongue	Irregular heartbeat
Anxiety (fears, uneasiness)	Gagging/throat clearing	High blood pressure
Mood swings (rapid changes)	Canker sores	TOTAL (0-8)
Irritability	Difficulty swallowing	<b>DIGESTIVE</b>
Forgetfulness	TOTAL (0-24)	Heartburn/reflux
Lack of concentration/Brain fog	<b>LUNGS</b>	Stomach pains/cramps
Low sex drive	Wheezing	Intestinal pains/cramps
TOTAL (0-28)	Chest congestion	Constipation
<b>HEAD/EARS</b>	Dry cough	Diarrhea
Headache (not migraine)	Wet cough	Bloating sensation
Migraine	Shortness of breath	Gas (of any kind)
Earache	TOTAL (0-20)	Nausea
Ear infection	<b>EYES</b>	Vomiting
Ringling in ears	Red or swollen eyes	Painful elimination
Itchy ears	Watery eyes	TOTAL (0-40)
Discharge from ears	Itchy eyes	<b>WEIGHT MANAGEMENT</b>
Sensitivity to sound	Dark circles or "bags"	Current weight:
TOTAL (0-32)	Sensitivity to light	Fluctuating weight
<b>SKIN</b>	Aura	Food cravings
Blemishes, acne	TOTAL (0-24)	Water retention
Rashes or hives	<b>GENITOURINARY</b>	Binge eating or drinking
Eczema or psoriasis	Increased urinary frequency	Purging (all methods)
"Rosy" cheeks	Painful urination	TOTAL (0-20)
Flushing	Bladder pain	<b>LIST OTHER SYMPTOMS:</b>
Itchy skin	Bedwetting	
TOTAL (0-24)	TOTAL (0-16)	