



AUTHENTIC
HEALTH

Re-Exam Patient Health Form

AuthenticHealthLLC.com

Name:

Date:

What has improved?

Has anything gotten worse?

Any new complaints?

Any change in medications?

Current weight? Changes?

Consistency in taking supplements %

LIST YOUR PRIMARY CONCERNS / GOALS IN ORDER OF IMPORTANCE:

- 1.
- 2.
- 3.
- 4.
- 5.

Please describe the following areas:

Digestion/Elimination:

Diet:

Immune/Allergy:

Sleep:

Pain or Headache:

Exercise:

CRAMPS/ACHES/RESTLESS

Leg	Cramps	Aches	Restless
Feet	Cramps	Aches	Restless
Arms	Cramps	Aches	Restless
Hands	Cramps	Aches	Restless
Other:			

PAIN/STIFFNESS/SWELLING/NUMBNESS/TINGLING

TMJ	Left	Right
Upper Neck	Left	Right
Lower Neck	Left	Right
Upper Back	Left	Right
Shoulders	Left	Right
Elbows	Left	Right
Wrist	Left	Right
Hand	Left	Right
Mid Back	Left	Right
Low Back	Left	Right
SI Joint	Left	Right
Hips	Left	Right
Sciatica	Left	Right
Legs	Left	Right
Knees	Left	Right
Ankles	Left	Right
Feet	Left	Right
Other		

System Review

___ Stress: scale 1-10
 ___ Bowel Movement: x /wk
 ___ Water: oz / day
 ___ Juice: glasses / day

___ Coffee: cups / day
 ___ Soda: oz / day
 ___ Alcohol: glasses / wk
 ___ Tobacco: x / day

Soy Use: _____
 Artificial Sweetener Use:
 Equal (Aspartame)
 Splenda (Sucralose)

___ Cardio: x / wk
 ___ Weight Train: x / wk
 ___ Yoga/Pilates: x / wk
 ___ Sports: hrs / wk

Rank any symptoms you are currently having 1 - 10 or check applicable boxes.

EARS

___ Noise (Ring/Hiss/Pound)
 ___ Plugged
 ___ Popping
 ___ Ache / Infection
 ___ Draining
 ___ Itchy
 ___ Dizziness/Vertigo
 ___ Excessive Ear Wax
 ___ Other _____

EYES

___ Burn / Tear / Itchy
 ___ Ache / Dry / Red
 ___ Crust in am / Film
 ___ Bouts of Blurriness
 ___ Floaters / Spots
 ___ Tired / Puffy
 ___ Sty
 ___ Twitching around eye
 ___ Dark circles
 ___ Light sensitive
 ___ Other _____

SINUS

___ Nosebleeds
 ___ Dry
 ___ Drain
 ___ Stuffy/plugged
 ___ Sneeze frequently
 ___ Taste / Smell loss
 ___ Post nasal drip

SKIN/HAIR/NAILS

___ Skin: _____
 ___ Acne: _____
 ___ Butt Acne
 ___ Dry skin
 ___ Eczema / Psoriasis
 ___ Nails (white spots /ridges)
 ___ Nails (weak / peeling)
 ___ Hair loss
 ___ Limp Hair
 ___ Damp hands / feet
 ___ Dandruff
 ___ Red dots
 ___ Bruise easily
 ___ Bumps on Back of Arms
 ___ Missing outer 1/3 of eyebrow
 ___ Cold hands / feet
 ___ Ingrown toenails
 ___ Other _____

STOMACH

___ Heartburn
 ___ Indigestion
 ___ Stomach Ache / Cramps
 ___ Nausea/Vomiting
 ___ Bloat After Eat
 ___ Gas / Flatulence
 ___ Belching
 ___ Other _____

BOWEL

___ Diarrhea
 ___ Constipation
 ___ Incomplete
 ___ Bulky
 ___ Cramps in Abdomen
 ___ Pain w/ Bowel Movement
 Laxative / Suppository Use
 Colonics / Enemas
 ___ Anal Itching
 ___ Hemorrhoids:
 ___ Swollen / Achy
 ___ Burning / Itchy
 ___ Blood
 ___ Other _____

STOOL CONSISTENCY

Normal _____ %
 ___ Light colored feces
 ___ Soft
 ___ Fluffy
 ___ Hard
 ___ Pebbles
 ___ Ribbon-like
 ___ Mucous
 ___ Contain string-like
 black/white specks
 ___ Contain undigested food

APPETITE/DIET

Low Normal High
 ___ Crave Starch / Sweets
 ___ Crave Salt
 ___ Crave Chocolate / Ice Cream
 ___ Eat lots of spicy foods
 ___ Nighttime snack: _____
 If meals are missed:
 ___ Nausea
 ___ Extreme hunger
 ___ Cold / Clammy
 ___ Rapid heartbeat
 ___ Irritability
 ___ Light headed

LIBIDO/SEXUALITY

Low Normal High
 Orgasms:
 None Poor Good Great

CHEST

___ Tension / Tight
 ___ Pressure / Heaviness
 ___ Congestion
 ___ Chest / Sternal Pain
 ___ Palpitations-Heart Skip
 ___ Heart Racing / Slowing
 ___ Other: _____

RESPIRATORY

___ Short of breath: Constant
 ___ Short of breath: Exertion
 ___ Wheeze
 ___ Air hunger / yawn
 ___ Frequent Sighs
 ___ Upper Resp Infx
 ___ Asthma
 ___ Other: _____

SLEEP

Quality of Sleep:
 Poor Good Great
 Hours in bed: _____
 Hours asleep: _____
 Interrupted ____/night
 Waking at ____ AM
 ___ Difficulty falling asleep
 ___ Difficulty staying asleep
 ___ Crave sleep during day
 ___ Awaken Suddenly (Jolt)
 Don't dream
 ___ Nightmares / Epic dreams
 ___ Night sweats
 ___ Restlessness
 ___ Restless Leg Syndrome

EMOTIONS

___ Sadness / Depression
 ___ Moodiness / Irritable
 ___ Frustrated / Angry
 ___ Nervous / Anxiety
 ___ Grief
 ___ Panic / Fear
 ___ Cry
 ___ S.A.D.
 ___ OCD
 ___ Other: _____

HEADACHES

___ Base of Skull (back)
 ___ Side of Head (temples)
 ___ Frontal (above eyes)
 ___ Top of Head
 ___ Entire Head
 ___ Migraines

COGNITION

___ Forget Names
 ___ Forget Numbers
 ___ Forget Words
 ___ Forget Actions
 ___ Difficulty Concentrating
 ___ Other: _____

ENERGY

Norm Low Variable High
 ___ Slow to start in am
 ___ Low energy after meals
 ___ Energy crash at ____ am/pm
 ___ Other: _____

URINATION

___ X during the night
 ___ Urgency
 ___ Burning/Pain
 ___ Odor/Foamy
 ___ Dark color
 ___ Incontinence
 ___ Urinary tract infection
 ___ Kidney troubles
 ___ Other: _____

MALE ONLY

___ Erectile Dysfunction
 ___ Prostate Problems
 ___ Burn
 ___ Achy / Pain
 ___ Restriction / Swelling
 ___ Other: _____

FEMALE ONLY

Menopause
 Date Last Period: _____
 Cycle Length (28-30 days): _____
 # of Days of Flow: _____
 Cramps: mild mod severe
 PMS: mild mod severe
 ___ Vaginal Itching / Discharge
 ___ Heavy flow
 ___ Large clots
 ___ Yeast Infection
 ___ Hot Flashes
 ___ Vaginal Dryness
 ___ Painful Intercourse
 ___ Other: _____

OTHER HEALTH ISSUES

___ = 1-10
 = ✓
 _____ = Further details