Better Health

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Session Update Form

NAME:_____ Date_____

What is the most important question or symptom you want to discuss in your appointment?

_____
_____
_____

List 3 self-nourishing behaviors you've accomplished in the last 2 weeks

1. _____
2. _____
3. _____

List 3 things you are grateful for today

4. _____
5. _____
6. _____

Cooking: same more less **What is your diet like these days?**

B _____
L _____
D _____
Snacks _____
Beverages _____

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Please help us keep an updated list

List all medications (and dosages) and supplements (and dosages) you take each day.
Please list any trouble you are having with these medications or supplements. THANK YOU

Medications: **Time of day you take this:**

1. _____ Time _____
2. _____ Time _____
3. _____ Time _____
4. _____ Time _____
5. _____ Time _____

Supplements **Time of day you take this:**

6. _____ Time _____
7. _____ Time _____
8. _____ Time _____
9. _____ Time _____
10. _____ Time _____

11. _____ Time _____
12. _____ Time _____
13. _____ Time _____
14. _____ Time _____
15. _____ Time _____

What's on your mind? Please tell me what YOU want to discuss this session:

_____
_____
_____
_____

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HEALTH PROFILE – Multiple System Questionnaire

Name _____ **Date** _____

Rate each of the following systems based upon your typical health profile for the last 30 days (or since your last session)

Point Scale: 0 – Never or almost never have symptom **1-** Occasionally have it, effect is mild
2 – Occasionally have it, effect is severe **3-** Frequently have it, effect is mild **4-** Frequently have it, effect is severe

HEAD	
Headaches	_____
Faintness	_____
Dizziness	_____
Foggy brain	_____
Total for this section	_____
Eyes	
Watery or itchy eyes	_____
Swollen, red or sticky lids	_____
Bags or dark circles	_____
Blurred/tunneled vision	_____
Glaucoma	_____
Total for this section	_____
Ears	
Itchy ears	_____
Ear aches/infections	_____
Ringing/hearing loss	_____
Drainage from ears	_____
Total for this section	_____
Nose	
Stuffy	_____
Sinus problems	_____
Hayfever	_____
Sneezing attacks	_____
Excessive mucous	_____
Total for this section	_____
Mouth/Throat	
Chronic cough	_____
Gagging, frequent throat clear	____
Hoarse/sore throat	_____
Swollen gums, lips, tongue	_____
Canker sores	_____
Total for this section	_____
Skin	
Acne	_____
Hives, rashes, dry skin	_____
Hair loss	_____
Flushing	_____
White patches	_____
Total for this section	_____

Heart	
Irregular or skipped beats	_____
Rapid or pounding hear	_____
Chest pain	_____
Total for this section	_____
Lungs	
Chest Congestion	_____
Shortness of breath	_____
Astham, bronchitis	_____
Difficulty breathing	_____
Total for this section	_____
Digestive tract	
Nausea, Vomitting	_____
Diarrhea	_____
Constipation	_____
Bloated	_____
Belching, Passing gas	_____
Heartburn, Reflux	_____
Intestinal/Stomach pain	_____
Total for this section	_____
Joints/Muscles	
Pain or aching	_____
Arthritis	_____
Stiffness or limintation	_____
Pain, aches or tremors	_____
Feeling of weakness	_____
Swelling	_____
Total for this section	_____
Weight	
Binge eating/drinking	_____
Excessive weight	_____
Compulsive eating	_____
Water retention	_____
Craving foods	_____
Underweight	_____
Total for this section	_____
Sleep	
Falling asleep	_____
Staying asleep	_____
Total for this section	_____

Energy/Activity	
Fatigue, tired, sluggish	_____
Apathy, lethargy	_____
Hyperactivity	_____
Restlessness	_____
Total for this section	_____
Mind	
Poor memory	_____
Confusion	_____
Poor concentration	_____
Difficulty making decisions	_____
Stuttering or stammering	_____
Slurred speech	_____
Learning disabilities	_____
Poor physical coordination	_____
Total for this section	_____
Emotions	
Mood swings	_____
Anxiety, fear, Nervous	_____
Anger, irritable	_____
Panic attacks	_____
Depression	_____
Total for this section	_____
Temperature	
Chilled, cold hands/feet	_____
Hot, hot flashes	_____
Excessive sweating	_____
Total for this section	_____
Genitourinary	
Frequent urination/urge	_____
Stress incontinence	_____
Low urine flow	_____
low libido	_____
sexual dysfunction	_____
Total for this section	_____
Other	
Restless leg	_____
Frequent illness/colds	_____
Breast pain, cysts	_____
Total for this section	_____