Pamela Paetzhold D.C | N.D. | L.Ac | R.Dh
Maxwell Paetzhold B.S. | D.C.
www.maximumhealthclinic.com
Email: info@maximumhealthclinic.com

MAXIMUM HEALTH CLINIC

Phone: 503-557-8444
Fax: 503-557-8461
1832 Willamette Falls Drive
West Linn, Oregon 97068

Symptom Survey

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

Part 1 – Please list the 5 major health concerns you have in order of importance.

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

Part 2 – Please circle the appropriate number "0-3" on all questions below
0 as the least/never to 3 as the most/always

Colon:

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
Do you use laxatives frequently	0	1	2	3

Hypochlorydia:

Excessive belching or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficulty digesting fruits and vegetables; (Undigested foods found in stools)	0	1	2	3

Hyperacidity (Ulcer)

Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, and carbonated beverages	0	1	2	3

Small Intestine (Pancreas)

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, bloating, soreness on left side under rib cage	0	1	2	3
Nausea and or vomiting	0	1	2	3
Stool undigested, foul smelling	0	1	2	3
Mucous-like greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Biliary Insufficiency/Statis

Greasy or high fat foods cause distress	0	1	2	3
Unexplained itchy skin	0	1	2	3
Stool color alternates for clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry of flak skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes		No	

Hypoglycemia

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded and if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred Vision	0	1	2	3

Insulin Resistance

Fatigue after meals	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Increased thirst & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Adrenal Hypofunction

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Adrenal Hyperfunction

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Hypothyroid:

Tired, sluggish	0	1	2	3
Feel cold – hands, feel, all over	0	1	2	3
Require excessive amounts of sleep to function	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Outer third of eye thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Thyroid Hyperfunction

Heart palpations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervousness and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Pituitary Hypofunction

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Dental

Do you have any root canals?	Yes	No
Do you have any silver (mercury) fillings?	Yes	No
Do you have any TMJ Complaints?	Yes	No
If yes, how many and how long have you had them?	_____, _____	

Prostate (Male only)

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Leg nervousness at night	0	1	2	3

Andropause (Male only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty to maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Menstruating Females Only

Are you a menopausal	Yes		No	
Alternating menstrual cycle lengths	Yes		No	
Extended menstrual cycle, greater than 32 days	Yes		No	
Shortened menses, less than every 24 days	Yes		No	
Pain and cramping during periods	0	1	2	3
Scanty or heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Menopausal Females Only

How many years have you been menopausal?	_____			
Do you ever have uterine bleeding since menopause?	Yes		No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breast	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal, pain, dryness or itching	0	1	2	3

Part 3: Foods

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

How many times a week do you eat raw nuts or seeds? _____

List the three healthiest foods you eat during the average week?

_____, _____, _____

List the three worst foods you eat during the average week?

_____, _____, _____

How many times a week do you workout? _____

How many alcohol beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

Do you smoke? _____ If yes how many times a day?

Rate you stress levels on a scale of 1-10 on an average day _____

Please List any medications you currently take and for what conditions:

_____

Please List any natural supplements you currently take and for what conditions: _____