NEW PATIENT PACKET

Naturopathic Center for Wellness

Practice Policies for Patients

Dr. Julie Miller PCs.D, RND, RN, BSN, CCWFN, A TRADITIONAL NATUROPATH

The Naturopathic Center for Wellness was created in 2003 by Dr. Julianne Miller to be a peaceful environment where the health concerns of each client would be treated holistically. Clients are analyzed as a whole, while their symptoms and concerns are used as clues to find and treat the root causes of their disorder, chronic illness, etc. As preventative healthcare practitioners, we provide encouragement and options to clients who are feeling lost or confused by their current medical care or condition. Our goal is to not only treat each client, but educate them concerning the health benefits of whole food nutrition, supplementation, and Cranial Sacral therapy application.

We are committed to helping you obtain optimal health and we believe that journey requires guidance through the physical, emotional, mental and spiritual aspects of your life. We strongly believe that our holistic healthcare philosophy will give you the knowledge and the tools you need to make informed personal choices regarding your complete self.

Please read all the enclosed information carefully; print and fill out this packet in its entirety and bring the completed forms to your first appointment. Along with these forms, please bring any relevant medical test results you have had in the past year.

CONTACT INFORMATION

Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN
23041 Avenida De La Carlota STE 110
Laguna Hills, CA 92653

Our office hours are Tuesday, Wednesday, and Thursday, 10:00am-5:30pm
The front desk may be reached at : 949-273-6240
Our website is www.naturocw.com
Julie Miller's email is jmiller@naturocw.com

For after hours non-urgent questions, please call the above number, leave a message and our office staff will return your call on the next business day.

For after hours urgent concerns, please call Dr. Julie on her cell phone 949-280-3795. She will not always be available at this number; However, you may leave a message and she will get back to you as soon as possible.

Office Location
Naturopathic Center for Wellness is located in Laguna Hills at the end of furniture row in the 4 story Gray building.

23041 Avenida De La Carlota STE 110,
Laguna Hills, CA 92653

Website Information
Information about Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN and the Naturopathic Center for Wellness is available at our website: www.naturocw.com

Financial Agreement
Your first visit is an hour and a half office consultation for $255. Each visit thereafter are half hour appointments or phone consultations for $95. Dr Julie may request that you come in for an hour appointment, which is a charge of $135.

Payment is due on each day of services rendered. Payment options are cash, check or credit cards; Visa, MasterCard, American Express, Discover are accepted. There is a $25 service charge for returned checks.

Cancellation of Appointment Policy
We require a 24-hour notice of cancellation for ALL appointments. In the event of a late cancellation/missed appointment you will be charged a $50 flat rate. Early notice of cancellation allows us to schedule a client from the wait list!

As a courtesy to our patients, appointments will be confirmed prior to the appointed time by the front desk. It is however, **the patient's responsibility to respond to the confirmation or call to reschedule.** If the patient does not respond to the confirmation text 24 hours before the scheduled appointment, the appointment will be dropped and given to a patient from the wait-list (especially in the case of new patients!).

Please make sure the front desk has your cell phone number, as home and work phones are not always as easily accessible.

Insurance Information
The Naturopathic Center for Wellness does not bill for insurance or Medicare.

Medical Records
You may bring all previous medical records from other physicians or health care providers to your office visit, or have them emailed to the previously mentioned email address. To obtain medical records you can request the records from the physician or lab in which your records are held.

Emergencies
For any and all medical emergencies you are responsible to obtain medical attention, call 911 or go directly to the nearest Emergency Room.

Important Patient Information

-If necessary to cancel or reschedule your appointment, you may call/text the office at 949-273-6240
-There is no charge for questions on emails, text, or phone calls to our office.
-Please ensure that the front desk has a current cell phone number, not a work or home phone. If you do not have a cell phone, make sure the front desk is aware so that you can be reached quickly to confirm your appointment.

Lab Tests

-Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN may request blood lab tests, saliva, urine and /or stool tests to be completed.
-Any blood work will be preformed at an outside lab corp facility.
-Testing recommendations and costs per test will be reviewed with patient.
-Fees for lab tests are billed directly by our office or directly by the lab. Patient may inquire if the lab facility will work directly with insurance if necessary.
-You may receive a copy of your lab results from our office.

Live and Dry Blood Cell Analysis/Oxidative Stress Test

-This test is done in our office's lab and is used to obtain information regarding parasite and yeast overgrowth, presence of heavy metals, nutritional content of blood,toxicities, allergy indications, vitamin and mineral deficiencies, immune system health, etc.
-This test costs $30 and, while Dr Julie may recommend the test, it is done at your discretion.

Supplements

-Whole food nutritional supplements are available for purchase at the Naturopathic Center for Wellness
-Patients are under no obligation to purchase their supplements through our office.
-Our Office can ship supplements to your home with a standard shipping fee of $13.00

Patient Awareness and Responsibility

-Any therapy, no matter how well appointed, may fail to resolve your symptoms and improve your health. Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN makes no claim of cure for any condition.
-Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN will inform you of the treatment plan most relevant to your condition both conventional and alternative.
-You have the choice to accept, refuse or terminate these therapies at any time.
-By agreeing to do your best to comply with and implement that agreed upon program for you, you will receive full benefit of your visits with Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN.

-Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN <u>will NOT ask you to stop taking any medicines prescribed by another physician</u>. If you desire to stop taking any prescriptions, please consult the physician that prescribed the medications.

_____ _____
Patient Signature Date

Indicate relation if signing for patient: _____

Patient Contact Information

Patient Name _____ Date of First Visit_____

Date or Birth _____ Parent(s)/Guardian_____ Relationship_____

Address _____

City _____ State _____ Zip Code _____

Telephone _____

Email _____

Gender: Male _____ Female _____

Marital Status _____

Live with _____

Occupation _____

Employer _____

Emergency Contact _____ Relationship _____

Names and Contact Information for Health Care Providers from whom you are currently receiving care (or have seen within the past 12 months). And ANY Health Care Providers from whom you are obtaining prescriptions.

_____ Contact # _____

_____ Contact # _____

_____ Contact # _____

Notice of Privacy Practice (HIPPA Form)
Protected Personal Health Information

Patient Giving Consent:

Name: _____ Date: _____

To The Patient: Please read the following statement carefully.

Our pledge regarding Medical Information- Purpose Consent:

By signing this form you will consent to the use and disclosure of your protected health information only with your written consent. The privacy of your medical information is important to us. We understand that your medical information is person and we are committed to protecting it. We create a record of the care and services you receive at the Naturopathic Center for Wellness. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Notice of Privacy Practice:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice Provides a description of our treatment, payment and healthcare practices, the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revises Notice of Privacy Practices which will contain the changes. Those changes may apply to any of you protected health information that we maintain.

Right to Revoke:

You have the right to revoke this consent at any time by giving written notice of your revocation submitted to:
Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN
23041 Avenida De La Carlota STE 110,
Laguna Hills, CA 92653

Please understand that revocation of this consent will not affect action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment and healthcare plans.

_____ _____

Signature Authorized Provider Representative

_____ _____

Date Date

Patient Consent Form

Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN, A REGISTERED NATUROPATH
Naturopathic Center for Wellness
23041 Avenida De La Carlota #110
Laguna Hills, CA 92653

Name _____ Male __ Female __ Birth date __/__/____

Address _____

City _____ State _____ Zip _____

Welcome to the Naturopathic Center for Wellness, an alternative, Naturopathic, holistic, educational approach to total client care. Dr. Julie Miller PSc.D, RND, RN, BSN, CCWFN, is a graduate of Mount Saint Mary's College of Nursing holding an RN, BSN and Clayton College degree where she received with highest honors a Doctorate of Naturopathy and received a Doctorate of Pastoral Science and Medicine licensed by the P.M.A. She has practiced as a registered nurse for 26 years and as a TRADITIONAL NATUROPATH since 2003. She is also an advanced practitioner of Cranial Sacral Therapy.

The Naturopathic Center for Wellness wants to help you and your family members empower yourselves. We will educate you so that you can make the best decisions for your own health care. We will discuss your health and review your personal history, making recommendations where applicable towards your care. We ask you to fill out a Client Intake Form, which will provide us the opportunity to become more familiar with you and your family.

Our approach to "Total Health Care" may include: Client Education- the physical, emotional, spiritual self, Basic Iridology, Whole Food Supplementation, Cranial Sacral Therapy, Somato-Emotional Release, Acupressure, Herbs and blended Eastern/Western Exam.

Your signature below acknowledges you have read this consent form and gives us full consent to enable you to empower yourself.

Date _____

Patient Name _____

Patient Signature _____

_____
Indicate relationship is signing on behalf of patient

Health History Questionnaire

Present Complaint _____

Other Healthcare providers you are seeing, and their specialties _____

_____

First Noticed?_____

# of Children _____

Religion (optional) _____

Have you been Exposed to Toxic Chemicals? _____

What Diagnosis were you given? _____

WOMEN ONLY:

Age of Onset of Menstruation _____ No. Miscarriage/C-section/Abortions _____

Age of onset Menopause_____

Health as a Child? Excellent Good Fair Poor

Were there any complications with your delivery?

Explain: _____

Were you breast fed? _____ How Long? _____

Did you have any serious emotional or mental trauma as a child?

_____

Please circle diseases for which you have been immunized?

Measles Mumps Rubella Small Pox Tetanus Diphtheria

What is your blood type? A B AB O Don't know

Allergies/Sensitives (Please Specify)

Chemicals _____

Drugs/Medications _____

Dust/Molds _____

Foods _____

Grasses/Weeds [Pollen] _____

Other _____

Test History
Please List the date of your most recent procedure and indicate any tests that were abnormal.

_____

Health Habits
Please list all supplements, herbs, homeopathic you are currently taking.

_____

_____

Please Circle any of the Medications you are currently taking or have taken in last 3 months.

Allergy Medication	Chemotherapy	Oral Contraceptives	Ulcer Medication
Antacids	Cortisone	Pain Medication	Other_____
Anti-Inflammatory	Heart Medication	Radiation	
Antibiotics/Anti-fungal	High Blood Pressure	"Recreational Drugs"	
Antidepressants	Hormones	Relaxants	
Anti-diabetic / Insulin	Laxatives	Sleeping Pills	
Aspirin/Tylenol/Advil	Lithium	Thyroid	

Do you use/ Drink any of the following?

__ Tobacco	Packs per Day/Week _____	How Many Years? _____
__ Coffee	Cups per Day/Week _____	How Many Years?_____
__ Black Tea	Cups per Day/Week _____	How Many Years? _____
__ Alcohol	Cups per Day/Week _____	How Many Years? _____
__ Soda	Cups per Day/Week _____	How Many Years? _____
__ Artificial Sweeteners		How Many Years? _____

Family History

	Age	Health Problems
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
1	_____	_____
2	_____	_____
3	_____	_____
Children	_____	_____
1	_____	_____
2	_____	_____
3	_____	_____
Grandmother(M)	_____	_____
Grandfather (M)	_____	_____
Grandmother(F)	_____	_____
Grandfather(F)	_____	_____

How many times a week do you eat in a restaurant? Breakfast ___ Lunch___ Dinner___
What types of restaurants do you eat at?_____
What are your favorite foods? _____
Do you Crave Sweets? _____ At what time? _____ Do you Salt your food?_____
Are there other foods you crave? Bread Pasta Dairy Meat Other: _____
What foods do you really dislike?_____
Are you on any specific diet? Which Diet? _____
Would you like to increase or decrease your weight? If so, by how much: _____
When did you last have a significant change in weight? (More than 10lbs) _____
What exercise do you do and how often? _____

____ Sedentary
____ Mild Exercise (I.E. Climbs stairs, walk 3 blocks, golf)
____ Occasional Vigorous exercise (I.E. work or recreation, Less than 4x/week for 30 min.)
____ Regular Vigorous exercise (I.E. Work or recreation, 4x/week for 30 minutes

How Many hours of sleep do you get each night? _____ Do you wake rested? _____
Are you Presently sexually Active? _____ Any difficulties? _____ Method of BC_____

Please Rate from 1-10 (1 being lowest and 10 being highest)
Current Stress level ___ How much does this affect you? _____
What are the major stress factors? _____
Rate your current Emotional Health: Excellent Good Fair Poor Unstable Crisis
Are you currently in Psychotherapy?_____ Do you have a good support team?_____
Does your home environment have a supportive effect on your health? _____
How many hours of relaxation do you give yourself during the work week? _____
During Weekends? _____ Favorite recreational activities? _____
When was your last Eye Exam? _____ Do you wear contacts? _____ Hard/Soft
Do you drink purified bottled water? _____ If so, what brand? _____
Do you have an air purifier in the room you sleep in? _____ What brand? _____

Do you have Amalgam (silver fillings)? _____ Any other dental problems? _____
Do you make an effort to eat organically grown foods? _____ what % _____
Are you considering any elective surgery or medical procedures in the near future? _____

Please Check the appropriate area if you have had any of the following health problems.

	NOW	PAST	Treatment / Dates
Anemia			
Anorexia/Bulimia			
Arthritis			
Asthma			
Blood pressure (high or low)			
Bone/Joint			
Cancer			
Cirrhosis/Liver Disease			
Diabetes			
Epilepsy/Seizures			
Eye Disease/Blindness			
Fibromyalgia/Muscle Pain			
Glaucoma			
Headaches			
Head Injury/ Brain Tumor			
Heart Disease			
Hepatitis/Jaundice			
Kidney Disease			
Lung Disease			
Menstrual Pain			
Oral Health/Dental			
Stomach/Bowel Problems			
Stroke			
Thyroid			
Tuberculosis			
AIDS/HIV			
STDS			
Learning Problems			
Speech Problems			
Anxiety			
Bipolar Disorder			
Depression			
Eating Disorder			
Hyperactivity/ADD			
Schizophrenia			
Sexual Problems			
Sleep Disorder			
Suicide Attempts/Thoughts			
Other			

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurred once or twice last 6 months).
○ ● ○ MODERATE symptoms (occurred once or twice last month).
○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	
				GROUP 1
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Cut heals slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold, clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Fever easily raised
18	○	○	○	Neuralgia-like pains
19	○	○	○	Staring, blinks little
20	○	○	○	Sour stomach often
				GROUP 2
21	○	○	○	Joint stiffness on arising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen, puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; feels "lightheaded" often
29	○	○	○	Digestion rapid
30	○	○	○	Vomiting frequent
31	○	○	○	Hoarseness frequent
32	○	○	○	Breathing irregular
33	○	○	○	Pulse slow; feels "irregular"
34	○	○	○	Gagging reflex slow
35	○	○	○	Difficulty swallowing
36	○	○	○	Constipation, diarrhea alternating
37	○	○	○	"Slow starter"
38	○	○	○	Get "chilled" infrequently
39	○	○	○	Perspire easily
40	○	○	○	Circulation poor, sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				GROUP 3
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetite
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Fatigue, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Overeating sweets upsets
52	○	○	○	Awaken after few hours sleep - hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression - "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				GROUP 4
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	High altitude discomfort
60	○	○	○	Opens windows in closed rooms
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon "yawner"
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles, worse at night
65	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily, "black and blue" spots
69	○	○	○	Tendency to anemia
70	○	○	○	"Nose bleeds" frequent
71	○	○	○	Noises in head, or "ringing in ears"
72	○	○	○	Tension under the breastbone, or feeling of "tightness", worse on exertion
				GROUP 5
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter, metallic taste in mouth in mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Worrier, feels insecure
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upset
85	○	○	○	Stools light colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Use laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmare type bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				GROUP 6
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul-smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucous colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

	1	2	3	
				GROUP 7A
107	O	O	O	Insomnia
108	O	O	O	Nervousness
109	O	O	O	Can't gain weight
110	O	O	O	Intolerance to heat
111	O	O	O	Highly emotional
112	O	O	O	Flush easily
113	O	O	O	Night sweats
114	O	O	O	Thin, moist skin
115	O	O	O	Inward trembling
116	O	O	O	Heart palpitates
117	O	O	O	Increased appetite without weight gain
118	O	O	O	Pulse fast at rest
119	O	O	O	Eyelids and face twitch
120	O	O	O	Irritable and restless
121	O	O	O	Can't work under pressure
				GROUP 7B
122	O	O	O	Increase in weight
123	O	O	O	Decrease in appetite
124	O	O	O	Fatigue easily
125	O	O	O	Ringing in ears
126	O	O	O	Sleepy during day
127	O	O	O	Sensitive to cold
128	O	O	O	Dry or scaly skin
129	O	O	O	Constipation
130	O	O	O	Mental sluggishness
131	O	O	O	Hair coarse, falls out
132	O	O	O	Headaches upon arising, wear off during day
133	O	O	O	Slow pulse, below 65
134	O	O	O	Frequency of urination
135	O	O	O	Impaired hearing
136	O	O	O	Reduced initiative
				GROUP 7C
137	O	O	O	Failing memory
138	O	O	O	Low blood pressure
139	O	O	O	Increased sex drive
140	O	O	O	Headaches, "splitting or rending" type
141	O	O	O	Decreased sugar tolerance
				GROUP 7D
142	O	O	O	Abnormal thirst
143	O	O	O	Bloating of abdomen
144	O	O	O	Weight gain around hips or waist
145	O	O	O	Sex drive reduced or lacking
146	O	O	O	Tendency to ulcers, colitis
147	O	O	O	Increased sugar tolerance
148	O	O	O	Women: menstrual disorders
149	O	O	O	Young girls: lack of menstrual function
				GROUP 7E
150	O	O	O	Dizziness
151	O	O	O	Headaches
152	O	O	O	Hot flashes
153	O	O	O	Increased blood pressure
154	O	O	O	Hair growth on face or body (female)
155	O	O	O	Sugar in urine (not diabetes)
156	O	O	O	Masculine tendencies (female)
				GROUP 7F
157	O	O	O	Weakness, dizziness
158	O	O	O	Chronic fatigue
159	O	O	O	Low blood pressure
160	O	O	O	Nails weak, ridged
161	O	O	O	Tendency to hives
162	O	O	O	Arthritic tendencies
163	O	O	O	Perspiration increase
164	O	O	O	Bowel disorders
165	O	O	O	Poor circulation
166	O	O	O	Swollen ankles
167	O	O	O	Crave salt
168	O	O	O	Brown spots or bronzing of skin
169	O	O	O	Allergies - tendency to asthma

	1	2	3	
170	O	O	O	Weakness after colds, influenza
171	O	O	O	Exhaustion - muscular and nervous
172	O	O	O	Respiratory disorders
				GROUP 8
173	O	O	O	Apprehension
174	O	O	O	Irritability
175	O	O	O	Morbid fears
176	O	O	O	Never seems to get well
177	O	O	O	Forgetfulness
178	O	O	O	Indigestion
179	O	O	O	Poor appetite
180	O	O	O	Craving for sweets
181	O	O	O	Muscular soreness
182	O	O	O	Depression; feelings of dread
183	O	O	O	Noise sensitivity
184	O	O	O	Acoustic hallucinations
185	O	O	O	Tendency to cry without reason
186	O	O	O	Hair is coarse and/or thinning
187	O	O	O	Weakness
188	O	O	O	Fatigue
189	O	O	O	Skin sensitive to touch
190	O	O	O	Tendency toward hives
191	O	O	O	Nervousness
192	O	O	O	Headache
193	O	O	O	Insomnia
194	O	O	O	Anxiety
195	O	O	O	Anorexia
196	O	O	O	Inability to concentrate; confusion
197	O	O	O	Frequent stuffy nose; sinus infections
198	O	O	O	Allergy to some foods
199	O	O	O	Loose joints
				FEMALE ONLY
200	O	O	O	Very easily fatigued
201	O	O	O	Premenstrual tension
202	O	O	O	Painful menses
203	O	O	O	Depressed feelings before menstruation
204	O	O	O	Menstruation excessive and prolonged
205	O	O	O	Painful breasts
206	O	O	O	Menstruate too frequently
207	O	O	O	Vaginal discharge
208			O	Hysterectomy / ovaries removed
209	O	O	O	Menopausal hot flashes
210	O	O	O	Menses scanty or missed
211	O	O	O	Acne, worse at menses
212	O	O	O	Depression of long standing
				MALE ONLY
213	O	O	O	Prostate trouble
214	O	O	O	Urination difficult or dribbling
215	O	O	O	Night urination frequent
216	O	O	O	Depression
217	O	O	O	Pain on inside of legs or heels
218	O	O	O	Feeling of incomplete bowel evacuation
219	O	O	O	Lack of energy
220	O	O	O	Migrating aches and pains
221	O	O	O	Tire too easily
222	O	O	O	Avoids activity
223	O	O	O	Leg nervousness at night
224	O	O	O	Diminished sex drive

List the five main complaints you have in the order of their importance:

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