NEW PATIENT PACKET

Naturopathic Center for Wellness

Practice Policies for Patients

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

We have created a peaceful and holistic environment that is conducive to meet your needs, listen to your desires, concerns, and fears. As a preventative, primary healthcare practitioners, we provide encouragement and options if you are feeling lost or confused by your current medical care of condition. Our motto is to "Trust what we feel and treat what we find." Our goal is to treat our patients and their families holistically, where the family unit will be educated, learning the importance of daily nutrition application, supplementation when recommended, and cranial sacral therapy application, achieving total comprehensive healthcare.

We are committed to helping you obtain an optimal healthy life. We provide you with highest level of personal care: physical, emotional, mental and spiritual. We strongly believe this will enable you (and those you love) to experience the hidden, incredible healing power and capabilities of your individual body's needs. Understanding our Philosophy of care, making informed personal choices, desiring to heal, and accepting our guidance as practitioners, enables our patients to make good decisions in the future regarding their complete physical, emotion, and spiritual ***holistic*** life style.

Please read all the enclosed information carefully. Please sign and bring the completed forms to your first appointment. Along with these forms, please bring and relevant medical test results you have had in the past year.

CONTACT INFORMATION

Dr. Julie Miller PSc.D, RND, RN, BSN
23041 Avenida De La Carlota STE 110
Laguna Hills, CA 92653
Office: 949-273-6240
Fax: 949-273-6241

Our Office hours are Monday, Tuesday and Thursday 10:00am-6:00pm
We may be reached at : 949-273-6240
Our website is www.Naturocw.com
Julie Miller's email is Jmiller@naturocw.com

(Doctor Licensed by PMA. Not Licensed ND in California)

If you need a timely answer, please call the office. 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 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.

When leaving a message, please be brief and include the following information:

Full name
Reason for call
Phone Number to reach you at
Best time to call back

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

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

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

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

Financial Agreement
Your first visit is a hour and a half office consultation for $240. Each visit thereafter is 1 hour for $130. Half hour appointments and Phone consultations are $90.

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. Missed appointments are costly and take away time for other patients. All patients are important to us and we wish to get please all scheduling needs. In the event of a late cancellation/missed appointment you will receive: first offense: a warning, second offense: $25 missed appointment fee, third offense and thereafter: Full charge of 1 hour appointment.

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. To obtain medical records you can request the records from the physician or lab in which your records are held.

Important Patient Information

Appointment and Cancellation Fees

As a courtesy to our patients, appointments will be confirmed prior to the appointed time. It is however, the patient's responsibility to keep the schedule appointment or call to reschedule.

-There is a 24 hour cancellation policy. We require 24 hour notice for all appointments that need to be canceled or rescheduled.

-If necessary to cancel or reschedule your appointment, you may call the office at 949-273-6240, email: jmiller@naturocw.com or after hours by calling Julie Miller on personal phone: 949-280-3795

-New patients undergo 90 minute office consultation for $240.00

-Follow up appointments are 1 hour office visit for $130.00

-45 minute phone consultation and half hour office appointments are available for $90.00

-There is no charge for questions on emails, text, or phone calls to our office.

Lab Tests

-Dr. Julie Miller PSc.D, RND, RN, BSN 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.

Billing and Insurance

-Payment for supplements and the office visit or phone appointment is required at time of service and can be in the form of check, cash or credit card. All credit card payments will be processed the same day of the visit or phone consult.

-You will receive an invoice at the completion of your visit.

-The Naturopathic Center for Wellness does not bill insurance companies or Medicare.

Patient Initials _____

Supplements

-Whole food nutritional supplements are available for purchase at the Naturopathic Center for Wellness

-Patients are under no obligation to purchase their supplements are the office.

-Our Office will ship supplements to your home with a standard shipping fee of $15.00

-Return Policy. All supplements are FINAL SALE.

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 makes no claim of cure for any condition.

-Dr. Julie Miller PSc.D, RND, RN, BSN 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.

-It is your responsibility to seek professional attention from Julie Miller Psc.D, RND, RN, BSN, CST, TRADITIONAL NATUROPATH (Doctor Licensed by PMA. Not Licensed ND in California)or another medical facility if your conditions worsen.

-You are aware that Dr. Julie Miller PSc.D, RND, RN, BSN will NOT ask you to stop taking any medicines prescribed by another physician. If you desire to stop taking any prescriptions, please consult your physician that prescribed the medications.

Evening and Weekend Calls

-Dr. Julie Miller PSc.D, RND, RN, BSN does not maintain regular calls on evenings, Wednesdays, Fridays nor weekends and holidays.

-If you have a non-urgent question, please call during office hours or email Dr. Julie Miller PSc.D, RND, RN, BSN directly. If you call, please leave a message at the office and she will respond to your question during the work days.

-If you have an urgent concern you may leave a message on Dr. Julie's personal phone 949-280-3795. She will not always be available on this number, but please leave your name and number and she will respond to you as quickly as possible.

Emergencies

-In the even of an emergency you are responsible to obtain medical attention. Call 911 or go to the nearest emergency room.

_____ _____

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
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, 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, 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? _____

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

History of Illnesses/Injuries/Surgeries/Accidents

_____

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. Circle any tests that were abnormal.

	Year		Year		Year
Chest X-ray		TB Test		Pap Smear	
Kidney X-ray		EKG		Mammogram	
GI Series		MRI		Sigmoidoscopy	
Colon X-ray		CAT Scan		Rectal Exam	
Spine X-ray		Cardiac Stress Test			
Blood Tests		Cholesterol		PSA	
Complete Physical Exam					

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	_____	_____
3	_____	_____
Children	_____	_____
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
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 box is 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			
Other			
Other			

SYMPTOM SURVEY FORM

Maestro.

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ☐ Female ☐

Pulse: Recumbent _____ Standing _____ Vegetarian: Yes ☐ No ☐

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ☐

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. _____