

HEALTH REVIEW

Name: _____ Date: _____

Mark (X) those that apply to you

Pain	Skin	Heart	Neurological
<input type="checkbox"/> Head	<input type="checkbox"/> Frequent Rashes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Depression
<input type="checkbox"/> Face	<input type="checkbox"/> Acne	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Jaw - TMJ	<input type="checkbox"/> Hives	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Mood Swings
<input type="checkbox"/> Throat	<input type="checkbox"/> Shingles	<input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> Poor Concentration
<input type="checkbox"/> Neck	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Poor Memory
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Eczema	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Brain Fog
<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Psoriasis	Bowels	<input type="checkbox"/> Tremors
<input type="checkbox"/> Elbow	Sinus	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Seizures
<input type="checkbox"/> Forearm	<input type="checkbox"/> Excess Drainage	<input type="checkbox"/> Constipation	<input type="checkbox"/> Numbness
<input type="checkbox"/> Wrist	<input type="checkbox"/> Excess Congestion	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Hand	Head	<input type="checkbox"/> Foul Odor	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Fingers	<input type="checkbox"/> Headaches	<input type="checkbox"/> Gas	<input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> Chest	<input type="checkbox"/> Migraines	<input type="checkbox"/> Colitis	<input type="checkbox"/> Attention Deficit (ADD)
<input type="checkbox"/> Ribs	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> OCD
<input type="checkbox"/> Shoulder Blade	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Bi-Polar
<input type="checkbox"/> Upper Back	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Irritable Bowel	Circulation
<input type="checkbox"/> Lower Back	Eyes	Digestion	<input type="checkbox"/> Bleed or Bruise Easily
<input type="checkbox"/> Tailbone	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Cold Fingers or Toes
<input type="checkbox"/> Pelvic	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Food Allergies	Allergies
<input type="checkbox"/> Abdominal	Ears	<input type="checkbox"/> Heartburn / Reflux	<input type="checkbox"/> Animal
<input type="checkbox"/> Hip	<input type="checkbox"/> Poor Hearing	<input type="checkbox"/> Nausea	<input type="checkbox"/> Plants
<input type="checkbox"/> Upper Leg	<input type="checkbox"/> Earaches	<input type="checkbox"/> Sores in Mouth	<input type="checkbox"/> Dust, Mold, Etc
<input type="checkbox"/> Knee	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Seasonal
<input type="checkbox"/> Lower Leg	Thyroid	<input type="checkbox"/> Weight Loss	Throat
<input type="checkbox"/> Ankle	<input type="checkbox"/> Under Active (Hypo)	<input type="checkbox"/> Abdominal Bloating	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Foot	<input type="checkbox"/> Over Active (Hyper)	<input type="checkbox"/> Gas	<input type="checkbox"/> Soreness
<input type="checkbox"/> Toes	Lungs	<input type="checkbox"/> Belching	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Muscle Cramps	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Stomach Pain	Female
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Gallbladder Problems	<input type="checkbox"/> PMS
<input type="checkbox"/> Restless Legs	<input type="checkbox"/> Asthma	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Feel Poorly after Eating	<input type="checkbox"/> Heavy Bleeding
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Feel Better after Eating	<input type="checkbox"/> Irregular Cycle
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Hiatal Hernia	Blood Sugar	<input type="checkbox"/> Painful Breast
Stress Level	<input type="checkbox"/> COPD	<input type="checkbox"/> High	<input type="checkbox"/> Low Sex Drive
<input type="checkbox"/> Mild	Auto-Immune	<input type="checkbox"/> Low	<input type="checkbox"/> Water Retention
<input type="checkbox"/> Moderate	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Diabetic	Male
<input type="checkbox"/> Severe	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Hypoglycemic	<input type="checkbox"/> Low Sex Drive
Sleep Problems	<input type="checkbox"/> ALS	Urinary	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Falling Asleep	<input type="checkbox"/> Grave's Disease	<input type="checkbox"/> Difficulty in Urinating	<input type="checkbox"/> Erectile Dysfunction
<input type="checkbox"/> Staying Asleep	<input type="checkbox"/> Epstein-Barr	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Impotence
<input type="checkbox"/> Restless Sleep	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Frequent Infections	Are you Over Weight
Sweating	<input type="checkbox"/> Cancer	<input type="checkbox"/> Water Retention	<input type="checkbox"/> Slightly
<input type="checkbox"/> Night Sweats	Other	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Moderately
<input type="checkbox"/> Rarely Sweat	<input type="checkbox"/> Knee Replacement	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Obese
<input type="checkbox"/> Excessive	<input type="checkbox"/> Hip Replacement	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> I want to lose Weight