Synchrony Energetics Community – Natural Health Survey

Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

Instructions: Indicate the symptoms which apply to you using the following scale. Please total your points for each category. (**0**) if "never" (**1**) if "rarely" (**2**) if "time to time" (**3**) if "often"

SECTION A: DIGESTIVE

Value	Symptom	Value	Symptom
	Lower bowel gas several hours after eating		Excessive belching/burping
	Burning stomach sensation, eating relieves		Bad breath
	Tongue is white or gray		Alternating diarrhea/constipation
	Indigestion after eating		Have pets eg. dogs, cats, farm animals, etc.
	Carbonated drinks 3+ per week?		Rectal itching
	Difficult bowel movements		Can't gain weight
	Ulcers?/Colitis?/ Gastritis?		International travel
	Stomach bloating after eating		Stomach/intestine cramping/diarrhea
	Total		

SECTION B: SUGAR HANDLING PROBLEMS

Value	Symptom	Value	Symptom
	Afternoon headaches		Abnormal craving for sweets or snacks
	Get "shaky" if hungry		Thirsty much of the time
	Faintness if meals delayed		History of diabetes
	Heart palpitates if meals missed or delayed		Excessive, frequent urination
	Eat when nervous		Blurred vision/failing eyesight
	Awaken after few hours of sleep		Breath smells sweet
	Hard to get back to sleep		Tingling, numbness, prickling sensation in extremities.
	Crave candy or coffee in afternoon		
	TOTAL		

SECTION C: CARDIAC

Value	Symptom	Value	Symptom
	Bruise easily, "black & blue spots"		Hands & feet go to sleep easily
	Sigh frequently		Numbness in extremities
	Aware of "breathing heavily"		Tendency to anemia
	Susceptible to colds & fevers		Blushing with no apparent cause
	Swollen ankles, worse at night		Black stool (no iron supplementation)
	Muscle cramps, worse during night		Poor concentration
	Shortness of breath on exertion		Slurred speech
	Nosebleeds		Headaches
	Ringing in the ears		Weakness/fatigue
	Heart palpitations		Out of breath frequently
	Dull pain in chest or radiating into left arm, worse on exertion		Nervousness
	TOTAL		

SECTION D: LIVER & GALL BLADDER

Value	Symptom	Value	Symptom
	Pain under right side of rib cage		Laxatives used often
	Frequent skin rashes		Gall bladder attacks or gallstones
	Bitter metallic taste in mouth in morning		History of hepatitis
	Bowel movements painful and difficult		History of jaundice
	Low energy, weakness, exhaustion		Sneezing attacks
	Upset from greasy/fatty foods		Itchy skin, worse at night
	Bruises easily		Dry flaky skin, hair
	Frequent headaches		General feeling of poor health
	Stools light colored		Aching muscles
	Pain between shoulder blades		Swollen feet and/or legs
	TOTAL		

SECTION E: THYROID

Value	Symptom	Value	Symptom
	Impaired hearing		Slow pulse, below 65
	Decrease in appetite		Cold hands and feet
	Ringing in ears		Gains weight easily
	Constipation		Weight gain around hips
	Tired/sluggish		"Emotional"
	Miscarriages		Flush easily
	Infertility		Night sweats
	Mental sluggishness/forgetfulness		Hair loss
	Headache upon rising; wears off during day		
	TOTAL		

SECTION F: ENVIRONMENTAL

Value	Symptom	Value	Symptom
	Exposure to fumes e.g., paint, salon, car		Skin disorders e.g., psoriasis, eczema etc.
	Use pesticides on garden		Loss of hair
	Live near power lines/high tension wires		Hormone disorders
	Have mercury amalgams (silver) in mouth		History of cancer/personal or familial
	TOTAL		

SECTION G: ADRENAL

Value	Symptom	Value	Symptom
	Low blood pressure		Crave salty foods
	Chronic fatigue		Feeling unrefreshed upon awakening
	Low energy, lack of stamina		Allergies
	General malaise, unhappiness		Exhaustion—muscular & nervous
	Tendency to hives		Respiratory disorders
	Arthritic tendency		Swollen ankles
	Excessive perspiration		Dizzy when stand up “too fast”
	Colds/flu often		Decreasing appetite
	Weakness after illness		Irritable
	Dark circles under the eyes		Bright lights irritate
	TOTAL		

SECTION H: FEMALE & MALE

FEMALE ONLY			MALE ONLY	
Value	**Symptom**		**Value**	**Symptom**
	Painful menses			Tired too easily
	Premenstrual tension			Urination difficult
	Very easily fatigued			Night urination frequent
	Depressed feeling			Pain on inside of legs or heel
	Menstruation excessive and prolonged			Feeling of incomplete bowel evacuation
	Painful breasts (monthly)			Prostrate trouble
	Lumpy breasts/worst at menses			Leg nervous at night
	Have taken birth control pills			Diminished sex drive
	Menopause, hot flashes, etc.			Erectile dysfunction
	Menses scanty or irregular			**TOTAL - MALE**
	Acne, worse at menses			
	Vaginal discharge/yeast, etc			
	TOTAL - FEMALE			

SECTION I: LUNG

Value	Symptom	Value	Symptom
	Chronic cough		Bronchitis (frequent)
	Pain around ribs		Infections settle in lungs
	Shortness of breath		Sensitive to smog
	Chest pain		Asthma
	Difficulty breathing		Wheezing
	Postnasal drip		Smoker
	Sinus and nasal congestion		Chronic lung congestions
	Coughing up phlegm		Breathes through mouth
	Coughing up blood		Shallow breather
	TOTAL		

SECTION J: IMMUNE

Value	Symptom	Value	Symptom
	Throat Infections		Cough with mucus
	Poor wound healing		Swollen tongue
	Slow to recover from colds or flu		Dark areas under the eyes/cheeks
	Gets boils, cysts, or sties		Sore throat
	Swollen lymph glands		Postnasal drip
	Catch colds and flu easily		Earaches and infections
	Bumpy skin on arms		Herpes/cold sores
	Inflamed or *bleeding gums*		
	TOTAL		

SECTION K: KIDNEYS

Value	Symptom	Value	Symptom
	Frequent urination		Strong smelling urine
	Rose-coloured (bloody) urine		Mild back pain
	Dripping after urination		Interrupted urine stream
	Difficulty passing urine		Tingling in joints
	Cloudy urine		Joint and muscle pain/cramping
	Rarely need to urinate		Can't hold urine
	Frequent bladder infections		Dark circles under eyes
	Painful/burning when urinating		Frequent urge to urinate but pass only small amounts
	Urination when cough or sneeze		
	TOTAL		

SECTION L:

205. How often do you take (or have you taken) antibiotics_____

206. Reactions to vaccinations? ☐Y / ☐N

207. How many silver amalgams do you have in your mouth?_____
Root Canals?_____ Crowns/Bridges?_____

208 Were your wisdom teeth impacted? ☐Y / ☐N Other Dental Problems? ☐Y / ☐N

209. Allergies? ☐Y / ☐N (List Main):
_____

210 Are you experiencing bone loss or osteoporosis? ☐Y / ☐N

211. Do you smoke? ☐Y / ☐N

212. Have you ever been diagnosed with parasites? ☐Y / ☐N

213. Have you ever been diagnosed with Candida? ☐Y / ☐N

214. Exposure to pesticides? ☐Y / ☐N

215. Drink 6 – 8 glasses of water daily? ☐Y / ☐N

216. Are you currently, or have you ever, taken Hormone Replacement Medications? ☐Y / ☐N

IMPORTANT: Please list your five main health complaints in the *order of importance:*

1. _____

2. _____

3. _____

4. _____

5. _____

I hereby acknowledge that I understand that this and following consultations done with Amanda Lange or Catherine Warren are intended to promote health maintenance and education and are not intended to diagnose or treat medical conditions, disclosed or undisclosed. I acknowledge that I am accountable for the status of my health.

Signature _____Date _____