PHYSICAL ASSESSMENT

The information presented in this form is intended to help provide a profile of your past and present nutritional health. Please fill out completely to the best of your knowledge. We will review this form in your consultation.

PERSONAL INFORMATION

Name: Date:

Street Address: Birthdate:

City: Gender:

Phone #: Height:

Email: Weight (pounds):

Current Occupation: Stress Level:

Cholesterol: Date of Test: Blood Pressure: Date of Test:

Number of people in household: Stress Level:

Are you ready to make lifestyle changes? Scale of 1-10: 1 2 3 4 5 6 7 8 9 10

What are some limitations to reaching your goals?

Any trauma (physical or emotional) or loss in the last 5 years?
How many hours of sleep do you get on an average night?

On average, how many bowel movements do you have each day? Each week?

What are your sources of motivation or support?

What are your health concerns and how long have they been an issue? Please give details.

1.

2.

3.

What medications, medical procedures, supplements or therapies have you previously tried for your condition? Which were helpful and which were not effective?

Please list: Helpful / Ineffective

_____ _____ _____

_____ _____ _____

_____ _____ _____

If you are under a doctor's care for any condition, please list them along with any medications or therapies you are using:

Medical Condition Medications or therapies

_____-_____, _____, _____

_____-_____, _____, _____

_____-_____, _____, _____

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List any allergies you have:

Indicate any surgeries, accidents or other trauma you have had in the past:

_____

_____

What nutritional supplements are you currently taking?

_____ _____

_____ _____

_____ _____

BODY SYSTEMS

RESPIRATORY/SINUS /13
____ allergies
____ asthma or wheezing
____ sore throat frequently
____ sinus infections
____ frequent cough
____ bronchial infections
____ phlegm in throat
____ food sensitivities
____ constipation/diarrhea
____ congested air passages
____ itchy nose/ears
____ sinus headaches/congestion
____ swollen lymph glands

STRUCTURAL /12
____ join stiffness upon arising
____ brittle bones or fingernails
____ history of joint injuries
____ muscle cramps at night
____ osteoporosis
____ joint pain, arthritis or gout
____ bulging/compressed disks
____ tendonitis/bursitis
____ feet hurt in the morning
____ dry skin
____ frequent backaches
____ weak legs, knees or ankles

LIVER/GALLBLADDER /13
____ pain between shoulder
____ history of gallstones
____ crave fatty or greasy foods
____ frequent skin rashes
____ stools light-colored or float
____ bad breath or body odor
____ abdominal pain/discomfort
____ difficulty falling asleep
____ fatigue or low energy
____ food allergies
____ constipation/diarrhea
____ headaches/migraines
____ varicose veins

INTESTINAL /13
____ abdominal pain/discomfort
____ bad breath or body odor
____ colitis or crohns
____ constipation or dry stool
____ excess mucus production
____ fatigue or low energy
____ intestinal gas or bloating
____ loose stools or diarrhea
____ confusion, mental sluggishness
____ sinus congestion
____ headaches
____ swollen lymph glands
____ irritable bowel syndrome

DIGESTION /13
____ poor/excessive appetite
____ pale complexion or anemia
____ strong thirst
____ nausea/vomiting
____ acid reflux/heartburn
____ ulcers
____ gas/bloating
____ diarrhea/constipation
____ abdominal pain/discomfort
____ anxiety, nervousness, tension
____ cravings for sugar
____ food allergies
____ general weakness or illness

URINARY /12
____ burning/painful urination
____ dark circles or eye puffiness
____ frequent backache
____ frequent UTI
____ elevated blood pressure
____ scant/excessive urination
____ incontinence
____ joint pain, arthritis, gout
____ kidney stones
____ osteoporosis
____ water retention
____ weak legs, knees or ankles

PHYSICAL ASSESSMENT

BODY SYSTEMS

IMMUNE /13

____ antibiotic use in the last year
____ frequent stuffy/runny nose
____ chronic fatigue or low energy
____ craving sweets or chocolate
____ bronchial infections
____ skin problems
____ nail fungus
____ muscular soreness
____ food allergies
____ frequent infections
____ general weakness or illness
____ itchy nose/ears
____ swollen lymph glands

CARDIOVASCULAR /13

____ high/low blood pressure
____ irregular heartbeat
____ heavy or difficult breathing
____ bruise easily
____ dizziness/light headedness
____ swollen ankles
____ ringing/pounding in ears
____ varicose veins
____ numb or coldness in hands/feet
____ craving fats
____ fatigue or low energy
____ diagnosis of any heart problems
____ wounds won't heal in extremity

STRESS/ANXIETY/DEPRESSION /14

____ apprehension/nervousness
____ depression/hopelessness
____ irritability
____ addictions
____ panic attacks or anxiety
____ inability to concentrate
____ feeling overwhelmed
____ irritable bowel
____ difficulty going to sleep
____ fatigue or low energy
____ headaches/migraines
____ restless dreams or nightmares
____ waking up frequently at night
____ varicose veins

DETOXIFICATION

ELIMINATION HISTORY/HABITS

1. How many bowel movements do you have daily?
2. If bowel movements do not occur regularly, how many do you have weekly?
3. Do you have diarrhea? Constipation?
4. Do you frequently have gas?
5. Does gas cause you pain, bloating, and discomfort?
6. Which words describe(s) your typical bowel movements? (loose) (hard) (bloody) (floating) (diarrhea) (green) (often black) (contain mucus)
7. Do you have hemorrhoids?
8. Approximately how many times do you urinate daily
9. Which words best describe your urine? (bloody) (clear) (strong odor) (contains particles)
10. Choose the word(s) that best describe(s) your urination processes/habits: (cramping) (urgency) (easy flow) (burning/pain) (frequently at night) (incontinence) (unable to empty bladder fully) (flank pain)
11. Do you have a history of urinary tract infections?
12. Which best describe(s) how your body sweats?
13. Does your sweat have an unpleasant odor?
14. Do you regularly use a(n): (antiperspirant), (deodorant)
15. Do you ever have any unexplained or unusual swelling, inflammation or fluid retention?
16. If applicable, list area(s) of swelling/inflammation/fluid retention?

PHYSICAL ASSESSMENT

DETOXIFICATION

PARASITES /14

____ yeast infections
____ antibiotics in the past 5 years
____ nausea
____ indigestion, heartburn, GERD
____ joint & muscle pain
____ fatigue
____ frequent ear/nose/throat infection
____ auto-immune disease
____ rashes/hives/psoriasis/boils/acne
____ swelling in lymph nodes around neck
____ anemia
____ hypoglycemia (low blood sugar)
____ irritable bowel syndrome
____ diverticulitis/colitis/Crohns disease

ENVIRONMENTAL /13

____ # of amalgam fillings
____ # of root canals
____ live near environmental pollutant
____ frequent exposed to toxic materials
____ home/work recently painted
____ smoke now or in the past
____ exposed to second hand smoke
____ exposed to radiation
____ toothpaste contains fluoride
____ history of drug addiction
____ vaccinated as a child
____ diagnosis of any heart problems
____ wounds won't heal in extremity

VIRAL /12

____ frequent viral infections
____ recurrent canker sores
____ recurrent warts
____ history of polio
____ history of mononucleosis
____ herpes simplex I, general
____ history of infections
____ frequent cold or flu symptoms
____ frequent muscular aches/chills
____ exposure to ill individuals
____ history of shingles (herpes zoster)
____ history of tonsillitis or croup

YEAST/FUNGAL /14

____ indigestion after eating fruits
____ bloating after meals
____ chronic sinus problems
____ itchy skin/scalp
____ frequent antibiotic usage
____ cravings for sweets
____ cloudy thinking/mental fog
____ history of eczema/psoriasis/dandruff
____ constipation/diarrhea
____ consume a lot of sugar
____ vaginal discharge
____ recurrent UTI
____ irritable bowel syndrome
____ rectal burning or itching

HEAVY METALS /14

____ metallic taste in mouth
____ loose teeth
____ chronic headaches
____ arthritis/pain in joints
____ mouth ulcers
____ swollen tongue
____ unexplained skin rashes
____ anxiety, depression
____ frequent exposure to fertilizers
____ frequent ingestions of seafood
____ tremors or twitching
____ autoimmune disease
____ bone loss around teeth
____ exposure to lead-based paints

BACTERIAL /11

____ frequent bacterial infections
____ chronic sinusitis
____ dental abscess
____ exposure to ill individuals
____ history of staph or stress infx
____ frequent ear infections
____ sinus discomfort or facial bone pain
____ unusual skin rash/eczema
____ frequent discolored mucus/ nasal secretions
____ history of tuberculosis
____ bitten by a deer tick

GLANDULAR SYSTEMS

STRESS

1. Are you under stress? If so, explain:
2. I respond to stress by: ___exploding ____ lashing out _____ holding it in _____ eating ____ anxious/ nervous
3. My daily stress level is: Scale of 1-10: 1 2 3 4 5 6 7 8 9 10
4. How many hours of sleep do you get each night on average?
5. Which statement best describes your sleep? (restless) (deep) (light) (hard to fall asleep) (wake up frequently)
6. On average, what is your energy level like? Scale of 1-10: 1 2 3 4 5 6 7 8 9 10

PHYSICAL ASSESSMENT

GLANDULAR SYSTEMS

ADRENAL /13

____ cravings for salt/sweets
____ constant or chronic fatigue
____ headaches/migraines
____ low blood pressure
____ chronic back pain
____ panic attacks
____ nervousness
____ muscular weakness
____ extreme sensitivity to odors/noise
____ stress-filled lifestyle
____ clenching or grinding of teeth at night
____ blood sugar disturbances
____ tendency to gain weight in the waist

THYROID /13

____ cold hands and feet
____ dry/brittle hair
____ fatigue
____ tired in AM and energetic in PM
____ slow or slurred speech
____ muscle cramps, especially at night
____ frequently constipated
____ PMS or menstrual difficulties
____ hair loss
____ cracks in bottom of your heels
____ low libido
____ swelling of hands and face
____ low body temperature

BLOOD SUGAR /13

____ eat when nervous
____ excessive appetite
____ hungry between meals
____ irritable before meals
____ get "shaky" if hungry
____ "lightheaded" if meals are delayed
____ heart palpitations if meals are missed
____ afternoon headaches
____ awaken after a few hours of sleep
____ crave sweets or coffee
____ afternoon fatigue
____ history of shingles (herpes zoster)
____ history of tonsillitis or croup

FEMALE ED/EL /22

____ tender breasts
____ anxious/nervous feelings
____ weight gain in hip/waist area
____ menstrual bleeding changes
____ water retention
____ uterine fibroids
____ fibrocystic breasts
____ mood swings/irritability
____ cold body temperature
____ headaches
____ infertility
____ hot flashes
____ foggy thinking/memory lapses
____ heart palpitations
____ night sweats
____ bone loss
____ increase in facial/body hair
____ increased urinary urge/ incontinence
____ vaginal dryness
____ trouble falling asleep or staying asleep
____ weight gain around waist
____ depression

PITUITARY/HYPOTHALAMUS /10

____ failing memory
____ low blood pressure
____ increased sex drive
____ splitting headaches
____ decreased sugar tolerance
____ abnormal thirst
____ bloating of abdomen
____ tendency toward ulcers
____ weight around hips or waist
____ sugar cravings

MALE HEALTH /10

____ enlarged prostate
____ elevated PSA count
____ difficult or dribbling urination
____ lack of motivation/energy
____ depression
____ leg nervousness at night
____ diminished sex drive
____ erectile dysfunction
____ migrating aches and pains
____ feeling of incomplete bowel evacuation

I have read and understand the above disclosure. I have voluntarily submitted all the accompanying information, and have not been coerced in any manner. I acknowledge that I assume full responsibility for my choices regarding health care, wellness philosophies, and my decision to participate in any services, assessments or consultations provided by Cedrick Wellness Resources, LLC. I do not hold Cedrick Wellness Resources, or any associated employee or person, liable in any way for recommendations or suggestions made on mine, or my family's behalf. I understand that any information provided is intended for educational purposes only and is not to be used to diagnose, treat or cure any disease. I further understand that the primary emphasis of this establishment is on total wellness and good health practices, not on specific treatment of illness or disease. I am seeking education advice, and am not visiting on a mission of entrapment or as a representative of any state or local authority. *Note: If you have a serious health problem, please consult a competent health care practitioner.*

Signature_____ Date_____