Name:_____ **Date:**_____

Stomach Do you have

- ☐ Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ None of the above

Joints and Muscles Do you have

- ☐ Pain
- ☐ Weakness
- ☐ Other
- ☐ None of the above

Endocrine Do you have

- ☐ Thirst
- ☐ Increased Urination
- ☐ Often cold
- ☐ Often hot
- ☐ Overweight
- ☐ Other _____
- ☐ None of the above

Infection Do you have

- ☐ Discharge
- ☐ Urinary pain
- ☐ Other _____
- ☐ None of the above

Blood Do you have

- ☐ Bleeding
- ☐ Easy bruising
- ☐ Other _____
- ☐ None of the above

Auto immune Do you have

- ☐ Sun sensitivity
- ☐ Fingertip changes
- ☐ Other _____
- ☐ None of the above

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