BACK TO THE FUTURE IN HEALTH

BioEnergetic Testing
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Full name: _____ Date of Birth: _____
Address: _____
Phone Number: _____ Email Address: _____
Preferred method of communication: ☐ Phone ☐ Email
Current Occupation: _____ Past Occupations: _____
Family Physician: _____

Instructions: Please indicate if symptoms apply to you currently or in the past by indicating C for current and P for past
leave blank if symptom does not apply

DIGESTION

_____ Lower bowel gas several hours after eating
_____ Burning stomach sensation, eating relieves
_____ Coated tongue
_____ Indigestion 1/2 hour up to 4 hours after
_____ Carbonated drinks 3+ per week
_____ Difficult bowel movements
_____ Ulcers? Colitis? Gastritis?
_____ Stomach bloating after eating
_____ Excessive belching/burping
_____ Bad breath
_____ Alternating diarrhea/constipation
_____ Have pets: Dogs, cats, farm animals, etc.
_____ Rectal itching
_____ Can't gain weight
_____ International travel
_____ Stomach/intestinal cramping/diarrhea

SUGAR HANDLING

_____ Afternoon headaches
_____ Get "shaky" if hungry
_____ Faintness if meals delayed
_____ Heart palpitations if meals delayed or missed
_____ Eat when nervous
_____ Awaken after few hours of sleep
_____ Crave candy or coffee in afternoon
_____ Thirsty much of the time
_____ Diabetes
_____ Excessive frequent urination
_____ Blurred vision/failing eyesight
_____ Breath smells sweet
_____ Hard to get back to sleep
_____ Abnormal craving for sweets or snacks

CARDIAC

_____ Bruise easily
_____ Sigh frequently
_____ Aware of 'breathing heavily'
_____ Open window in closed room
_____ Susceptible to colds/fevers
_____ Swollen ankles, worse at night
_____ Muscle cramps, worse at night
_____ Shortness of breath on exertion
_____ Nosebleeds
_____ Ringing in the ears
_____ Heart palpitations
_____ Dull pain in chest or radiating into left arm worse on exertion
_____ Hands and feet fall asleep easily
_____ Numbness in extremities
_____ Tendency to anemia (low iron)
_____ Tension under breastbone or feeling of tightness, worse on exertion
_____ Blushing with no apparent cause
_____ Black stool (no iron supplementation)
_____ Poor concentration
_____ Slurred speech
_____ Headaches
_____ Weakness/fatigue
_____ Frequently out of breath
_____ Nervousness

LIVER AND GALL BLADDER

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

THYROID

_____ Impaired hearing
_____ Decrease in appetite
_____ Ringing in ears
_____ Constipation
_____ Puffy hands and/or face
_____ Tired/sluggish
_____ Miscarriages
_____ Infertility
_____ Mental sluggishness/forgetfulness
_____ Headache upon rising; wears off during day
_____ Slow pulse, below 65
_____ Cold hands and feet
_____ Gain weight easily
_____ Weight gain around hips
_____ Outer third of eyebrow thinning
_____ Emotional
_____ Blushing with no apparent cause
_____ Night sweats
_____ Hair loss

BONE DEVELOPMENT / MINERALS

_____ Hip and/or joint pain
_____ Receding gums and/or dental cavities
_____ Tendency to slouch, weakness
_____ Bone loss/osteoporosis in family
_____ Crunching/creaking joints

ENVIRONMENTAL

_____ Regular exposure to fumes (salon, paint, auto, etc.)
_____ Use pesticides on lawn and/or garden
_____ Live near power lines/high tension wires
_____ Have silver (mercury) fillings in mouth
_____ Skin disorders (psoriasis, eczema, etc.)
_____ Hair loss
_____ Hormone disorders
_____ Cancer history - personal / family

MUSCLE AND LIGAMENT

_____ Muscle aches, stiffness, cramping, pain
_____ Chiropractic adjustments don't hold
_____ Whiplash and/or ligament trauma/strain
_____ Fatigue, sluggishness
_____ Upper and/or lower back pain
_____ Stiff neck and shoulders

ADRENALS

_____ Low blood pressure
_____ Chronic fatigue
_____ Low energy, lack of stamina
_____ General malaise, unhappiness
_____ Tendency to hives
_____ Arthritic tendency
_____ Excessive perspiration
_____ Colds and/or flus often
_____ Weakness after illness
_____ Dark circles under eyes
_____ Not feeling refreshed upon awakening
_____ Allergies
_____ Exhaustion - muscular / nervous
_____ Respiratory disorders
_____ Swollen ankles
_____ Dizzy when standing too quickly
_____ Decreasing appetite
_____ Irritable
_____ Bright lights irritate
_____ Crave salty foods

REPRODUCTIVE

FEMALE ONLY

_____ Premenstrual tension
_____ Painful menses
_____ Easily fatigued
_____ Depressed feeling
_____ Menstruation excessive and prolonged
_____ Painful breasts (monthly)
_____ Have taken birth control pills
_____ Menopause, hot flashes, etc.
_____ Menses light and/or irregular
_____ Acne, worse at menses
_____ Vaginal discharge, yeast

MALE ONLY

_____ Easily tired
_____ Urination difficult
_____ Night urination frequent
_____ Pain on inside of legs and/or feet
_____ Feeling of incomplete bowel evacuation
_____ Prostate concerns and/or issues
_____ Restless leg(s) at night
_____ Diminished sex drive

LUNG

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

IMMUNE

_____ Throat infections
_____ Wounds slow to heal
_____ Slow recovery from colds and/or flus
_____ Get boils or sties
_____ Swollen lymph glands
_____ Quick to catch colds and/or flus
_____ Bumpy skin on arms
_____ Inflamed and/or bleeding gums
_____ Cough with mucus
_____ Swollen tongue
_____ Dark areas under the eyes
_____ Sore throat
_____ Post nasal drip
_____ Ear aches and/or infections
_____ Herpes and/or cold sores

KIDNEY

_____ Frequent urination
_____ Bloody urine
_____ Dripping after urination
_____ Difficulty urinating
_____ Cloudy urine
_____ Rarely need to urinate
_____ Frequent bladder infections
_____ Pain and/or burning when urinating
_____ Urination when cough and/or sneeze
_____ Strong smelling urine
_____ Mild back pain
_____ Interrupted urine stream
_____ Tingling in joints
_____ Joint and muscle pain/cramping
_____ Can't hold urine
_____ Dark circles under eyes
_____ Frequent urge to urinate but passing only small amounts

OVERVIEW

Have you taken antibiotics in the last 2 years? ☐ YES ☐ NO
Have you had vaccinations? ☐ Childhood ☐ COVID ☐ Shingles ☐ Flu ☐ to travel: Twinrix, typhoid, etc.
How many root canals have you had? _____
Please list any known allergies:

_____

Please list all medications and/or supplements you are currently taking:

_____

_____

Please list your health complaints in order of priority:

_____

_____

_____

Are you happy with your current state of life? ☐ YES ☐ NO
Do you look forward to your day? ☐ YES ☐ NO