Robert Jacobs Health Natural

AN INTEGRATED APPROACH TO NATURAL HEALTH

NAME_____ DATE _____

ADDRESS_____

_____

REFERRAL _____

PHONE_____

DATE OF BIRTH _____ Male ___ Female ___

Circle any of the following medications you are taking:
Antacids Antibiotic/Antifungal Antidepressants Anti-diabetic/Insulin Aspirin/Paracetamol Chemotherapy Cortisone/Anti-inflammatory Heart Medications High Blood Pressure Hormones Laxatives Lithium Oral Contraceptives Radiation Recreational Drugs: Relaxants/Sleeping Pills Thyroid Ulcer Medications
Other (specify):
_____

Circle if you eat, drink or use:
Alcohol Candy/Sweets Fizzy drinks Cigarettes Coffee Distilled water Fast food restaurants regularly Fried Foods Deli Meats Margarine Refined sugars
Saccharine/Aspartame (Canderel, Splenda etc) Chewing tobacco
Vitamins/Minerals (list)_____

_____

Circle if you:
Diet often Do not exercise regularly Salt food without tasting
Are under excessive stress Are exposed to chemicals at work
Are exposed to cigarette smoke

In the following sections circle or mark the number which best describes your symptoms:—
0 = Symptom is not present
1 = Mild
2 = Moderate
3 = Severe
If you do not know the answer to a question leave it blank.

Part 1 Section A

1	Burping	0	1	2	3
2	Fullness after meals	0	1	2	3
3	Bloating	0	1	2	3
4	Stomach upsets easily	0	1	2	3

Part 1 Section B

1	Abdominal cramps	0	1	2	3
2	Indigestion 1-3 hours after eating	0	1	2	3
3	Intestinal gas	0	1	2	3
4	Alternating constipation and diarrhoea	0	1	2	3
5	Diarrhoea	0	1	2	3
6	Roughage and fibre causes constipation	0	1	2	3
7	Mucous in stools	0	1	2	3
8	Stool poorly formed	0	1	2	3
9	Shiny stool	0	1	2	3
10	3 or more large bowel movements daily	0	1	2	3

Part 1 Section C

1	Burning in stomach	0	1	2	3
2	Indigestion	0	1	2	3
3	Acid reflux	0	1	2	3
4	Difficulty belching	0	1	2	3
5	Heartburn	0	1	2	3
6	Sudden acute indigestion	no			yes (3)
7	History of ulcer or gastritis	no			yes (3)
8	Nausea	no			yes (10)

Part 1 Section D

1	Hard stools	0	1	2	3
2	Abdominal cramps or pain in lower abdomen	0	1	2	3
3	Bloating or lower bowel gas	0	1	2	3
4	Alternating diarrhoea/constipation	0	1	2	3
5	Constipation	0	1	2	3
6	Rectal bleeding	no			yes (3)

Part 2 Section A

1	Intolerance to greasy foods	0	1	2	3
2	Elevated liver enzymes	0	1	2	3
3	Light coloured stool	0	1	2	3
4	Foul smelling stool	0	1	2	3
5	Sour taste in mouth	0	1	2	3
6	Grey coloured skin	0	1	2	3
7	Yellow in whites of eyes	0	1	2	3
8	Bad breath	0	1	2	3
9	Body odour	0	1	2	3
10	Pain in liver area, right side under rib cage	0	1	2	3
11	Big toe painful	0	1	2	3
12	Red blood in stool	no			yes (6)
13	Have had jaundice or hepatitis	no			yes (3)

Part 2 Section B

1	Swollen eyes (bulging)	0	1	2	3
2	Palpitations	0	1	2	3
3	Insomnia	0	1	2	3
4	Heat intolerance	0	1	2	3
5	Nervousness	0	1	2	3

Part 2 Section C

1	Cold Intolerance	0	1	2	3
2	Chronic fatigue	0	1	2	3
3	Depressed, apathetic	0	1	2	3
4	Low sex drive	0	1	2	3
5	Dry, rough pale skin	0	1	2	3
6	Muscle cramps and muscle aches	0	1	2	3
7	Constipation	0	1	2	3
8	Thinning or loss of outside portion of eyebrow	no			yes (3)
9	Gain weight easily	no			yes (3)
10	Axillary temperature below 36.5°C	no			yes (3)
11	Abnormal menstrual cycles	no			yes (3)

Part 3 Section A

1	Itchy eyes	0	1	2	3
2	Red or inflamed eyes	0	1	2	3
3	Low blood pressure	0	1	2	3
4	Sensitive to fumes/smoke/smog/chemicals	0	1	2	3
5	Cannot tolerate much exercise	0	1	2	3
6	Depression or rapid mood swings	0	1	2	3
7	Dark circles under eyes	0	1	2	3
8	Dizziness upon standing	0	1	2	3
9	Lack of mental alertness	0	1	2	3
10	Catch colds easily when weather changes	0	1	2	3
11	Water retention	0	1	2	3
12	Eyes sensitive to bright light	0	1	2	3
13	Feel weak and shaky	0	1	2	3

Part 3 Section B

1	Itching of nose or eyes	0	1	2	3
2	Itching of roof of mouth or throat	0	1	2	3
3	Swollen joints	0	1	2	3
4	Food sensitivity or allergy	0	1	2	3
5	Alternating constipation and diarrhoea	0	1	2	3
6	Watery eyes	0	1	2	3
7	Running nose	0	1	2	3
8	Swollen tongue	0	1	2	3
9	Difficulty swallowing	0	1	2	3
10	Wheezing	0	1	2	3
11	Skin rashes	0	1	2	3
12	Sneezing (allergic)	0	1	2	3
13	Migraine headaches	no			yes (3)

Part 3 Section C

1	Running nose (chronic)	0	1	2	3
2	Get boils or styes	0	1	2	3
3	Throat infections	0	1	2	3
4	Cold sores, fever blisters	0	1	2	3
5	Poor wound healing	0	1	2	3
6	Joint inflammation and swelling	0	1	2	3
7	Swollen lymph glands	0	1	2	3
8	Ear infections (chronic)	0	1	2	3
9	Slow to recover from cold or flu	0	1	2	3
10	Catch colds or flu easily	0	1	2	3

Part 4 Section A

1	Chest pain while walking	0	1	2	3
2	Heaviness in legs	0	1	2	3
3	Heart pounds easily	0	1	2	3
4	Dizziness	0	1	2	3
5	Heart misses beats or has extra beats	0	1	2	3
6	Swelling of feet and ankles	0	1	2	3
7	Rapidly beating heart	0	1	2	3
8	Pain in left arm	0	1	2	3
9	Exhaustion with minor exertion	0	1	2	3
10	Have you been told you have heart trouble?	no			yes (5)

Part 4 Section B

1	Cold hands and feet	0	1	2	3
2	Weakened veins or varicose veins	0	1	2	3
3	Swollen extremities	0	1	2	3
4	Numbness in extremities	0	1	2	3
5	Poor concentration	0	1	2	3
6	Ringing in ears	0	1	2	3
7	Tingling and/or burning in hands and feet	no			yes (3)
8	Spider veins on nose and/or face	no			yes (3)

Part 4 Section C

1	Pain getting up in morning in back of head	0	1	2	3
2	Dizziness	0	1	2	3
3	Tightness or discomfort in chest	0	1	2	3
4	Nosebleeds	0	1	2	3
5	Is your blood pressure high?	no			yes (10)
6	Swollen extremities	0	1	2	3

Part 5 Section A

1	Dizziness when standing suddenly	0	1	2	3
2	Fainting	0	1	2	3
3	Crave sweets	0	1	2	3
4	Headache relieved by consumption of sweets	0	1	2	3
5	Feel shaky or jittery	0	1	2	3
6	Irritable, tired or weak if meal is missed	0	1	2	3
7	Wake up in middle of night craving sweets	0	1	2	3
8	Impatient, moody, nervous	0	1	2	3
9	Feel tired 1-3 hours after eating	0	1	2	3
10	Calmer after eating	no			yes (3)

Part 5 Section B

1	Night sweats (not menopausal hot flashes)	0	1	2	3
2	Lowered resistance to infection	0	1	2	3
3	Fatigue (chronic)	0	1	2	3
4	Deteriorating eyesight	0	1	2	3
5	Lesions and cuts take a long time to heal	0	1	2	3
6	Weight gain or inability to lose weight	0	1	2	3
7	Numbness in extremities	no			yes (5)
8	Family history of diabetes	no			yes (5)
9	Crave sweets, eating sweets does not help	no			yes (3)

Part 6

1	Chest pain	0	1	2	3
2	Chronic cough	0	1	2	3
3	Difficulty breathing	0	1	2	3
4	Coughing up blood	0	1	2	3
5	Coughing up phlegm	0	1	2	3
6	Pain around ribs	0	1	2	3
7	Shortness of breath	0	1	2	3
8	Rattling mucous when you breath	0	1	2	3
9	Infections settle in lungs	0	1	2	3
10	Bronchitis	no			yes (10)
11	Exposed to chemicals and radiation	no			yes (6)
12	Asthma	no			yes (6)

Part 7

1	Frequent urination	0	1	2	3
2	Frequent bladder infections	0	1	2	3
3	Urination when you cough or sneeze	0	1	2	3
4	Painful/burning when you pass urine	0	1	2	3
5	Difficulty passing urine	0	1	2	3
6	Dripping after urination	0	1	2	3
7	Can't hold urine	0	1	2	3
8	Rose coloured (bloody) urine	0	1	2	3
9	Cloudy urine	0	1	2	3
10	Strong smelling urine	0	1	2	3
11	Back or leg pains with dripping after urination	0	1	2	3
12	Back pain in kidney area	0	1	2	3
13	General water retention	0	1	2	3
14	History of kidney or bladder infections	no			yes (3)
15	Often used antibiotics to control urinary infection	no			yes (3)
16	Increased thirst	0	1	2	3

Part 8 Section A (Males only)

1	Difficulty urinating	0	1	2	3
2	A sense of bladder fullness	0	1	2	3
3	Weak urinary flow	0	1	2	3
4	Blood in semen	0	1	2	3
5	Pain or burning when urinating	0	1	2	3
6	Wake up to urinate at night	0	1	2	3
7	Dripping after urination	0	1	2	3
8	Urinary tract infections	0	1	2	3
9	Ejaculation causes pain	0	1	2	3

Part 8 Section B (Males only)

1	Difficult attaining and/or maintaining erection	0	1	2	3
2	Low sexual drive	0	1	2	3
3	Premature ejaculation	0	1	2	3
4	Pain/coldness in genital area	0	1	2	3
5	Infertile	no			yes (5)
6	Varicose veins on scrotum	no			yes (3)
7	Low sperm count	no			yes (5)

Part 9 Section A (Females only)

1	Abnormal flow (too heavy or light or irregular)	0	1	2	3
2	Depression	0	1	2	3
3	Moodiness/irritability	0	1	2	3
4	Bloating and swelling	0	1	2	3
5	Cramps	0	1	2	3
6	Headaches (second half of cycle)	0	1	2	3
7	Anger (second half of cycle)	0	1	2	3
8	Tender breasts	0	1	2	3

Part 9 Section B (Females only)

1	Low abdominal pain	0	1	2	3
2	Dull ache radiating to low back or legs	0	1	2	3
3	Increased urinary frequency	0	1	2	3
4	Pelvic soreness	0	1	2	3
5	Abdominal bloating	0	1	2	3
6	Menstrual pain	0	1	2	3
7	Have to lie down on first 1 or 2 days of period	0	1	2	3
8	Light, scanty blood flow	0	1	2	3
9	Pain and cramps without blood flow	0	1	2	3
10	Heavy menstrual bleeding	0	1	2	3
11	Anxiety about menstrual cycle	0	1	2	3
12	Pain during period gets worse with time	0	1	2	3

Part 9 Section C (Females only)

1	Hot flashes	0	1	2	3
2	Night sweats	0	1	2	3
3	Depression/mood swings	0	1	2	3
4	Insomnia	0	1	2	3
5	Heavy bleeding 2 weeks out of the month	0	1	2	3
6	Sweating throughout the day	0	1	2	3
7	Dryness of skin, hair and vagina	0	1	2	3
8	Painful intercourse	0	1	2	3
9	Vaginal pain/dryness	0	1	2	3
10	Osteoporosis (bone loss)	no			yes (5)
11	Total hysterectomy	no			yes (5)

Part 10 Section A

1	Pain in fingers	0	1	2	3
2	Bones sore/painful	0	1	2	3
3	Arthritis	0	1	2	3
4	Bone loss	no			yes (3)
5	Calcium deposits	no			yes (3)
6	Bone deformity	no			yes (5)
7	You have osteoporosis/ osteomalacia?	no			yes (5)
8	Recent bone fracture	no			yes (3)
9	Long-term steroid use	no			yes (3)
10	Loss of mobility	0	1	2	3

Part 10 Section B

1	Muscle spasm	0	1	2	3
2	Tightness in shoulder muscles	0	1	2	3
3	Muscle cramps	0	1	2	3
4	Pain in arms, hands	0	1	2	3
5	Leg cramps at night	0	1	2	3
6	Stiff all over	0	1	2	3
7	Stiff in morning	0	1	2	3
8	Unable to sit straight	0	1	2	3
9	Pain in neck and/or shoulders	0	1	2	3
10	Back pain	0	1	2	3
11	Atrophy	0	1	2	3

Part 10 Section C

1	Over-flexible joints (double jointed)	0	1	2	3
2	Tennis elbow	0	1	2	3
3	Swollen knees/elbows	0	1	2	3
4	Rheumatoid arthritis	0	1	2	3
5	Bursitis	0	1	2	3
6	Tendonitis	0	1	2	3
7	Joint pain	0	1	2	3
8	Slipped disk	0	1	2	3
9	Herniated disk	no			yes (5)
10	Injure easily	no			yes (3)

Part 11

1	Head feels heavy	0	1	2	3
2	Light headedness/fainting	0	1	2	3
3	Loss of balance	0	1	2	3
4	Dizziness	0	1	2	3
5	Ringing/buzzing in the ears	0	1	2	3
6	Trembling hands	0	1	2	3
7	Loss of feeling in hands and/or feet (toes)	0	1	2	3
8	Exhaustion on slightest effort	0	1	2	3
9	Limbs feel heavy to hold up	0	1	2	3
10	Loss of grip strength	0	1	2	3
11	Tingling pain sensation	0	1	2	3
12	Un-coordination	0	1	2	3
13	Nervousness	0	1	2	3
14	Convulsions	no			yes (10)
15	Loss of muscle tone	no			yes (3)
16	Have you had shingles?	no			yes (3)

Part 12 — Sleep Patterns

1	Nightmares	0	1	2	3
2	Can't fall asleep	0	1	2	3
3	Intense dreams	0	1	2	3
4	Restless leg at night	0	1	2	3
5	Restless, uneasy sleeper	0	1	2	3
6	Awake frequently throughout the night	no			yes (5)
7	Wake up in the night, can't fall back to sleep	no			yes (5)
8	Sleepwalk	no			yes (10)

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Signature:

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