EMPOWERING BETTER HEALTH
via the alchemy of life

General Questions

Please answer the following questions in as much detail as possible. Please think through all of the details and nuisances of your life's events as this will become meaningful and imperative to your overall health plan.

1. Describe your main complaint?
2. What other issues or complaints / feelings do you have in your body?
3. What mental sufferings / feelings do you have associated with your physical sufferings?
4. What exactly do you feel when you are at your worst?
5. When did these complaints start? Can you connect your issues / complaints with a specific event, trauma or disease?
6. What time of the day are you at your worst?
7. What are the things which aggravate or make your complaint better?
8. Do you think your complaint has a correlation to any external stimuli (e.g. change of place, weather, music, food, etc.)? Do you think it has anything to do with an internal biological change in your body (e.g. Anniversary of a traumatic event, female menstrual cycle, etc.)?
9. Do you feel better during hot or cold weather? Humid or dry weather? Sunny or cloudy?
10. Describe your general demeanor. Are you Moody, Arrogant, Mild, Agreeable, Changeable, Nervous, Suspicious, Easily offended, Quiet, Arguing, Irritating, Lazy, etc.
11. How do you feel before and/or during a thunderstorm?
12. Do you like being consoled during your tough times or do you prefer being left alone?
13. Are you sensitive to external stimuli like smell, noise, light, etc? If yes, what is the reaction to these external stimuli?
14. Do you have any habits or gestures (e.g. nail biting, unprovoked weeping, talking to yourself, etc.)? If yes, what are those habits or gestures?
15. How do you feel about your friends, family, your children and especially your spouse or significant other?
16. What are your fears?
17. Do you have recurring dreams? If so, what are those dreams (please provide as much detail as possible.
18. What are your food cravings?
19. What are your food aversions?

20. Please rate your thirst level on a day to day basis: Less, Normal or Excessive?
21. Please rate your current appetite: Less, Normal or Excessive?
22. Are there any types of food which your body can't tolerate? If so, please describe which types of foods you can't tolerate and what the symptoms are that you experience.
23. Please rate your sweat level: Less than normal, Normal, More than normal. Where do you sweat more: Head, Torso, Limbs?
24. How is your bowel movement and stool type? Any tendency to diarrhea or constipation?

    a. How many times a day do you have a bowel movement?
    b. Do you have a bowel movement at the same time each day or does it occur at varying times of the day?
    c. What color is your stool?
    d. What is the consistency of your stool on a regular basis? Hard, soft or loose like wet pudding?
    e. Are you ever constipated? If so how often does this occur?
    f. Do you ever have diarrhea or constipation? If so how often does this occur? Can you provide details that would help support why you may have diarrhea (does it occur after you eat a specific food, take certain medicines, experience certain events, etc.)
    g. Do you have hemorrhoids?

25. How well do you sleep? Do you have a particular posture when sleeping such as on one side, back, stomach, etc.?
26. Do you think you are able to satisfy your sexual desires in general?
27. How do you think you are different from others, if at all?
28. Please provide a list of all medications are you currently taking? Do you have any particular symptoms that arise after you take the medication?
29. Please list all diseases or conditions that run in your family?
30. Describe your overall appearance (e.g. short, tall, overweight, toned, healthy or ruddy complexion (skin tone), poor posture, etc.).

Women ONLY

1. Based on the chart below, are you or do you perceive that you are in any state of menopause?
2. Please give details of your current / past menstruation
3. Are your periods early, regular or late?
4. How long do your periods last?
5. Do you suffer from any kind of physical or mental discomfort before, during or after your periods?
6. Is your flow scanty, normal or excessive?
7. Is the blood thick, bright red, dark brown or pale & watery?
8. Do you notice any clots in your flow?

Stages	**Reproductive**			**Menopausal Transition**		**Postmenopause**		
	Early	Peak	Late	Early	Late	Early		Late
				Perimenopause				
Duration of stage	variable			variable		1 year	4 years	until death
Mentrual cycles	regular to variable	regular		variable cycle length (more than 7 days different than normal)	more than 2 skipped cycles and 260 consecutive days without a period	first full year of no mentrual periods	none	
FSH levels	normal		rising	rising		consistently above 40		