PERSONAL HISTORY

Date: ____ / ____ / ____ E-mail:_____

Name: _____ Street Address: _____

City: _____ State: _____ Zip:_____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Birth Date: ____/____/____ Sex: _____ Height: _____ Weight: _____

Your Employer: _____ Type of Work: _____

Name & Phone # of Person to Contact in Case of Emergency: _____

Circle If You Are: Married Single Widowed Divorced Separated

Name of Spouse: _____ Birth Date: _____

Spouse's Employer: _____ Phone #: _____

Parent/Guardian of Patient (if under age 18)_____

Person Responsible for Your Bill: ( ) Self ( ) Spouse ( ) Employer ( ) Insurance

( ) Other - name:_____ birthdate: ____ / ____ / ____

Type of Insurance Coverage:
( ) Workman's Compensation ( ) Auto. Insurance Policy
( ) Medicare ( ) 3rd Party Auto. Insurance
( ) Personal Policy ( ) Group Policy
( ) Medicaid/HIP ( ) PPO/HMO _____

Name of Insurance Company: _____

How did you hear about our office/Who referred you to us? _____

FAMILY HEALTH HISTORY

RELATION	NAME	AGE	PRESENT SYMPTOMS	PREVIOUS SERIOUS ILLNESSES
Father				
Mother				
Siblings				
Children				

PAST HEALTH HISTORY

PLEASE CHECK APPLICABLE ITEMS – (*indicate date of surgery*).

OPERATIONS:

Appendectomy _____ Cardiovascular/Heart _____ Female Organs _____

Gall Bladder _____ Hernia _____ Rectal _____

Spinal _____ Tonsillectomy _____ Others _____

_____

ACCIDENTS OR FALLS: (Please describe) _____

_____

FRACTURES OR DISLOCATIONS: _____

_____

HABITS: Exercise (what type/how often?) _____ Hobbies _____ Sleep (hours)_____

Tobacco (How much?) _____ Alcohol___drinks per ( )day ( )week ( )month

Coffee (avg. # of cups/day) regular____ decaf.____ Tea (avg. # of cups/day) regular____ herbal___

Soft Drinks (avg. # of 12 oz. cans per day) ( )regular____ ( )diet____ ( )caf. free_____

Water (8 oz. glasses/day) _____ city____ well____ distilled____ spring____ filtered____

List the names of any drugs you are taking and the reason why you take them (Rx or non-Rx):

Name of Drug	*Reason you take it*	*Name of Drug*	*Reason you take it*
1.		4.	
2.		5.	
3.		6.	

List all vitamins, minerals and herbs you take_____

_____

CIRCLE Any of the Following Diseases You Have Had:

ADD / ADHD	Eczema	Impotency	Thyroid Condition
Alcoholism	Emphysema	Infertility	Tourette's Syndrome
Alzheimer's	Endometriosis	Multiple Sclerosis	Trigeminal Neuralgia
Anemia	Epilepsy	Muscular Dystrophy	Tuberculosis
Arthritis	Fibromyalgia	Osteoporosis	Ulcers
Bell's Palsy	Glaucoma	Parkinson's Disease	Venereal Infection
Cancer	Goiter	Parasites	Chronic Fatigue
Candida	Heart Disease	Pleurisy	Hepatitis
Crohn's Disease	Herpes	Pneumonia	Phlebitis
Diabetes	Hodgkin's Disease	Stroke	Other

Underline All of the Symptoms You Have Had Previously

Circle All of the Symptoms You Have Now

GENERAL SYMPTOMS
Chills
Convulsions
Dizziness
Fainting
Fatigue
Fever
Hair Loss
Headache
Hernia
Loss of Sleep
Nervousness
Neuralgia / Nerve Pain
Numbness in arms, hands, or legs
Pain in arms, hands, or legs
Sweats
Tremors
Weak Fingernails
Weight Gain
Weight Loss

E.E.N.T.
Allergies
Asthma
Cataracts
Deafness
Dental Decay/Painful Teeth
Ear Discharge
Ear Noises/Ringing
Earache
Enlarged Glands
Enlarged Thyroid
Eye Pain
Failing Vision
Far Sightedness
Frequent Colds
Gum Trouble
Hay Fever
Hoarseness
Macular Degeneration
Nasal Drainage
Nasal Obstruction
Near Sightedness
Nose Bleeds
Sinus Infection
Sore Throat
Tonsillitis

SKIN
Acne
Boils
Bruise Easily
Cysts
Dryness
Hives
Itching
Sensitive Skin
Skin Eruptions
Varicose Veins

RESPIRATORY
Chest Pain
Chronic Cough
Difficult Breathing
Spitting Up Blood
Spitting Up Phlegm
Wheezing

CARDIO-VASCULAR
Cold Hands or Feet
Hardening of Arteries
High Blood Pressure
High Cholesterol
Low Blood Pressure
Pain Over Heart
Paralytic Stroke
Poor Circulation
Rapid Beating Heart
Slow Beating Heart
Swelling of Ankles

MUSCLE & JOINT
Backache
Carpal Tunnel Syndrome
Faulty Posture
Muscle Tightness/Spasm
Pain Between Shoulders
Painful Ankle
Painful Elbow
Painful Foot
Painful Hand
Painful Head
Painful Hip
Painful Knee
Painful Shoulder
Painful Tail Bone
Painful Wrist
Spinal Curvature/Scoliosis

GASTROINTESTINAL
Belching or Gas
Colitis
Colon Trouble
Constipation
Diarrhea
Difficult Digestion
Distention of Abdomen
Excessive Hunger
Gall Bladder Trouble
Hemorrhoids
Intestinal Worms
Jaundice
Liver Trouble
Nausea
Painful Bowel Movements
Pain Over Stomach
Poor Appetite
Vomiting
Vomiting of Blood

GENITOURINARY
Bed Wetting
Frequent Urination
Frequent Kidney or Bladder Infections
Inability to Control Urine
Kidney Stones
Painful Urination
Prostate Trouble
Pus/Blood in Urine

For Women Only
Cramps or Backache
Excessive Flow
Hot Flashes
Irregular Cycle
Lumps in Breast
Menopausal Symptoms
Painful Menstrual Periods
Previous Miscarriage
Vaginal Discharge

Are you Pregnant?
( ) Yes ( ) No
Do you think you might be Pregnant?
( ) Yes ( ) No

Patient's Signature:_____ Date: _____

Instructions for filling out the Symptom Survey form

Read all symptoms for group one through seven and the male or female section as it applies to you. The boxes next to the symptom will either be *filled in or left blank* depending on your response.

- For mild symptoms (1 to 2 times a month), put a 1 in that box.
- For moderate symptoms (the symptom occurs several times a month), put a 2 in the box.
- For severe symptoms (you are aware of the symptom almost constantly), put a 3 in that box.
- Leave blank those boxes in which the symptoms mentioned do not occur with you.

Finally, fill in your 5 main complaints in order of importance (1st complaint the one most bothering or concerning you) and you are done. Please bring in the form with your appointment. Each group represents a different system of the body. A lot of important information is gathered from the symptom survey. We will print out a computer summary to assist the Doctor with your condition. Thank you for taking an active interest in your health!

Dr. Jim Ruckel

Systems Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

List your 5 main health complaints in the order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Weight: _____ ❑ Vegetarian ❑ Vegan

Height: _____ ❑ Gluten-free ❑ Dairy-free

Organs Removed:

❑ Gallbladder ❑ Thyroid ❑ Colon ❑ Spleen
❑ Uterus ❑ Ovaries ❑ Breast ❑ Prostate
❑ Tonsils ❑ Appendix ❑ Other: _____

Circle the appropriate number that applies on all questions below. 0 is the least/never to 3 as the most/always

Group 1

1. Acid foods upset 0 1 2 3
2. Get the chills often 0 1 2 3
3. "Lump" in throat 0 1 2 3
4. Dry mouth, eyes, or nose 0 1 2 3
5. Pulse increases after a meal 0 1 2 3
6. Keyed up, difficult to calm down 0 1 2 3
7. Cuts or scratches heal slowly 0 1 2 3
8. Gag easily 0 1 2 3
9. Unable to relax; startle easily 0 1 2 3
10. Clammy or cold hands/feet 0 1 2 3
11. Irritated by strong light 0 1 2 3
12. Urine amount reduced 0 1 2 3
13. Heart pounds after retiring 0 1 2 3
14. "Nervous" stomach 0 1 2 3
15. Forgets to eat meals 0 1 2 3
16. Cold sweats 0 1 2 3
17. Temperature raises easily, fevers 0 1 2 3
18. Skin sensitive or painful if touched 0 1 2 3
19. Eyes lock in fixed stare (few seconds) 0 1 2 3
20. Queasy or sour stomach 0 1 2 3

Group 2

21. Joint stiffness on arising 0 1 2 3
22. Muscle, leg, or toe cramps at night 0 1 2 3
23. "Butterfly" stomach, cramps 0 1 2 3
24. Eyes or nose watery 0 1 2 3
25. Eyes blink rapidly 0 1 2 3
26. Eyelids swollen or puffy 0 1 2 3
27. Indigestion soon after meals 0 1 2 3
28. Always feel hungry; "lightheaded" often 0 1 2 3
29. Digestion is rapid 0 1 2 3
30. Occasional nausea or vomiting 0 1 2 3
31. Voice gets hoarse or raspy 0 1 2 3
32. Slow or Irregular breathing pattern 0 1 2 3
33. Pulse skips or feels "irregular" 0 1 2 3
34. Excessive saliva production 0 1 2 3
35. Difficulty swallowing food or pills 0 1 2 3
36. Alternating constipation & diarrhea 0 1 2 3
37. Slow starter in the morning 0 1 2 3
38. Ears get hot or red 0 1 2 3
39. Sweat easily 0 1 2 3
40. Feel cold – hands, feet, all over 0 1 2 3
41. Colds or respiratory infections 0 1 2 3

Group 3

42. Eat when nervous or anxious 0 1 2 3
43. Excessive appetite 0 1 2 3
44. Hungry between meals 0 1 2 3
45. Irritated before meals (hangry) 0 1 2 3
46. Get "shaky" or "jittery" if hungry 0 1 2 3
47. Fatigue after meals (food coma) 0 1 2 3
48. "Lightheaded" if meals delayed 0 1 2 3
49. Can feel heart beat, palpitates 0 1 2 3
50. Afternoon Headaches 0 1 2 3
51. Bloating after eating fiber, starch, sugar 0 1 2 3
52. Insomnia: Cannot stay asleep 0 1 2 3
53. Crave candy or coffee during the day 0 1 2 3
54. Depression, lack of motivation 0 1 2 3
55. Crave sweets or snacks during the day 0 1 2 3

Group 4

56. Hands or feet go to sleep, numbness 0 1 2 3
57. Sigh frequently, "Air hunger" 0 1 2 3
58. Aware of "breathing heavily" 0 1 2 3
59. High-Altitude discomfort 0 1 2 3
60. Feel must open windows in closed rooms 0 1 2 3
61. Easily gets colds or fevers 0 1 2 3
62. Afternoon "yawner" 0 1 2 3
63. Feel "drowsy" 0 1 2 3
64. Ankle or wrist swelling, fluid retention 0 1 2 3
65. Muscle cramps 0 1 2 3
66. Shallow, rapid breathing 0 1 2 3
67. Chest tightness, pressure or pain 0 1 2 3
68. Bruise easily, "black and blue" spots 0 1 2 3
69. Tendency to Anemia 0 1 2 3
70. "Nose bleeds" 0 1 2 3
71. Noises in head, or "ringing in ears" 0 1 2 3
72. Shortness of breath upon exertion 0 1 2 3

Group 5

73. Dizziness 0 1 2 3
74. Dry or flaky skin (scalp, feet, anywhere) 0 1 2 3
75. Burning or itching feet 0 1 2 3
76. Blurred vision 0 1 2 3
77. Unexplained itching skin or rash anywhere 0 1 2 3
78. Excessive falling hair 0 1 2 3
79. Reddened skin, especially palms or feet 0 1 2 3
80. Bitter or metallic taste in mouth in mornings 0 1 2 3
81. Bowel movements painful or difficult 0 1 2 3
82. Worrier, feel insecure 0 1 2 3
83. Tightness/headache over eyes 0 1 2 3
84. Greasy or high-fat foods cause distress 0 1 2 3
85. Stool color is pale, white or light colored 0 1 2 3
86. Perfume/fragrance sensitivity 0 1 2 3
87. Muscle tightness between shoulder blades 0 1 2 3
88. Occasional constipation 0 1 2 3
89. Stools alternate from soft to watery 0 1 2 3
90. History of gallbladder spasms or stones 0 1 2 3
91. Sneezing attacks 0 1 2 3
92. Nightmare-type dreams or terrors 0 1 2 3
93. Bad breath (halitosis) 0 1 2 3
94. Dairy, Milk products cause distress or lactose intolerant 0 1 2 3
95. Sensitive to hot weather 0 1 2 3
96. Itching or burning anus 0 1 2 3
97. Sweet and sour cravings 0 1 2 3

Group 6

98. Loss of interest to eat meat 0 1 2 3
99. Use antacids 0 1 2 3
100. Burning stomach relieved by eating 0 1 2 3
101. White coating on tongue 0 1 2 3
102. Pass large amounts of foul-smelling gas 0 1 2 3
103. Bloating lasts hours after eating 0 1 2 3
104. Unpredictable urgency to defecate 0 1 2 3
105. Pass large amounts of gas: No odor 0 1 2 3
106. Heartburn when lying down 0 1 2 3

Symptoms listed on this form are not intended to be used as a diagnosis of any disease or condition.

Group 7A

107. Insomnia: Hard to fall asleep 0 1 2 3
108. Nervousness, feel on edge 0 1 2 3
109. Difficult to gain weight 0 1 2 3
110. Intolerance to heat 0 1 2 3
111. Highly emotional 0 1 2 3
112. Face or skin flushes easily 0 1 2 3
113. Night sweats 0 1 2 3
114. Thin, moist skin 0 1 2 3
115. Inward trembling 0 1 2 3
116. Can hear heartbeat on pillow 0 1 2 3
117. Increased appetite but can't gain weight 0 1 2 3
118. Increased or rapid pulse at rest 0 1 2 3
119. Eyelids or face twitch 0 1 2 3
120. Irritable and restless 0 1 2 3
121. Difficulty working under pressure 0 1 2 3

Group 7B

122. Increase in weight 0 1 2 3
123. Decrease in appetite 0 1 2 3
124. Fatigue easily 0 1 2 3
125. Ringing in ears (Pitch: ❑ High ❑Low) 0 1 2 3
126. Sleepy during day 0 1 2 3
127. Sensitive to cold 0 1 2 3
128. Dry or scaly skin 0 1 2 3
129. Use laxatives 0 1 2 3
130. Mental sluggishness 0 1 2 3
131. Hair coarse or falling out 0 1 2 3
132. Headaches in mornings, wear off during the day 0 1 2 3
133. Slow pulse, below 65 0 1 2 3
134. Frequent urination 0 1 2 3
135. Impaired or loss of hearing 0 1 2 3
136. Reduced initiative or motivation 0 1 2 3

Group 7C

137. Failing memory 0 1 2 3
138. Low blood pressure 0 1 2 3
139. Increased sex drive 0 1 2 3
140. "Splitting or rending" headache near the temple 0 1 2 3
141. Cannot handle sugar well 0 1 2 3

Group 7D

142. Thirsty all the time 0 1 2 3
143. Bloating of abdomen 0 1 2 3
144. Weight gain around hips or waist 0 1 2 3
145. Sex drive reduced or lacking 0 1 2 3
146. Tendency to ulcers, colitis 0 1 2 3
147. Can eat and burn sugar easily 0 1 2 3
148. Increased urine output 0 1 2 3
149. Sexual dysfunction 0 1 2 3

Group 7E

150. Feel off balance, vertigo 0 1 2 3
151. Headaches that go away with caffeine 0 1 2 3
152. Hot flashes 0 1 2 3
153. Increased blood pressure 0 1 2 3
154. Thinning skin on arms or hands 0 1 2 3
155. Urine smells sweet or fruity 0 1 2 3
156. Over aggressive tendencies 0 1 2 3

Group 7F

157. Dizzy after standing up quickly 0 1 2 3
158. Chronic fatigue 0 1 2 3
159. Headaches w/ exertion, stress 0 1 2 3
160. Weak nails or have ridges 0 1 2 3
161. Tendency to hives 0 1 2 3
162. Joint pain and stiffness 0 1 2 3
163. Perspiration increase 0 1 2 3
164. Bowel inflammation 0 1 2 3
165. Poor circulation 0 1 2 3
166. Swelling of ankles (❑ Left ❑ Right) 0 1 2 3
167. Crave salt 0 1 2 3
168. Brown spots or bronzing of skin 0 1 2 3
169. Allergies 0 1 2 3
170. Weakness after colds, influenza 0 1 2 3
171. Exhaustion - muscular and nervous 0 1 2 3
172. Respiratory or breathing challenges 0 1 2 3

Group 8 | B Complex

173. Muscle weakness 0 1 2 3
174. Lack of Stamina 0 1 2 3
175. Drowsiness after eating 0 1 2 3
176. Muscular soreness 0 1 2 3
177. Rapid heart beat 0 1 2 3
178. Hyper-irritable 0 1 2 3
179. Feeling of a band around the head 0 1 2 3
180. Melancholia (feeling of sadness) 0 1 2 3
181. Difficult to concentrate 0 1 2 3
182. Diminished urination 0 1 2 3
183. Tendency to consume sweets or carbohydrates 0 1 2 3

Group 8 | G Complex

184. Muscle spasms, twitches 0 1 2 3
185. Anxiety 0 1 2 3
186. Loss of muscular control 0 1 2 3
187. Numbness 0 1 2 3
188. Night sweats 0 1 2 3
189. Rapid digestion 0 1 2 3
190. Sensitivity to noise 0 1 2 3
191. Cracking of skin, hands or bottom of feet 0 1 2 3
192. Visible veins on chest and abdomen 0 1 2 3
193. Hemorrhoids or spider veins 0 1 2 3
194. Apprehension (feeling that something bad will happen) 0 1 2 3
195. Nervousness causing loss of appetite 0 1 2 3
196. Nervousness with indigestion 0 1 2 3
197. Gastritis 0 1 2 3
198. Forgetfulness 0 1 2 3
199. Thinning hair 0 1 2 3

FEMALE ONLY

200. Very easily fatigued 0 1 2 3
201. Premenstrual tension 0 1 2 3
202. Painful menses or ovulation 0 1 2 3
203. Depressed feelings before menstruation 0 1 2 3
204. Menstruation excessive and prolonged 0 1 2 3
205. Painful breasts 0 1 2 3
206. Menstruate too frequently 0 1 2 3
207. Vaginal discharge 0 1 2 3
208. Hair growth on face (upper lip, chin) areola, abdomen 0 1 2 3
209. Hot flashes 0 1 2 3
210. Menses scanty or missed 0 1 2 3
211. Acne, worse at menses 0 1 2 3
212. Raised bumps on skin of arm 0 1 2 3

MALE ONLY

213. Prostate challenges 0 1 2 3
214. Urination difficult or dribbling 0 1 2 3
215. Frequent night urination 0 1 2 3
216. Depression, melancholy 0 1 2 3
217. Pain on inside of legs or heels 0 1 2 3
218. Feeling of incomplete bowel evacuation 0 1 2 3
219. Lack of energy 0 1 2 3
220. Migrating aches or pain 0 1 2 3
221. Tire too easily 0 1 2 3
222. Avoid social activity 0 1 2 3
223. Restless legs at night 0 1 2 3
224. Diminished sex drive 0 1 2 3

OFFICE USE ONLY

❑ Food Diary
❑ Tongue
❑ Fingernails

Zinc Test Results: _____

Postural Hypotension:

Recumbent: _____/_____ Pulse: ____

Standing: _____/_____ Pulse: ____

SpO_2: _____%

Calcium Cuff Test:

Before: _____ After: _____

The Nutritional Exam:

❑ HCL ❑ Ascending
❑ Enzyme ❑ Transverse
❑ Murphy's Sign ❑ Descending

Notes:

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