

## General Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Married Single Partner Divorced Widowed Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Referred By \_\_\_\_\_

Family Physician \_\_\_\_\_ Contact # \_\_\_\_\_

Have you had Acupuncture or Oriental medicine before? Yes No

Are you presently under a doctor's care? Yes No Who and for what? \_\_\_\_\_

Are there any other therapies which you are involved in? Who and for what? \_\_\_\_\_

## FOCUS

What is your primary reason for seeking care at our office? \_\_\_\_\_

What was the initial cause? \_\_\_\_\_

When did it begin? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

How does this problem interfere with your daily activities?

<input type="checkbox"/> Work	<input type="checkbox"/> Standing	<input type="checkbox"/> Sexually	<input type="checkbox"/> Other
<input type="checkbox"/> Sleep	<input type="checkbox"/> Emotional	<input type="checkbox"/> Recreation	_____
<input type="checkbox"/> Walking	<input type="checkbox"/> Relationships	<input type="checkbox"/> Bending	_____
<input type="checkbox"/> Sitting	<input type="checkbox"/> Social Life	<input type="checkbox"/> Stretching	_____

What have you done about this? \_\_\_\_\_

Do you sleep well? Yes No Do you dream? Yes No

Do you have a high point during the day? Yes No When? \_\_\_\_\_ Do you have a low point during the day? Yes No When? \_\_\_\_\_

What are your indulgences? \_\_\_\_\_

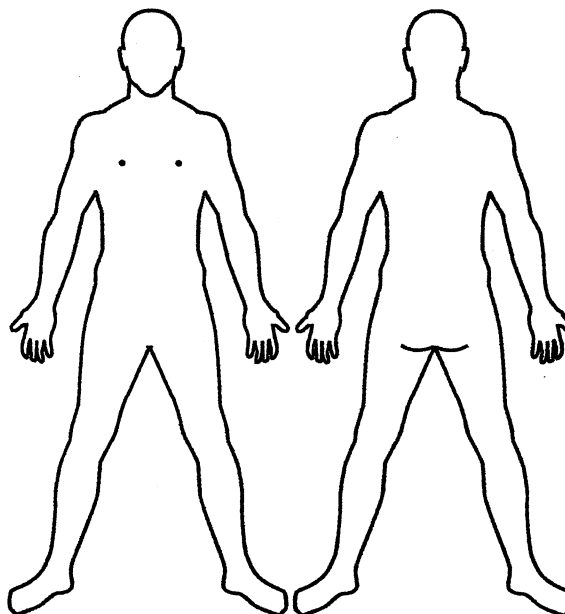
What are your hobbies/pleasures? \_\_\_\_\_

## Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

	No pain	Moderate pain	Severe pain	Terrible pain
<b>Sleeping</b>	No problem	Mildly disturbed	Greatly disturbed	Cannot sleep
<b>Work - Can do:</b>	Usual work	25% of work	50% of Work	No work
<b>Frequency of pain</b>	25% of time	50% of time	75% of time	100% of time
<b>Travel</b>	No problem on long trips	Moderate pain on trips	Severe pain	
<b>Recreation - Can do:</b>	All activities	Some activities	No activities	
<b>Walking</b>	Can walk any distance	Pain after 1/2 mile	Cannot walk	
<b>Sitting</b>	No pain sitting	Some pain while sitting	Cannot sit	



List any past or future surgeries. \_\_\_\_\_

List any significant trauma. When did it occur? (auto accident, falls, emotional, sexual, etc...) \_\_\_\_\_

List exercise and sport activities you have been or are currently involved in: \_\_\_\_\_

### Signs/Symptoms

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="radio"/> Abdominal pain/distention | <input type="radio"/> Coughing blood            | <input type="radio"/> Hemorrhoids             | <input type="radio"/> Mucous in stools      | <input type="radio"/> Seizures              |
| <input type="radio"/> Abuse survivor            | <input type="radio"/> Dark stools               | <input type="radio"/> Heart palpitations      | <input type="radio"/> Muscle cramps/pain    | <input type="radio"/> Seeing a therapist    |
| <input type="radio"/> Acid regurgitation        | <input type="radio"/> Decreased libido          | <input type="radio"/> Hiccup                  | <input type="radio"/> Nasal congestion      | <input type="radio"/> Short temper          |
| <input type="radio"/> Acne                      | <input type="radio"/> Depression                | <input type="radio"/> High blood pressure     | <input type="radio"/> Neck/shoulder pain    | <input type="radio"/> Shortness of breath   |
| <input type="radio"/> Asthma                    | <input type="radio"/> Dizziness/vertigo         | <input type="radio"/> Impotence               | <input type="radio"/> Night sweat           | <input type="radio"/> Sinus pressure        |
| <input type="radio"/> Bad breath                | <input type="radio"/> Dry throat/mouth          | <input type="radio"/> Increased libido        | <input type="radio"/> Nocturnal emission    | <input type="radio"/> Skin fungal infection |
| <input type="radio"/> Blood in stools           | <input type="radio"/> Diarrhea                  | <input type="radio"/> Indigestion             | <input type="radio"/> Nose bleeds           | <input type="radio"/> Spots in eyes         |
| <input type="radio"/> Blood in urine            | <input type="radio"/> Ear aches                 | <input type="radio"/> Intestinal pain/cramps  | <input type="radio"/> Numbness              | <input type="radio"/> Sweat easily          |
| <input type="radio"/> Blurry vision             | <input type="radio"/> Enlarged thyroid          | <input type="radio"/> Irritable               | <input type="radio"/> Odorous stools        | <input type="radio"/> Sore throat           |
| <input type="radio"/> Breast lump/pain          | <input type="radio"/> Eye pain/strain/tension   | <input type="radio"/> Itchy eyes              | <input type="radio"/> Pain upon urination   | <input type="radio"/> Sudden energy drop    |
| <input type="radio"/> Bruise easily             | <input type="radio"/> Excessive phlegm Color of | <input type="radio"/> Itchy skin              | <input type="radio"/> Peculiar tastes       | <input type="radio"/> Swollen glands        |
| <input type="radio"/> Chest pains               | <input type="radio"/> Excessive saliva          | <input type="radio"/> Joint pain              | <input type="radio"/> Poor appetite         | <input type="radio"/> Teeth/gum problems    |
| <input type="radio"/> Chills                    | <input type="radio"/> Fatigue                   | <input type="radio"/> Kidney stones           | <input type="radio"/> Poor circulation      | <input type="radio"/> Ulcerations           |
| <input type="radio"/> Cold hands/feet           | <input type="radio"/> Fever                     | <input type="radio"/> Laxative use            | <input type="radio"/> Poor memory           | <input type="radio"/> Upper back pain       |
| <input type="radio"/> Concussion                | <input type="radio"/> Frequent urination        | <input type="radio"/> Limited range of motion | <input type="radio"/> Poor sleep            | <input type="radio"/> Urgent urination      |
| <input type="radio"/> Confusion                 | <input type="radio"/> Gas/belching              | <input type="radio"/> Loss of hair            | <input type="radio"/> Premature ejaculation | <input type="radio"/> Vomiting              |
| <input type="radio"/> Constipation              | <input type="radio"/> Grinding teeth            | <input type="radio"/> Low back pain           | <input type="radio"/> Psoriasis             | <input type="radio"/> Wake to urinate       |
| <input type="radio"/> Cough                     | <input type="radio"/> Headache                  | <input type="radio"/> Migraine                | <input type="radio"/> Rash                  | <input type="radio"/> Weight loss/gain      |
|   |   | <input type="radio"/> Mouth sores             | <input type="radio"/> Redness of eyes       | <input type="radio"/> Wheezing              |

### Female Concerns

Date of last menstruation \_\_\_\_\_ Is your cycle regular? Yes No Is your cycle painful? Yes No  
Have you ever been pregnant? Yes No Birth control? Yes No How long? \_\_\_\_\_  
 PMS  Clotting  Vaginal sores  Vaginal pain  Discharge

### Medical History

Do you have any allergies? Yes No If so, to what? \_\_\_\_\_  
Do you take medication? Yes No If so what types and how often \_\_\_\_\_  
Do you take supplements? Yes No If so what types and how often \_\_\_\_\_

- Please indicate if you or any family members have or had any of the following conditions:
- |                                    |   |  |   |  |
|------------------------------------|---|--|---|--|
| <input type="radio"/> Pneumonia    | <input type="radio"/> Drug reaction     | <input type="radio"/> Mental breakdown | <input type="radio"/> Gonorrhea/Herpes        | <input type="radio"/> Cancer             |
| <input type="radio"/> Tuberculosis | <input type="radio"/> Heart attack      | <input type="radio"/> Jaundice         | <input type="radio"/> HIV/Aids                | <input type="radio"/> Mental illness     |
| <input type="radio"/> Hepatitis    | <input type="radio"/> Blood transfusion | <input type="radio"/> Parasites        | <input type="radio"/> High/low blood pressure | <input type="radio"/> Hypo/hyper thyroid |
| <input type="radio"/> Diabetes     | <input type="radio"/> Anemia            | <input type="radio"/> Measles          | <input type="radio"/> Heart disease           | <input type="radio"/> Premature graying  |
| <input type="radio"/> Epilepsy     | <input type="radio"/> Arthritis         | <input type="radio"/> Mumps            | <input type="radio"/> Gout                    | <input type="radio"/> Seizures           |
| <input type="radio"/> Kidney Stone | <input type="radio"/> Obesity           | <input type="radio"/> Syphilis         |   | <input type="radio"/> Multiple Sclerosis |

# Metabolic Assessment Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

## PART I

Please list your 5 major health concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## PART II

Please circle the appropriate number on all questions below.

0 as the least/never to 3 as the most/always.

<p><b>Category I</b></p> <p>Feeling that bowels do not empty completely      0 1 2 3</p> <p>Lower abdominal pain relieved by passing stool or gas      0 1 2 3</p> <p>Alternating constipation and diarrhea      0 1 2 3</p> <p>Diarrhea      0 1 2 3</p> <p>Constipation      0 1 2 3</p> <p>Hard, dry, or small stool      0 1 2 3</p> <p>Coated tongue or "fuzzy" debris on tongue      0 1 2 3</p> <p>Pass large amount of foul-smelling gas      0 1 2 3</p> <p>More than 3 bowel movements daily      0 1 2 3</p> <p>Use laxatives frequently      0 1 2 3</p> <p><b>Category II</b></p> <p>Increasing frequency of food reactions      0 1 2 3</p> <p>Unpredictable food reactions      0 1 2 3</p> <p>Aches, pains, and swelling throughout the body      0 1 2 3</p> <p>Unpredictable abdominal swelling      0 1 2 3</p> <p>Frequent bloating and distention after eating      0 1 2 3</p> <p>Abdominal intolerance to sugars and starches      0 1 2 3</p> <p><b>Category III</b></p> <p>Intolerance to smells      0 1 2 3</p> <p>Intolerance to jewelry      0 1 2 3</p> <p>Intolerance to shampoo, lotion, detergents, etc.      0 1 2 3</p> <p>Multiple smell and chemical sensitivities      0 1 2 3</p> <p>Constant skin outbreaks      0 1 2 3</p> <p><b>Category IV</b></p> <p>Excessive belching, burping, or bloating      0 1 2 3</p> <p>Gas immediately following a meal      0 1 2 3</p> <p>Offensive breath      0 1 2 3</p> <p>Difficult bowel movement      0 1 2 3</p> <p>Sense of fullness during and after meals      0 1 2 3</p> <p>Difficulty digesting fruits and vegetables; undigested food found in stools      0 1 2 3</p> <p><b>Category V</b></p> <p>Stomach pain, burning, or aching 1-4 hours after eating      0 1 2 3</p> <p>Use antacids      0 1 2 3</p> <p>Feel hungry an hour or two after eating      0 1 2 3</p> <p>Heartburn when lying down or bending forward      0 1 2 3</p> <p>Temporary relief by using antacids, food, milk, or carbonated beverages      0 1 2 3</p> <p>Digestive problems subside with rest and relaxation      0 1 2 3</p> <p>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine      0 1 2 3</p> <p><b>Category VI</b></p> <p>Roughage and fiber cause constipation      0 1 2 3</p> <p>Indigestion and fullness last 2-4 hours after eating      0 1 2 3</p> <p>Pain, tenderness, soreness on left side under rib cage      0 1 2 3</p>	<p><b>Category VI (continued)</b></p> <p>Excessive passage of gas      0 1 2 3</p> <p>Nausea and/or vomiting      0 1 2 3</p> <p>Stool undigested, foul smelling, mucous like, greasy, or poorly formed      0 1 2 3</p> <p>Frequent urination      0 1 2 3</p> <p>Increased thirst and appetite      0 1 2 3</p> <p>Difficulty losing weight      0 1 2 3</p> <p><b>Category VII</b></p> <p>Greasy or high-fat foods cause distress      0 1 2 3</p> <p>Lower bowel gas and/or bloating several hours after eating      0 1 2 3</p> <p>Bitter metallic taste in mouth, especially in the morning      0 1 2 3</p> <p>Unexplained itchy skin      0 1 2 3</p> <p>Yellowish cast to eyes      0 1 2 3</p> <p>Stool color alternates from clay colored to normal brown      0 1 2 3</p> <p>Reddened skin, especially palms      0 1 2 3</p> <p>Dry or flaky skin and/or hair      0 1 2 3</p> <p>History of gallbladder attacks or stones      0 1 2 3</p> <p>Have you had your gallbladder removed?      Yes No</p> <p><b>Category VIII</b></p> <p>Acne and unhealthy skin      0 1 2 3</p> <p>Excessive hair loss      0 1 2 3</p> <p>Overall sense of bloating      0 1 2 3</p> <p>Bodily swelling for no reason      0 1 2 3</p> <p>Hormone imbalances      0 1 2 3</p> <p>Weight gain      0 1 2 3</p> <p>Poor bowel function      0 1 2 3</p> <p>Excessively foul-smelling sweat      0 1 2 3</p> <p><b>Category IX</b></p> <p>Crave sweets during the day      0 1 2 3</p> <p>Irritable if meals are missed      0 1 2 3</p> <p>Depend on coffee to keep going/get started      0 1 2 3</p> <p>Get light-headed if meals are missed      0 1 2 3</p> <p>Eating relieves fatigue      0 1 2 3</p> <p>Feel shaky, jittery, or have tremors      0 1 2 3</p> <p>Agitated, easily upset, nervous      0 1 2 3</p> <p>Poor memory/forgetful      0 1 2 3</p> <p>Blurred vision      0 1 2 3</p> <p><b>Category X</b></p> <p>Fatigue after meals      0 1 2 3</p> <p>Crave sweets during the day      0 1 2 3</p> <p>Eating sweets does not relieve cravings for sugar      0 1 2 3</p> <p>Must have sweets after meals      0 1 2 3</p> <p>Waist girth is equal or larger than hip girth      0 1 2 3</p> <p>Frequent urination      0 1 2 3</p> <p>Increased thirst and appetite      0 1 2 3</p> <p>Difficulty losing weight      0 1 2 3</p>
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<b>Category XI</b>				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3
<b>Category XII</b>				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3
<b>Category XIII</b>				
Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3
<b>Category XIV</b>				
Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
<b>Category XV</b>				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
<b>Category XVI</b>				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

<b>Category XVII</b>				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3
<b>Category XVIII (Males Only)</b>				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3
<b>Category XIX (Males Only)</b>				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3
<b>Category XX (Menstruating Females Only)</b>				
Perimenopausal		Yes	No	
Alternating menstrual cycle lengths		Yes	No	
Extended menstrual cycle (greater than 32 days)		Yes	No	
Shortened menstrual cycle (less than 24 days)		Yes	No	
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3
<b>Category XXI (Menopausal Females Only)</b>				
How many years have you been menopausal?				_____ years
Since menopause, do you ever have uterine bleeding?		Yes	No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

**PART III**

How many alcoholic beverages do you consume per week? \_\_\_\_\_

How many caffeinated beverages do you consume per day? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times do you eat raw nuts or seeds per week? \_\_\_\_\_

List the three worst foods you eat during the average week: \_\_\_\_\_

List the three healthiest foods you eat during the average week: \_\_\_\_\_

Rate your stress level on a scale of 1-10 during the average week: \_\_\_\_\_

How many times do you eat fish per week? \_\_\_\_\_

How many times do you work out per week? \_\_\_\_\_

**PART IV**

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

# MIND/BODY QUESTIONNAIRE

**NAME:** \_\_\_\_\_

**TELEPHONE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

Which of the following have you been unhappy or stressed about and for how long:  
(Please rate the amount of stress [1 low – 10 high] in the provided space)

How Long	Stress Rate	WORK	How Long	Stress Rate	FAMILY	How Long	Stress Rate	GENERAL
<input type="checkbox"/>	<input type="checkbox"/>	Managers	<input type="checkbox"/>	<input type="checkbox"/>	In-laws	<input type="checkbox"/>	<input type="checkbox"/>	Trust issues
<input type="checkbox"/>	<input type="checkbox"/>	Other employees	<input type="checkbox"/>	<input type="checkbox"/>	Spouse	<input type="checkbox"/>	<input type="checkbox"/>	Let down
<input type="checkbox"/>	<input type="checkbox"/>	Work atmosphere	<input type="checkbox"/>	<input type="checkbox"/>	Children	<input type="checkbox"/>	<input type="checkbox"/>	Not feeling recognized
<input type="checkbox"/>	<input type="checkbox"/>	Amount of earnings	<input type="checkbox"/>	<input type="checkbox"/>	Parents	<input type="checkbox"/>	<input type="checkbox"/>	Moving to new area
<input type="checkbox"/>	<input type="checkbox"/>	Change of responsibility	<input type="checkbox"/>	<input type="checkbox"/>	Close friends	<input type="checkbox"/>	<input type="checkbox"/>	Accidents
<input type="checkbox"/>	<input type="checkbox"/>	Too many responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	Other relationships	<input type="checkbox"/>	<input type="checkbox"/>	Lack of discipline
<input type="checkbox"/>	<input type="checkbox"/>	Insecure future	<input type="checkbox"/>	<input type="checkbox"/>	Not having children	<input type="checkbox"/>	<input type="checkbox"/>	World events
<input type="checkbox"/>	<input type="checkbox"/>	Too much work	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Political issues
<input type="checkbox"/>	<input type="checkbox"/>	Lack of work	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Lawsuit
<input type="checkbox"/>	<input type="checkbox"/>	Work hours	<input type="checkbox"/>	<input type="checkbox"/>	Divorce	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Feeling trapped	<input type="checkbox"/>	<input type="checkbox"/>	Had abortion	<input type="checkbox"/>	<input type="checkbox"/>	<b>FINANCIAL</b>
<input type="checkbox"/>	<input type="checkbox"/>	Lack of organization	<input type="checkbox"/>	<input type="checkbox"/>	Lack of intimacy/ romance	<input type="checkbox"/>	<input type="checkbox"/>	Home
<input type="checkbox"/>	<input type="checkbox"/>	Lack of fulfillment	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Car
<input type="checkbox"/>	<input type="checkbox"/>	Nature of work	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Investments
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Payments
						<input type="checkbox"/>	<input type="checkbox"/>	Loans (mortgage)
						<input type="checkbox"/>	<input type="checkbox"/>	Loss of money
						<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Which of the following do you currently and predominantly experience in your life?

<input type="checkbox"/> 1. Anger	<input type="checkbox"/> 10. Feeling stuck	<input type="checkbox"/> 19. Jealousy	<input type="checkbox"/> 27. Not good enough
<input type="checkbox"/> 2. Apathy	<input type="checkbox"/> 11. Frustration	<input type="checkbox"/> 20. Let down from others	<input type="checkbox"/> 28. Rejection
<input type="checkbox"/> 3. Childhood abuse issues	<input type="checkbox"/> 12. Easily offended	<input type="checkbox"/> 21. Low self-esteem	<input type="checkbox"/> 29. Restlessness
<input type="checkbox"/> 4. Disappointment	<input type="checkbox"/> 13. Grief	<input type="checkbox"/> 22. Loss	<input type="checkbox"/> 30. Sadness
<input type="checkbox"/> 5. Discontent	<input type="checkbox"/> 14. Guilt	<input type="checkbox"/> 23. Loss of control	<input type="checkbox"/> 31. Shyness
<input type="checkbox"/> 6. Despondency	<input type="checkbox"/> 15. Hate	<input type="checkbox"/> 24. Loss of focus	<input type="checkbox"/> 32. Unloved
<input type="checkbox"/> 7. Discouraged easily	<input type="checkbox"/> 16. Heartache	<input type="checkbox"/> 25. Melancholy	<input type="checkbox"/> 33. Victimized
<input type="checkbox"/> 8. Dissatisfaction	<input type="checkbox"/> 17. Hopelessness/despair	<input type="checkbox"/> 26. Not getting what you deserve	<input type="checkbox"/> 34. Why me
<input type="checkbox"/> 9. Fear	<input type="checkbox"/> 18. Indifference		<input type="checkbox"/> 35. Worthlessness

Is something bothering you, burdening your heart, or are you struggling with something that you have not indicated above?

\_\_\_\_\_

\_\_\_\_\_

Do you feel accepted and acknowledged?  Yes  No Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you feel fulfilled?  Yes  No Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there a goal you are working toward in your life:  Yes  No Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_