Dear Patient,

Thank you for the opportunity to be a partner with you in your health care.

We have included several important forms that we will review at your first appointment. Your detailed and thoughtful responses will help us to utilize our time more effectively. **Please bring in these forms to your first office visit.** Your first visit will be a thorough assessment of your health and you should allow up to two and a half hours for this visit.

If you are unable to keep your scheduled appointment time, please let us know at least 48 hours prior to the scheduled time so that we may allow other patients to have your appointment. We will be glad to reschedule your visit. Please help us to serve you better by keeping scheduled appointments.

Please remember to bring in copies of any recent lab work or medical records as well as all the bottles of supplements and/or medications you are currently taking.

We look forward to seeing you. Our goal is to become a trusted partner in assisting you with your health care needs.

Yours in health,

Carolinas Natural Health Center

1212 Mann Drive, Suite 100 ☼ Matthews, NC 28105 ☼ Ph: 704-708-4404 ☼ Fax: 704-708-4417

CAROLINAS NATURAL HEALTH CENTER

PATIENT REGISTRATION FORM

Date:_____

New Patient Information

Name:_____ _____ DOB: ___/___/___ Age:_____
(Last) (First) (Sex)

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Email Address: _____Would you like to receive our email newsletter? Y N

Additional Patient Information

Primary Care Physician: _____Physician's Phone: (___)_____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Marital Status(circle): Single Married Separated Divorced With Partner Widow(er)

Number of Children:_____

Name of Spouse/Partner: _____

Emergency Contact: _____ Relationship to you: _____

Emergency Contact #: (___)_____

Referral Information

How did you hear of us? _____

Were you referred by a physician?: ☐ Yes ☐ No

If "Yes", could you provide us with as much information as possible for the Referring Physician?

Referring Physician's Name: _____

Address, City, State, Zip: _____

Telephone Number: _____

Entered by:_____

FINANCIAL RESPONSIBILITY AND POLICY STATEMENT

Thank you for choosing Carolinas Natural Health Center (CNHC) for your healthcare needs. Our healthcare providers and staff are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

PAYMENT FOR SERVICES

CNHC is a fee for service clinic. Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.

For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover and American Express. Returned checks are subject to a $25 return fee and no further personal checks will be accepted.

We are sensitive to those with special financial needs and will consider a sliding scale for qualified individuals.

PHONE SUPPORT

Phone support is to aid in answering any questions or concerns that may arise, or to clarify instructions. This is not intended to take the place of an office visit.

Phone consultations that *cover new material, require new information, take an extensive amount of time, or require a change in the treatment plan* are considered substitutes for an office visit. These will be billed for the same rate as the visit for which they substitute. For example, a phone consultation that substitutes for a limited visit will be billed at $90.

CANCELLATION POLICY

If you are not able to keep your scheduled appointment, please notify us within 48 hours of the appointment. There is no charge if an appointment is cancelled within 48 hours. A cancellation with less than 48 hours notice does not allow enough time for other interested patients to be scheduled, and is a great inconvenience for our center. Thus, for naturopathic visits there is a $100 charge for new patient and a $50 charge for follow-up cancellations. For all other services (massage, acupuncture, etc.), 50% of the service will be charged for late cancellations. Full service fees will be charged if no notice is given.

I agree to the above defined financial policies. In case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I the undersigned, have read, understand and accept the information and conditions specified in this document.

_____ _____

Patient or Parent/Guardian Signature Date

1212 Mann Drive, Suite 100 ☼ Matthews, NC 28105 ☼ Ph: 704-708-4404

CAROLINAS NATURAL HEALTH CENTER

NATUROPATHIC PATIENT INTAKE FORM

Patient Name: _____ **DOB:**_____

List in order of importance what your health concerns are:

1) _____
2) _____
3) _____
4) _____
5) _____

Last time you had blood work done and with what physician: _____

_____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for death:						
Cancer type:						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List all surgeries & hospitalizations, including date occurred:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please note when & why you have had each of the following:

X-Rays: _____ MRI/Cat Scans: _____

Ultrasounds: _____ Accidents: _____

TB Test: _____ Hepatitis C: _____

HIV: _____ Last Dental Visit: _____

Last Eye Exam: _____

Patient Name: _____ **DOB:** _____

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

Measles: D I N **Chicken Pox**: D I N **Mumps**: D I N **Rubella**: D I N
Tetanus: D I N **Whooping Cough**: D I N **Hemophilus (Hib)**: D I N **Hepatits B**: D I N
German Measles: D I N **Any vaccination reactions:** _____

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Antacids: Y N P **Steroids**: Y N P **Smoking**: Y N P **Packs per day & number of years**: _____
Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day if Yes/Past**: _____
Soda Pop: Y N P **Ounces per day if Yes/Past**: _____
Alcohol: Y N P **How often & how much if Yes/Past**: _____
Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P
Recreational Drugs: Y N P **Any Drug Addictions**: Y N P
Any Drug Treatment: Y N P

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and include dosage if known:

_____
_____
_____

List all known drug allergies and reaction you get when you take the medication:

_____
_____
_____

Review of Systems:

Present Weight: _____ **Weight one year ago**: _____ **Height**: _____
Maximum weight and when: _____ **Minimum weight as adult & when**: _____
Ideal Weight: _____

REGARDING THE NEXT SECTION: Please circle (**Y)** if you have the problem **NOW**, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

Good Energy: Y N P
Fatigue: Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst? _____
If you have fatigue, can you do what you need to during the day? Y N

Patient Name: _____ **DOB:** _____

SKIN				
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer:	Y N P		**Perspiration:**	Y N P
HEAD				
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P

NOSE				
Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Post Nasal Drip:**	Y N P
Polyps:	Y N P		**Seasonal Allergies:**	Y N P
EYES				
Dry/Watery:	Y N P		**Blurry Vision:**	Y N P
Double Vision	Y N P		**Cataracts:**	Y N P
Glaucoma:	Y N P		**Styes:**	Y N P
Strain:	Y N P		**Discharge:**	Y N P
Itchy:	Y N P		**Dark under Eyelid:**	Y N P
MOUTH/THROAT				
Canker sores:	Y N P		**Cold sores:**	Y N P
Sore Throat:	Y N P		**Gum disease:**	Y N P
Dentures:	Y N P		**Cavities:**	Y N P
Loss of taste:	Y N P		**Hoarseness:**	Y N P
NECK				
Stiffness:	Y N P		**Swollen Glands:**	Y N P
Full movement:	Y N P		**Tension:**	Y N P

Patient Name: _____ **DOB:** _____

		RESPIRATORY		
Cough:	Y N P		**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P		**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P		**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P		**Asthma:**	Y N P
Wheezing:	Y N P		**Painful breathing:**	Y N P
		CARDIOVASCULAR		
High Blood Pressure:	Y N P		**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P		**Murmurs:**	Y N P
Arrhythmias:	Y N P		**Palpitations:**	Y N P
Edema:	Y N P		**Chest Pain:**	Y N P
		URINARY TRACT		
Incontinence:	Y N P		**Pain w/ Urination**	Y N P
Frequent Infections:	Y N P		**Kidney Stones**	Y N P
Urgency:	Y N P		**Discharge/Blood:**	Y N P
		GASTROINTESTINAL		
Heartburn:	Y N P		**Bowel Movement Freq:**	
Indigestion:	Y N P		**Recent BM Change:**	Y N P
Bloating:	Y N P		**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P		**Hemorrhoids:**	Y N P
Vomiting:	Y N P		**Gall Bladder Disease**	Y N P
Change in Appetite:	Y N P		**Liver Disease:**	Y N P
Pancreatitis:	Y N P		**Ulcer**	Y N P
		MALE HEALTH		
Testicular pain/swelling:	Y N P		**Sexually Active:**	Y N P
Hernia:	Y N P		**S.T.D.:**	Y N P
Discharge:	Y N P		**Prostate Disease/Symptoms:**	Y N P
Impotency:	Y N P		**Sexual Orientation:**	Hetero Homo Bi

Patient Name: _____ **DOB:** _____

FEMALE HEALTH			
Age Period Began:		**How Often Period Occurs:**	
How long period lasts:		**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P	**Menstrual Pain:**	Y N P
PMS:	Y N P	**Food cravings:**	Y N P
Times Pregnant:		**How many births:**	
Miscarriages:		**Abortions:**	
Last Pap Smear:		**Diagnosis:**	
Any abnormal paps:	Y N P	**When was abnormal:**	
Menopausal since what age:		**Use of hormones:**	Y N P
Type of hormones used:		**Healthy libido:**	Y N P
Dry vagina:	Y N P	**Sexually Active:**	Y N P
Pain w/ Intercourse:	Y N P	**Vaginitis:**	Y N P
S.T.D.:	Y N P	**Mammography:**	Y N P
Dexa Bone Scan:	Y N P	**If Yes, what were results:**	
Sexual Orientation:	Hetero Homo Bi		

Please list any birth control used and ages used: _____

_____

MUSCULOSKELETAL			
Weakness:	Y N P	**Arthritis:**	Y N P
Stiffness:	Y N P	**Leg Cramps:**	Y N P
Tremors:	Y N P	**Pain:**	Y N P
NERVOUS			
Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P
MENTAL/EMOTIONAL			
Depression:	Y N P	**Anger/irritability:**	Y N P
Suicidal:	Y N P	**High-strung/tense:**	Y N P
Anxiety:	Y N P	**Fear/Panic**	Y N P
Eating disorder:	Y N P	**Psych Hospitalization:**	Y N P

Patient Name: _____ **DOB:** _____

Exercise

How often do you exercise? _____ **What type of exercise**? _____

For how long? _____ **Hobbies**: _____

Sleep

How long per night? _____ **If you wake up frequently, what is the reason**? _____

Nightmares: Y N P **Wake Refreshed**: Y N P **Must nap during the day**: Y N P

Sleep walk: Y N P **Grind teeth**: Y N P **Snore**: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

Social Life

Enjoy job: Y N P **Hours worked per week**: _____ **Highest Level of Education**: _____

Active spiritual practice: Y N P **Quality of significant relationship**: _____

History of sexual, mental/emotional, physical abuse: Y N P **If so, at what age and by whom**: _____

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: Little Moderately Very

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Allergies

List all known Allergies (food, environment): _____

CAROLINAS NATURAL HEALTH CENTER

Instructions for Homeopathic Intake Form

Please answer the questions on the following pages as carefully, thoughtfully, and accurately as possible. Many of the questions may not seem directly related to your problem or main complaint, however, each one may help determine which homeopathic remedy is best suited for you. **All information in this questionnaire is kept confidential.**

The questionnaire is designed to be user friendly. You can answer many of the questions by placing a circle around the appropriate number. For example:

Which weather conditions are you most troubled by?
Circling a number closer to the clear end means that you are more troubled by clear weather.
Circling a number closer to the cloudy end means that you are troubled by cloudy weather.

Cloudy Clear
1 2 3 4 5 6 7 8 9 10

Some questions will ask you to rate how much you are troubled by a single particular symptom or how much of this quality characterizes you in general. Circling number "1" means that you are troubled very little while marking "10" means that you are troubled a lot. For example:

Do you worry about any of the following?

Circling closer to "10" means that you worry about your health a lot. Circling closer to "1" means that you do not worry about your health.

1 2 3 4 5 6 7 8 9 10 Health

Some questions ask you to circle the answer you think best fits you. For example:

What are your feelings toward disease?

Optimistic
Doubtful of Recovery
Fearful
Despair of Recovery

Name:_____

The following general symptoms pertain to you as a whole person.

Which weather conditions are you most troubled by?

Cloudy Clear
1 2 3 4 5 6 7 8 9 10

Wet Dry
1 2 3 4 5 6 7 8 9 10

Damp cold Snow (Dry Cold)
1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10 Storms

1 2 3 4 5 6 7 8 9 10 Wind

1 2 3 4 5 6 7 8 9 10 Fog

1 2 3 4 5 6 7 8 9 10 Hot Sun

Circle which seasons cause you the most trouble?

Winter Spring
Fall Summer

Are you worse being in the:

Mountains At the seashore
1 2 3 4 5 6 7 8 9 10

Are you generally sensitive to and/or troubled by:

1 2 3 4 5 6 7 8 9 10 Bright Light

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Open Air

1 2 3 4 5 6 7 8 9 10 Stuffy Rooms

1 2 3 4 5 6 7 8 9 10 Tight Clothing

1 2 3 4 5 6 7 8 9 10 Noise

1 2 3 4 5 6 7 8 9 10 Odors

1 2 3 4 5 6 7 8 9 10 Drafts

Are you generally chilly or warm?

Chilly Warm
1 2 3 4 5 6 7 8 9 10

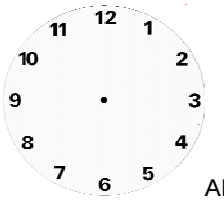
Date:_____

Which are you generally most sensitive to, warm or cold?

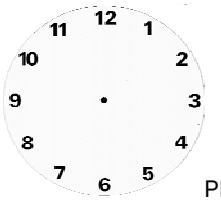
Cold Warm
1 2 3 4 5 6 7 8 9 10

What times of day are you generally worst (mood, energy, symptoms, etc.) What times are you best?

Worst

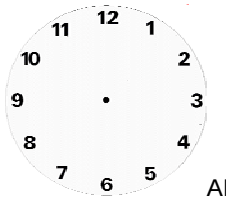


AM

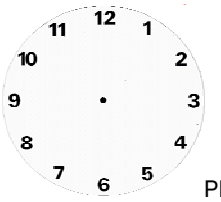


PM

Best



AM



PM

Symptoms during sleep. Circle which you have.

Tooth Grinding
Restlessness
Talking
Perspiration
Frequent Urination
Excess Heat or Cold
Laughing
Snoring
Nightmares
Recurring Dreams
Sleepwalking

Circle what you prefer. Do you sleep:

Without Covers
Partly Covered
Fully Covered (Not including Head)
Fully Covered (Including Head)
With Arms or Legs Out of the Covers
Without Clothing
With a Fan or Air Blowing on You
With the Window open

What position do you sleep in most often?

Right Side On Back
Left Side On Abdomen

How much do you perspire?

Never All the Time
1 2 3 4 5 6 7 8 9 10

Do you have difficulty waking?

Never All the Time
1 2 3 4 5 6 7 8 9 10

Do you wake unrefreshed?

Never All the Time
1 2 3 4 5 6 7 8 9 10

Food Desires and Aversions:
In the following questions you are asked how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. If you strongly desire or crave a food or taste, mark 10. If you detest a food or taste, mark 1.

Tastes:

1 2 3 4 5 6 7 8 9 10 Sweet

1 2 3 4 5 6 7 8 9 10 Sour

1 2 3 4 5 6 7 8 9 10 Salty

1 2 3 4 5 6 7 8 9 10 Bitter

1 2 3 4 5 6 7 8 9 10 Spicy (hot)

1 2 3 4 5 6 7 8 9 10 Smoked

1 2 3 4 5 6 7 8 9 10 Juicy

1 2 3 4 5 6 7 8 9 10 Refreshing

1 2 3 4 5 6 7 8 9 10 Pungent

Foods:

1 2 3 4 5 6 7 8 9 10 Alcohol

1 2 3 4 5 6 7 8 9 10 Apples

1 2 3 4 5 6 7 8 9 10 Bacon

1 2 3 4 5 6 7 8 9 10 Bread alone

1 2 3 4 5 6 7 8 9 10 Bread w/ butter

1 2 3 4 5 6 7 8 9 1 Butter alone

1 2 3 4 5 6 7 8 9 10 Cheese

1 2 3 4 5 6 7 8 9 10 Chocolate

1 2 3 4 5 6 7 8 9 10 Coffee

1 2 3 4 5 6 7 8 9 10 Pastries

1 2 3 4 5 6 7 8 9 10 Eggs

1 2 3 4 5 6 7 8 9 10 Fat (chicken,pork, etc.)

1 2 3 4 5 6 7 8 9 10 Fish

1 2 3 4 5 6 7 8 9 10 Fruit

1 2 3 4 5 6 7 8 9 10 Fruit (sour)

1 2 3 4 5 6 7 8 9 10 Grains (pasta, bread, cereals, etc.)

1 2 3 4 5 6 7 8 9 10 Ham

1 2 3 4 5 6 7 8 9 10 Ice

1 2 3 4 5 6 7 8 9 10 Ice cream

1 2 3 4 5 6 7 8 9 10 Indigestible things (chalk, clay, paper, etc.)

1 2 3 4 5 6 7 8 9 10 Lemonade

1 2 3 4 5 6 7 8 9 10 Meat

1 2 3 4 5 6 7 8 9 10 Milk

1 2 3 4 5 6 7 8 9 10 Nut butters

1 2 3 4 5 6 7 8 9 10 Oysters

1 2 3 4 5 6 7 8 9 10 Pickles

1 2 3 4 5 6 7 8 9 10 Vegetables

1 2 3 4 5 6 7 8 9 10 Vinegar

Temperature of food. Which do you prefer?

Warm Food Cold Food
1 2 3 4 5 6 7 8 9 10

Warm Drinks Cold Drinks
1 2 3 4 5 6 7 8 9 10

Do you notice any specific tastes in your mouth (e.g., metallic, bitter, foul, etc.)?

How thirsty are you generally?

Not at all Very

1 2 3 4 5 6 7 8 9 10

Mental and Emotional State:

How strong in general are the following emotional symptoms? The most mark 10. The least mark 1.

1 2 3 4 5 6 7 8 9 10 Anxiety (worry & fear)

Do you worry about any of the following?
10 means the most, 1 the least.

1 2 3 4 5 6 7 8 9 10 Creative Activities

1 2 3 4 5 6 7 8 9 10 Emotions

1 2 3 4 5 6 7 8 9 10 Financial Security

1 2 3 4 5 6 7 8 9 10 Health

1 2 3 4 5 6 7 8 9 10 Mental Functioning

1 2 3 4 5 6 7 8 9 10 Morals

1 2 3 4 5 6 7 8 9 10 Others (family & close friends) well being

1 2 3 4 5 6 7 8 9 10 Religion

1 2 3 4 5 6 7 8 9 10 Social Life

1 2 3 4 5 6 7 8 9 10 Social Position

1 2 3 4 5 6 7 8 9 10 The Future

1 2 3 4 5 6 7 8 9 10 Work

1 2 3 4 5 6 7 8 9 10 Irresolution (not being able to decide or stick to a decision)

1 2 3 4 5 6 7 8 9 10 Capriciousness (Willfulness,changeable and erratic desires that are difficult to satisfy)

1 2 3 4 5 6 7 8 9 10 Selfishness

Frightened Easily Never Afraid

1 2 3 4 5 6 7 8 9 10

Answer as honestly as you can about your personality traits.

Stingy Overly generous

1 2 3 4 5 6 7 8 9 10

Thrifty Extravagant

1 2 3 4 5 6 7 8 9 10

Hurried, impatient Slow

1 2 3 4 5 6 7 8 9 10

Messy Fastidious

1 2 3 4 5 6 7 8 9 10

Calm Restlessness

1 2 3 4 5 6 7 8 9 10

Indolence (Lazy) Always busy

1 2 3 4 5 6 7 8 9 10

Shyness/Timid/Bashful Outgoing

1 2 3 4 5 6 7 8 9 10

Anger Mildness

1 2 3 4 5 6 7 8 9 10

Lack of moral sense Guilty

1 2 3 4 5 6 7 8 9 10

No Religious feeling Highly Religious Feeling

1 2 3 4 5 6 7 8 9 10

Obstinate (stubborn) Yielding

1 2 3 4 5 6 7 8 9 10

Heedless/Reckless Cowardice

1 2 3 4 5 6 7 8 9 10

Social/Antisocial. In regard to being with other people or in company?

Aversion Desire for

1 2 3 4 5 6 7 8 9 10

Circle the expression that best describes your feelings about the following issues.

Significant past emotionally traumatic events:

Resolved Grief
Dwells on Past
Inconsolable
Remorse
Guilt

Feeling towards people close to you:

Loving
Affectionate
Indifferent
Resentment
Hatred

Feeling toward disease/condition:

Optimistic
Doubtful of recovery
Discouraged
Fearful
Despair of recovery

Feeling toward life

Love life
Indifferent
Bored
Weary of life
Loathing of life
Desires death
Suicidal thoughts
Suicidal disposition

Feeling toward spouse/lover:

Loving
Affectionate
Dissatisfaction
Disappointed
Indifferent
Resentment
Hatred

How much do you have the following symptoms?
10 a lot, 1 hardly ever.

1 2 3 4 5 6 7 8 9 10 Irritability

1 2 3 4 5 6 7 8 9 10 Jealousy

Alternating Moods Even Moods
1 2 3 4 5 6 7 8 9 10

Circle which best expresses your general mood.

Morose
Sad
Apathy/Indifferent
Excitement
Exhilaration

How do you experience sympathy or consolation?

Like Dislike
1 2 3 4 5 6 7 8 9 10

Better from Worse from
1 2 3 4 5 6 7 8 9 10

How talkative are you in general?

Aversion to talking Talkative
1 2 3 4 5 6 7 8 9 10

Not trusting Trusting
1 2 3 4 5 6 7 8 9 10

Gullible Suspicious
1 2 3 4 5 6 7 8 9 10

How often and easily do you weep?

Never Often
1 2 3 4 5 6 7 8 9 10

How often do you experience clairvoyance?

Never Often
1 2 3 4 5 6 7 8 9 10

How is your level of self-confidence?

Lack of confidence Pride/Haughty
1 2 3 4 5 6 7 8 9 10

How impulsive are you?

Never Often
1 2 3 4 5 6 7 8 9 10

How afraid are you of the following? 1, never. 10, very afraid.

1 2 3 4 5 6 7 8 9 10 Animals

1 2 3 4 5 6 7 8 9 10 Being alone

1 2 3 4 5 6 7 8 9 10 Death

1 2 3 4 5 6 7 8 9 10 Relative's Death

1 2 3 4 5 6 7 8 9 10 Impending Disease

1 2 3 4 5 6 7 8 9 10 Downward Motion

1 2 3 4 5 6 7 8 9 10 Evil

1 2 3 4 5 6 7 8 9 10 Failure

1 2 3 4 5 6 7 8 9 10 Falling

1 2 3 4 5 6 7 8 9 10 Ghosts

1 2 3 4 5 6 7 8 9 10 Heights

1 2 3 4 5 6 7 8 9 10 Insanity

1 2 3 4 5 6 7 8 9 10 Misfortune (bad luck)

1 2 3 4 5 6 7 8 9 10 Of a Crowd

1 2 3 4 5 6 7 8 9 10 People

1 2 3 4 5 6 7 8 9 10 Robbers/Intruders

1 2 3 4 5 6 7 8 9 10 Snakes

1 2 3 4 5 6 7 8 9 10 Spiders

1 2 3 4 5 6 7 8 9 10 Strangers

1 2 3 4 5 6 7 8 9 10 Having a Stroke

1 2 3 4 5 6 7 8 9 10 Something will happen

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Thunderstorms

1 2 3 4 5 6 7 8 9 10 Water

1 2 3 4 5 6 7 8 9 10 Wind

Are you forgetful of any of the following?
(1 not at all, 10 a lot)

1 2 3 4 5 6 7 8 9 10 Dates

1 2 3 4 5 6 7 8 9 10 Names

1 2 3 4 5 6 7 8 9 10 Numbers

1 2 3 4 5 6 7 8 9 10 Of what someone just said to you

1 2 3 4 5 6 7 8 9 10 Of what you just said

1 2 3 4 5 6 7 8 9 10 Of words

How often do you make mistakes with the following?

1 2 3 4 5 6 7 8 9 10 Numbers

1 2 3 4 5 6 7 8 9 10 Words (reading)

1 2 3 4 5 6 7 8 9 10 Words (speaking)

1 2 3 4 5 6 7 8 9 10 Words (writing)

How sensitive are you to any of the following?

1 2 3 4 5 6 7 8 9 10 Beauty

1 2 3 4 5 6 7 8 9 10 Criticism

1 2 3 4 5 6 7 8 9 10 Cruel Stories

1 2 3 4 5 6 7 8 9 10 Frightening things

1 2 3 4 5 6 7 8 9 10 Being made fun of

1 2 3 4 5 6 7 8 9 10 Music

1 2 3 4 5 6 7 8 9 10 Reprimand

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 The suffering of others

How do you handle conflict usually?

Quarrelsome Yielding
1 2 3 4 5 6 7 8 9 10

How are you in regard to authority?

Bossy/Dictatorial Yielding/Fawning
1 2 3 4 5 6 7 8 9 10

How critical are you of others?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How critical are you of yourself?

Not at All All the Time
1 2 3 4 5 6 7 8 9 10

How honest are you?

Always Lie Always honest
1 2 3 4 5 6 7 8 9 10

How often do you have the following behaviors?

1 2 3 4 5 6 7 8 9 10 Abusive

1 2 3 4 5 6 7 8 9 10 Biting

1 2 3 4 5 6 7 8 9 10 Breaks Things

1 2 3 4 5 6 7 8 9 10 Contrary (opposite to what is logically expected

1 2 3 4 5 6 7 8 9 10 Cursing

1 2 3 4 5 6 7 8 9 10 Disobedience

1 2 3 4 5 6 7 8 9 10 Insolent (insult, boldly rude)

1 2 3 4 5 6 7 8 9 10 Rage

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 Striking others

1 2 3 4 5 6 7 8 9 10 Striking self

1 2 3 4 5 6 7 8 9 10 Violence

Please circle the best approximation of your sexual desire. Please circle the level of your desire and not your actual frequency.

Never 2x/wk.
1x/year 4x/wk.
1x/3 mo. 1x/day
1x/mo. 2x/day
2x/mo. 4x/day
1x/wk.

How often do you actually have sex?

Never 2x/wk.
1x/year 4x/wk.
1x/3 mo. 1x/day
1x/mo. 2x/day
2x/mo. 4x/day
1x/wk.

How often do you masturbate?

Never 2x/wk.
1x/year 4x/wk.
1x/3 mo. 1x/day
1x/mo. 2x/day
2x/mo. 4x/day
1x/wk.

What worries or concerns do you have about your sexual life?

Not enough desire Too much desire
1 2 3 4 5 6 7 8 9 10

Not enough sex Too much sex
1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10 Lack of enjoyment

1 2 3 4 5 6 7 8 9 10 Difficulty reaching orgasm

1 2 3 4 5 6 7 8 9 10 Impotence

1 2 3 4 5 6 7 8 9 10 Troubling fantasies or thoughts

1 2 3 4 5 6 7 8 9 10 Sexual confidence

1 2 3 4 5 6 7 8 9 10 Unusual sexual practices or desires