

A HEALING ALTERNATIVE COUNELING AND WELLNESS CENTER, LLC

8603 CROWNHILLE SUITE 29 SAN ANTONIO, TX 78233

PHONE: (210)705-2121

FAX: (210) 568-4816

INFO@FAITHGHARPER.COM

Hey there, new person!

Enclosed in this packet is all the basic forms you will need to complete before your first in-office appointment. Paperwork can absolutely be completed during your first appointment, though many people prefer it all completed ahead of time. It can be printed and brought in the day of your appointment or emailed or faxed to me before the appointment time.

Copies of my HIPPA policy and my Social Media Policy are available as separate downloads and should be read before completing this packet. Additionally, I keep printed copies of them in the office and can provide them to you at your request.

There are other forms available on my website that you may need to complete such as a consent to release information if you are working with other treatment providers.

Please have each person who is entering services complete a packet. (Though don't freak out by the counseling contract...if you are attending as a couple or family unit you will only pay for the service visit, not per person!).

Because you are requesting a nutrition assessment as part of your services with me, I am including some nutrition screening tools in this packet. You can also send me any recent lab work you have completed for other practioners. If you are able to get this information back to me at least 48 hours before your appointment, that will give me time to create an individualized nutrition plan for you.

If you have any questions, do not hesitate to contact me at info@faithgharper.com

Faith G. Harper

Faith G. Harper, PhD, LPC-S, ACS, ACN
A Healing Alternative Counseling and Wellness Center, LLC
info@faithgharper.com www.faithgharper.com
Phone: (210)705-2121 Fax: (210) 568-4816

Counseling Contract

Counseling is most helpful when it takes place in a framework of trust, clarity, and understanding. This contract is intended to clarify and help this relationship. Should you have any questions concerning this covenant, please discuss them with me.

Financial Understanding

I/we understand that the fee for a 50 minute session is **\$135.00**; this fee is the same for an initial visit.

I have discussed this amount with the therapist along with my ability to pay. **I agree to a fee in the amount of _____.**

If I choose to use my insurance benefits to offset the cost of my therapy, then I understand that the full fee will be charged.

I agree to be responsible for that full fee amount.

Cancellation Policy

I understand that I will be charged the full fee of **\$135.00 for a missed appointment or if I fail to cancel without 24 hours notification.** This can be discussed with your therapist if special circumstances result in a missed appointment.

Limits of Confidentiality

I understand that while confidentiality is central to the process of therapy, it must be broken and a report made to the proper authorities when there is abuse or neglect of children, disabled persons, and the elderly; when there is intent to harm oneself, another, or property; or when a court order is issued.

Terminating Therapy

I understand that though I may stop therapy at any time, the ending of therapy is best if discussed with my therapist at least one session before it ends.

Consent to Counseling

I understand that there are certain risks in therapy and that there may be alternatives to therapy. I agree to counseling with Faith G. Harper. These services may also include group therapy, psychoeducation, assessment and diagnostic impressions, and referrals for other needed services.

Signed _____
Printed Name _____
Date _____

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CONTACT INFORMATION

Today's Date _____ Reverified Date _____ Reverified Date _____

Legal Name _____
Last First MI

Preferred Name _____

DOB ____/____/____

Legally Authorized Representative (if applicable) _____
Last First MI

Local Address _____
Street Apt#

City, State, Zip

Preferred Form of Contact? ___Phone ___Cell Phone ___Text ___Email

Cell Phone _____
If Phone Contact checked, OK to leave message? _____

Home Phone _____
If Phone Contact checked, OK to leave message? _____

Email address: _____

If you marked that you prefer email contact or text contact, please note the following:

I understand that the confidentiality of information transmitted via email or text cannot be guaranteed.

_____ *Your Initials*

In Case of Emergency, Notify:

Name _____
First Last

Relationship _____

Contact info: _____
Street Apt#

City, State, Zip

Home Phone _____

Cell Phone _____

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Signed _____
Witness _____
Date _____

Signed _____
Witness _____
Date _____

Receipt of Notice of Privacy Practices Form
A Healing Alternative Counseling and Wellness Center, LLC
Faith G. Harper, PhD, LPC-S

I, _____, hereby acknowledge receipt of the NOTICE OF PRIVACY PRACTICES from my therapist.

The NOTICE OF PRIVACY PRACTICE provides detailed information about how the practice may use and disclose my confidential information.

I understand that my therapist has reserved a right to change his or her privacy practices that are described in the NOTICE.

I also understand that a copy of any Revised NOTICE will be provided to me or made available.

CLIENT SIGNATURE

DATE

Faith G. Harper, PhD, LPC-S
A Healing Alternative Counseling and Wellness Center, LLC
info@faithgharper.com www.faithgharper.com
Phone: (210)705-2121 Fax: (210) 568-4816

Social Media Acknowledgement Form

I acknowledge that I have been provided a copy of Faith Harper’s social media policy which remains in effect even when I am no longer receiving services from her.

I understand that this policy is available for download and review at any time from her website (www.faithgharper.com) and updates in this policy will be discussed with me, if I am currently receiving services from her.

I understand that if any questions about social media arise are best discussed directly with her during our sessions.

Client Name: _____

Client Signature: _____

Date: _____

Counselor Signature: _____

Date: _____

Life History Questionnaire

FAITH G. HARPER, PhD, LPC-S, ACS, ACN

The purpose of this questionnaire is to obtain some information regarding the issues that bring you in today, as well as some of your experiences and background. Completing these questions as fully and as accurately as possible will benefit you through the development of a treatment plan suited to your specific needs.

Name: _____ Date: _____

Address: _____

Home Phone: () _____ Cell Phone:() _____

Email Address: _____

DOB: / / Age: Occupation: _____

SIGNIFICANT RELATIONSHIP STATUS:

Single Engaged Married Separated Divorced Widowed Committed Relationship

LIST ANY MEDICATIONS YOU ARE TAKING:

<u>Name</u>	<u>Dosage</u>	<u>Prescribed for</u>
_____	_____	_____
_____	_____	_____

PLEASE STATE WHAT BRINGS YOU IN:

HOW LONG HAS THIS BEEN OCCURRING?

On the scale below, please circle the severity:

1 **2** **3** **4** **5** **6** **7** **8** **9** **10**
 mildly upsetting ← — — — — — — — — — — → incapacitating

ALCOHOL AND OTHER DRUG USE

Please tell me about your use of alcohol and other substances:	Never	Seldom	Once a month	2-3 times a month	Weekly	Daily
I drink 4 or more drinks in a 24-hr period.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have missed work/school due to drinking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After drinking, I have forgotten where I was or what I did.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I use other recreational drugs*.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have missed work/school due to recreational drugs*.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After using recreational drugs*, I have forgotten where I was or what I did.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***RECREATIONAL DRUGS INCLUDE**, among others: marijuana; cocaine; ecstasy; heroin; meth; as well as any prescription or over-the-counter drugs taken for recreational purposes.

PREVIOUS MENTAL HEALTH TREATMENT:

Please list any psychiatrists, therapists, hospitals, self-help groups, and residential treatment centers, and the issues for which you were seen.

FAMILY MENTAL HEALTH HISTORY

Clinical Diagnosis	NO ONE	If YES, please check the box for <u>all</u> applicable family members							Successfully Treated?	
		Mother	Father	Brothers	Sisters	Cousins	Aunts/Uncles	Grand-parents	Yes	No
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD (Attention Deficit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Borderline Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia or Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or Other Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other family mental health information: _____

Please describe any illness, loss, accident, or hospitalization that had a big impact on your life, and give the dates of their occurrences

Do you have any major health concerns?

CURRENT & PREVIOUS SYMPTOMS/BEHAVIORS/EXPERIENCES

NOW	PAST		NOW	PAST	
DISTRESSING SYMPTOMS			WORK/ACADEMIC CONCERNS		
<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>	Procrastination
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Time management
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	Poor performance evaluations/grades
<input type="checkbox"/>	<input type="checkbox"/>	Perfectionism	<input type="checkbox"/>	<input type="checkbox"/>	Test, speech, or performance anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Fearfulness/paranoia	<input type="checkbox"/>	<input type="checkbox"/>	Conflict with a colleague, boss, or professor/teacher
<input type="checkbox"/>	<input type="checkbox"/>	Obsessive thoughts	BODY IMAGE AND FOOD USE		
<input type="checkbox"/>	<input type="checkbox"/>	Compulsions/rituals	<input type="checkbox"/>	<input type="checkbox"/>	Binge eating
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Purging (vomiting)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Laxative use/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Motivation problems	<input type="checkbox"/>	<input type="checkbox"/>	Diet pill use/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty <i>falling</i> asleep	<input type="checkbox"/>	<input type="checkbox"/>	Restricting food intake or avoiding food/fasting
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty <i>staying</i> asleep	<input type="checkbox"/>	<input type="checkbox"/>	Overeating
<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Dieting
<input type="checkbox"/>	<input type="checkbox"/>	Excessive crying	<input type="checkbox"/>	<input type="checkbox"/>	Being overweight or underweight
<input type="checkbox"/>	<input type="checkbox"/>	Irritability/anger/hostility	<input type="checkbox"/>	<input type="checkbox"/>	Excessive exercise
<input type="checkbox"/>	<input type="checkbox"/>	Mania (overly energized with unusual thoughts or behaviors)	ADDICTION/DEPENDENCE CONCERNS		
<input type="checkbox"/>	<input type="checkbox"/>	Suicidal feelings/thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol addiction/dependence/overuse/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt(s)	<input type="checkbox"/>	<input type="checkbox"/>	Drug addiction/dependence/overuse/abuse
ROMANTIC RELATIONSHIP CONCERNS			<input type="checkbox"/>	<input type="checkbox"/>	Prescription drug addiction/dependence/overuse/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Dating concerns	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/tobacco use
<input type="checkbox"/>	<input type="checkbox"/>	Concerns about sex	<input type="checkbox"/>	<input type="checkbox"/>	Gambling
<input type="checkbox"/>	<input type="checkbox"/>	Conflict with partner/spouse	<input type="checkbox"/>	<input type="checkbox"/>	Excessive internet use
<input type="checkbox"/>	<input type="checkbox"/>	Break-up/end of romantic relationship	<input type="checkbox"/>	<input type="checkbox"/>	Sexual addiction
SOCIAL RELATIONSHIP CONCERNS			CONCERNS INVOLVING VIOLENCE		
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty making friends	<input type="checkbox"/>	<input type="checkbox"/>	Unwanted sex
<input type="checkbox"/>	<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	<input type="checkbox"/>	Being stalked
<input type="checkbox"/>	<input type="checkbox"/>	Social anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Intimate relationship violence
<input type="checkbox"/>	<input type="checkbox"/>	Conflict with friend(s)	<input type="checkbox"/>	<input type="checkbox"/>	Problems with anger control
GENDER/SEXUAL ORIENTATION CONCERNS			<input type="checkbox"/>	<input type="checkbox"/>	Participant in a violent incident
<input type="checkbox"/>	<input type="checkbox"/>	Gender identity or gender issues or questions	<input type="checkbox"/>	<input type="checkbox"/>	Witness of a violent incident
<input type="checkbox"/>	<input type="checkbox"/>	Lesbian/gay/bisexual issues or orientation questions	<input type="checkbox"/>	<input type="checkbox"/>	Perpetrator of abuse (physical/sexual/psychological)
<input type="checkbox"/>	<input type="checkbox"/>	Asexual/Demisexual/Greysexual issues or questions	<input type="checkbox"/>	<input type="checkbox"/>	Survivor of abuse (physical/sexual/psychological)

HOME AND FAMILY EXPERIENCES

Did the following occur in your family/home environment?	Yes	No	Not Sure
Parents divorced or permanently separated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent, hostile arguing among family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death of a parent or sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent(s) or sibling(s) with a drinking or drug problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member with an eating problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member with a debilitating illness, injury, or disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member prosecuted for criminal activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member attempted/committed suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical abuse in your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse in your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there any other information about your mental health/emotional wellness that you believe will be pertinent to or could impact your care and treatment? Please explain below.

I hereby certify that all the above information is true and correct to the best of my knowledge and belief.

Signature

Name

Date

Systems Survey Form | Restricted to Professional Use



NAME: _____ AGE: _____ HEALTH CARE PROFESSIONAL: _____ DATE: _____

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, don't circle anything** for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

1.	1 2 3	Acid foods upset
2.	1 2 3	Get chilled often
3.	1 2 3	"Lump" in throat
4.	1 2 3	Dry mouth, eyes, nose
5.	1 2 3	Pulse speeds after meal
6.	1 2 3	Keyed up, fail to calm
7.	1 2 3	Gag occasionally
8.	1 2 3	Unable to relax, startle easily
9.	1 2 3	Extremities cold, clammy
10.	1 2 3	Strong light irritates
11.	1 2 3	Occasionally weak urine flow
12.	1 2 3	Heart pounds after retiring
13.	1 2 3	"Nervous" stomach
14.	1 2 3	Appetite reduced occasionally
15.	1 2 3	Cold sweats often
16.	1 2 3	Get heated easily
17.	1 2 3	Nerve discomfort
18.	1 2 3	Staring, blink little
19.	1 2 3	Sour stomach frequent
_____ TOTAL 1 2 3		

GROUP 2

20.	1 2 3	Joint stiffness after arising
21.	1 2 3	Muscle, leg, toe cramps at night
22.	1 2 3	"Butterfly" stomach, cramps
23.	1 2 3	Eyes or nose watery
24.	1 2 3	Eyes blink often
25.	1 2 3	Eyelids swollen, puffy
26.	1 2 3	Indigestion soon after meals
27.	1 2 3	Always seem hungry, feel "lightheaded" often
28.	1 2 3	Digestion rapid
29.	1 2 3	Vomit occasionally
30.	1 2 3	Hoarseness frequent
31.	1 2 3	Uneven breathing
32.	1 2 3	Pulse slow
33.	1 2 3	Gagging reflex slow
34.	1 2 3	Difficulty swallowing
35.	1 2 3	Temporary constipation or diarrhea
36.	1 2 3	"Slow starter"
37.	1 2 3	Get "chilled"
38.	1 2 3	Perspire easily
39.	1 2 3	Sensitive to cold
40.	1 2 3	Upper respiratory challenges
_____ TOTAL 1 2 3		

GROUP 3

41.	1 2 3	Eat when nervous
42.	1 2 3	Excessive appetite
43.	1 2 3	Hungry between meals
44.	1 2 3	Irritable before meals

45.	1 2 3	Get "shaky" if hungry
46.	1 2 3	Fatigue, eating relieves
47.	1 2 3	"Lightheaded" if meals delayed
48.	1 2 3	Heart palpitates if meals missed or delayed
49.	1 2 3	Fatigue in afternoon
50.	1 2 3	Overeating sweets upsets
51.	1 2 3	Awaken after few hours sleep, hard to get back to sleep
52.	1 2 3	Crave candy or coffee in afternoon
53.	1 2 3	Moods of "blues" or melancholy
54.	1 2 3	Craving for sweets or snacks
_____ TOTAL 1 2 3		

GROUP 4

55.	1 2 3	Hands and feet go to sleep easily, numbness
56.	1 2 3	Sigh frequently, "air hunger"
57.	1 2 3	Aware of "breathing heavily"
58.	1 2 3	High-altitude discomfort
59.	1 2 3	Open windows in closed room
60.	1 2 3	Immune system challenges
61.	1 2 3	Afternoon "yawner"
62.	1 2 3	Get "drowsy" often
63.	1 2 3	Swollen ankles worse at night
64.	1 2 3	Muscle cramps, worse during exercise; get "charley horse"
65.	1 2 3	Difficulty catching breath, especially during exercise
66.	1 2 3	Tightness or pressure in chest, worse on exertion
67.	1 2 3	Skin discolors easily after impact
68.	1 2 3	Tendency to anemia
69.	1 2 3	Noises in head or "ringing in ears"
70.	1 2 3	Fatigue upon exertion
_____ TOTAL 1 2 3		

GROUP 5

71.	1 2 3	Dizziness
72.	1 2 3	Dry skin
73.	1 2 3	Burning feet
74.	1 2 3	Blurred vision
75.	1 2 3	Itching skin and feet
76.	1 2 3	Hair loss
77.	1 2 3	Occasional skin rashes
78.	1 2 3	Bitter, metallic taste in mouth in morning
79.	1 2 3	Occasional constipation
80.	1 2 3	Worrier, feels insecure
81.	1 2 3	Nausea occasionally after eating
82.	1 2 3	Greasy foods upset
83.	1 2 3	Stools light-colored
84.	1 2 3	Skin peels on foot soles

85.	1 2 3	Discomfort between shoulder blades
86.	1 2 3	Occasional laxative use
87.	1 2 3	Stools alternate from soft to watery
88.	1 2 3	Sneezing attacks
89.	1 2 3	Dreaming, nightmare-type bad dreams
90.	1 2 3	Bad breath (halitosis)
91.	1 2 3	Milk products cause upset
92.	1 2 3	Sensitive to hot weather
93.	1 2 3	Burning or itching anus
94.	1 2 3	Crave sweets
_____ TOTAL 1 2 3		

GROUP 6

95.	1 2 3	Loss of taste for meat
96.	1 2 3	Lower bowel gas several hours after eating
97.	1 2 3	Burning stomach sensations, eating relieves
98.	1 2 3	Coated tongue
99.	1 2 3	Pass large amounts of foul-smelling gas
100.	1 2 3	Indigestion 1/2-1 hour after eating; may be up to 3-4 hours after
101.	1 2 3	Watery or loose stool
102.	1 2 3	Gas shortly after eating
103.	1 2 3	Stomach "bloating"
_____ TOTAL 1 2 3		

GROUP 7A

104.	1 2 3	Difficulty sleeping
105.	1 2 3	On edge
106.	1 2 3	Can't gain weight
107.	1 2 3	Intolerance to heat
108.	1 2 3	Highly emotional
109.	1 2 3	Flush easily
110.	1 2 3	Night sweats
111.	1 2 3	Thin, moist skin
112.	1 2 3	Inward trembling
113.	1 2 3	Heart races
114.	1 2 3	Increased appetite without weight gain
115.	1 2 3	Pulse fast at rest
116.	1 2 3	Eyelids and face twitch
117.	1 2 3	Irritable and restless
118.	1 2 3	Can't work under pressure
_____ TOTAL 1 2 3		

GROUP 7B

- 119. 1 2 3 Increase in weight
- 120. 1 2 3 Decrease in appetite
- 121. 1 2 3 Fatigue easily
- 122. 1 2 3 Ringing in ears
- 123. 1 2 3 Sleepy during day
- 124. 1 2 3 Sensitive to cold
- 125. 1 2 3 Dry or scaly skin
- 126. 1 2 3 Temporary constipation
- 127. 1 2 3 Mental sluggishness
- 128. 1 2 3 Hair coarse, falls out
- 129. 1 2 3 Tension in head upon arising
wears off during day
- 130. 1 2 3 Slow pulse below 65
- 131. 1 2 3 Changing urinary function
- 132. 1 2 3 Sounds appear diminished
- 133. 1 2 3 Reduced initiative

____ _ TOTAL
1 2 3

GROUP 7C

- 134. 1 2 3 Failing memory with age
- 135. 1 2 3 Increased sex drive
- 136. 1 2 3 Episodes of tension in head
- 137. 1 2 3 Decreased sugar tolerance

____ _ TOTAL
1 2 3

GROUP 7D

- 138. 1 2 3 Abnormal thirst
- 139. 1 2 3 Bloating of abdomen
- 140. 1 2 3 Weight gain around hips or waist
- 141. 1 2 3 Sex drive reduced or lacking
- 142. 1 2 3 Tendency for stomach issues
- 143. 1 2 3 Immune system challenges
- 144. 1 2 3 Menstrual disorders

____ _ TOTAL
1 2 3

GROUP 7E

- 145. 1 2 3 Dizziness
- 146. 1 2 3 Headaches
- 147. 1 2 3 Hot flashes
- 148. 1 2 3 Hair growth on face
or body (female)
- 149. 1 2 3 Sugar in urine (not diabetes)
- 150. 1 2 3 Masculine tendencies (female)

____ _ TOTAL
1 2 3

GROUP 7F

- 151. 1 2 3 Weakness, dizziness
- 152. 1 2 3 Tired throughout day
- 153. 1 2 3 Nails weak, ridged
- 154. 1 2 3 Sensitive skin
- 155. 1 2 3 Stiff joints
- 156. 1 2 3 Perspiration increase
- 157. 1 2 3 Bowel discomfort
- 158. 1 2 3 Poor circulation
- 159. 1 2 3 Swollen ankles
- 160. 1 2 3 Crave salt
- 161. 1 2 3 Areas of skin darkening
- 162. 1 2 3 Upper respiratory sensitivity
- 163. 1 2 3 Tiredness
- 164. 1 2 3 Breathing challenges

____ _ TOTAL
1 2 3

GROUP 8

- 165. 1 2 3 Muscle weakness
- 166. 1 2 3 Lack of stamina
- 167. 1 2 3 Drowsiness after eating
- 168. 1 2 3 Muscular soreness
- 169. 1 2 3 Heart races
- 170. 1 2 3 Hyperirritable
- 171. 1 2 3 Feeling of a band around head
- 172. 1 2 3 Melancholia (feeling of sadness)
- 173. 1 2 3 Swelling of ankles
- 174. 1 2 3 Change in urinary function
- 175. 1 2 3 Tendency to consume
sweets/carbohydrates
- 176. 1 2 3 Muscle spasms
- 177. 1 2 3 Blurred vision
- 178. 1 2 3 Involuntary muscle action
- 179. 1 2 3 Numbness
- 180. 1 2 3 Night sweats
- 181. 1 2 3 Rapid digestion
- 182. 1 2 3 Sensitivity to noise
- 183. 1 2 3 Redness of palms of hands and
bottom of feet
- 184. 1 2 3 Visible veins on chest and abdomen
- 185. 1 2 3 Hemorrhoids
- 186. 1 2 3 Apprehension (feeling that
something bad is going to happen)

- 187. 1 2 3 Nervousness causing
loss of appetite
- 188. 1 2 3 Nervousness with indigestion
- 189. 1 2 3 Gastritis
- 190. 1 2 3 Forgetfulness
- 191. 1 2 3 Thinning hair

____ _ TOTAL
1 2 3

FEMALE ONLY

- 192. 1 2 3 Very easily fatigued
- 193. 1 2 3 Premenstrual tension
- 194. 1 2 3 Menses more painful than usual
- 195. 1 2 3 Depressed feelings
before menstruation
- 196. 1 2 3 Painful breasts during menses
- 197. 1 2 3 Menstruate too frequently
- 198. 1 2 3 Hysterectomy/ovaries removed
- 199. 1 2 3 Menopausal hot flashes
- 200. 1 2 3 Menses scanty or missed
- 201. 1 2 3 Acne, worse at menses

____ _ TOTAL
1 2 3

MALE ONLY

- 202. 1 2 3 Less involved in
exercise/social activities
- 203. 1 2 3 Difficult to postpone urination
- 204. 1 2 3 Weak urinary stream
- 205. 1 2 3 Feeling of "blues" or melancholy
- 206. 1 2 3 Feeling of incomplete
bowel evacuation
- 207. 1 2 3 Lack of energy
- 208. 1 2 3 Muscles in arms and legs seem
softer/smaller
- 209. 1 2 3 Tire too easily
- 210. 1 2 3 Avoid activity
- 211. 1 2 3 Leg nervousness at night
- 212. 1 2 3 Diminished sex drive

____ _ TOTAL
1 2 3

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

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

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion	Large Intestine (Palpate)	Adrenals	Pass/Fail Zinc Taste Test
_____ Hydrochloric	_____ Ascending	_____ Pass/Fail Pupil Dilation Exam	_____ Pass/Fail Cuff Test
_____ Acid Point	_____ Transverse	_____ Postural Hypotension	_____ Cuff Pressure
_____ Enzyme Point	_____ Descending	_____ Supine	_____ pH of Saliva
_____ Murphy's Sign		_____ Standing	_____ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning before leaving bed, with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test such as getting up for any reason, shaking down the thermometer, etc. It is important that the test, be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES (any two days during the month)
FEMALES HAVING MENSTRUAL CYCLES (the second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. If you are a patient, you should not use the systems survey. If you are not a trained health care practitioner, you should not use the systems survey. Health care practitioners should only use the systems survey to provide services that are within the scope of their license or professional training. The systems survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.

Name:

Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a purification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloating feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4
Total:	_____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4
Total:	_____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4
Total:	_____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4
Total:	_____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4
Total:	_____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4
Total:	_____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4
Total:	_____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4
Total:	_____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4
Total:	_____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4
Total:	_____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4
Total:	_____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4
Total:	_____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Rheumatoid arthritis	0 1 2 3 4
c. Osteoarthritis	0 1 2 3 4
d. Stiffness or limited movement	0 1 2 3 4
e. Pain or aches in muscles	0 1 2 3 4
f. Recurrent back aches	0 1 2 3 4
g. Feeling of weakness or tiredness	0 1 2 3 4
Total:	_____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4
Total:	_____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4
Total:	_____

Section I Total: _____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.									
0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily
a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)									
									0 1 2 3 4
b. How often are pesticides used in your home?									
									0 1 2 3 4
c. How often do you have your home treated for insects?									
									0 1 2 3 4
d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?									
									0 1 2 3 4
e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics?									
									0 1 2 3 4
f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?									
									0 1 2 3 4
									Total: _____

17. Circle the corresponding number for questions 17a-17b below.									
0	No	1	Mild Change	2	Moderate Change	3	Drastic Change		
a. Have you noticed any negative change in your health since you moved into your home or apartment?									
									0 1 2 3
b. Have you noticed any change in your health since you started your new job?									
									0 1 2 3
									Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.									
								No	Yes
a. Do you have a water purification system in your home?									
								2	0
b. Do you have any indoor pets?									
								0	2
c. Do you have an air purification system in your home?									
								2	0
d. Are you a dentist, painter, farm worker, or construction worker?									
								0	2
									Total: _____

Section II Total:	
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Grand Total (Section I & Section II)	
<p>Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a purification program.</p>	

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.