Carol Shwery DC Health
Series Questionnaire #11
Elimination Assessment

Name:_____Date of Birth:_____ Date:_____

Address:_____City: _____State: ____Zip:_____

Dear Client,

Our ability to draw effective conclusions about your present state of health and how to improve it depends to a significant extent on your ability to respond thoughtfully and accurately to both these written questionnaires and those posed by the doctor during your consultations. The doctor is the only person who will review these forms and your confidentiality will be strictly maintained. Your careful consideration of each of the following questions will enhance the doctor's efficiency and will provide for more effective use of your scheduled consultation time. There are usually a few questions which you will not know the answers to, simply leave these bland for the time being and proceed from there. Thank you for your time in advance and we look forward to working together to achieve your health goals.

Colon/Bowels:

1. My bowels move: _____ x day, _____ x week (on the average)
2. Laxative use: _____ x day, _____ x weekly, _____ x monthly, _____ never, Type used _____

Answer codes for the below: 1 = never 2 = infrequent 3 = frequently 4 = constantly

3. My stools are:
   - _____ Large (3 fingers wide & 6" plus in length)
   - _____ Soft and well-formed (smooth texture)
   - _____ Medium (2 fingers wide & 4-6 plus in length and well-formed)
   - _____ Thin, long or narrow stools
   - _____ Often float
   - _____ Small and hard
   - _____ Large and hard
   - _____ Difficult to pass
   - _____ Loose but not watery
   - _____ Diarrhea
   - _____ Alternates between hard (constipated) and loose & watery (diarrhea-like)

Stool odor:
- _____ Offensive usually
- _____ Offensive occasionally

Answer codes for the below: 1 = never 2 – infrequent 3 = frequently 4 = constantly

Stool color is: _____ Medium brown, consistently
_____ Dark brown, consistently
_____ Very dark or black
_____ Yellow, light brown or clay colored
_____ Greenish color
_____ Greasy, shiny appearance
_____ Blood is visible in them
_____ Have mucus in them
_____ Varies a lot

Intestinal gas: _____ Daily
_____ Occasionally
_____ Excessive
_____ Present with pain
_____ Foul smelling
_____ Little odor

4. Do you have trouble initiating your bowel movement, yet the stool is not too large or too hard? Yes_____ No _____

4. Does abdominal discomfort or cramping ever accompany bowel movements? Yes_____ No _____ How often? _____

6. Have you ever been diagnosed as having a stomach, liver, gall bladder, pancreas, intestinal or bowel disorder or disease? Yes_____ No _____If yes, please explain:_____

_____

7. Have you had or do you have hemorrhoids or varicose veins? Explain:_____

_____

8. Do you make a conscious effort to eat a high fiber diet? Yes_____ No _____ What do you eat?

_____

9. Do you usually pay attention when nature calls? Yes_____ No _____

10. Do you use bottled water? Yes_____ No _____

11. Do you drink tap water? ____Well water or ____Municipal,

12. Do you make a conscious effort to drink 6-8 glasses of water daily? Yes_____ No _____

13. Do you feel satisfied that your bladder is completely empty after urination? Yes_____ No _____

14. Do you have any burning or irritation during or after urination? Yes_____ No _____

15. Do you have difficulty starting or stopping when urinating? Yes_____ No _____

16. Do you get up in the middle of the night to urinate? Yes_____ No _____
    How often? _____ x night _____ x week

17. Does your urine have a strong odor to it? Yes_____ No _____Is it usually:
    clear _____ cloudy _____ bright yellow _____
    dark yellow _____ orange _____

18. At times it has been: cloudy _____ orange _____ red _____
    greenish _____ brownish _____

19. Please list the number and nature of the beverages you drink daily and regularly? _____

_____

20. Do you get recurrent bladder infections? Yes_____ No _____

21. Do you get unexplained deep lower back pains just below your ribs? Yes_____ No _____

Exercises:

22. Do you exercise regularly? Yes_____ No _____ x daily, _____ x weekly, _____ x monthly

23. Please indicate the nature of the exercise and also the number of minutes per session.

24. Do you monitor your pulse while exercising Yes_____ No _____
    What is your resting pulse rate? _____ beats per minutes

25. Do you perspire with your exercise? Lightly _____ moderately _____ heavily _____

26. Do you perspire other than when exercising? Yes_____ No _____When?_____

27. Do you have difficulty perspiring? Yes_____ No _____

28. Does your perspiration smell strong? Yes_____ No _____
    Does it smell like urine? Yes_____ No _____

29. Do you get short of breath with even slight exertion? Yes_____ No _____

30. What is your basal temperature? (See "Axillary Temperature Test") _____

31. Do you take regular saunas, steam baths or do cold friction rubs? Yes_____ No _____

Occupational/Household:

32. What is your occupation? _____
Please describe the work? _____

33. Do you work in an office building? Yes_____ No _____
How many hours per week? _____
Do the windows open? Yes_____ No _____

34. Do you have specialized air filtration at your work place? Yes_____ No _____
What type?_____

35. Do you work in the presence of toxic fumes, or chemicals? Yes_____ No _____
Have you ever? Yes_____ No _____
Please provide details? _____

36. Do you smoke? Yes_____ No _____
How much do you smoke?_____

37. Are you exposed to second hand smoke? Yes_____ No _____

38. Do you drink alcohol? Yes_____ No _____
What type do you drink?

39. How often do you drink alcohol? Daily _____ Weekly _____ Monthly _____

40. Do you use any type of drug prescription or otherwise? Yes_____ No _____
What type/types?_____

41. How often, what dosage and for what symptom?_____

42. Do any of your hobbies involve toxic materials? Yes_____ No _____
If so, what kind (paints, plastics, gases, etc.)_____

43. Do you have specialized air filtration at home? Yes_____ No _____
What type?_____

44. Do you live in a city? Yes_____ No _____
How much time do you spend outside per day? _____ Per week? _____

45. Do you wear? sunglasses Yes_____ No _____, contact lenses Yes_____ No _____or glasses when outside Yes_____ No _____

46. Do you have any respiratory disorders, i.e., Sinusitis, Asthma, Emphysema, Bronchitis, etc.?

Yes_____ No _____Please explain _____

47. Do you have house pets? Yes_____ No _____

What type?_____

48. Have you ever conducted a detoxification program supervised by a qualified health professional? Yes_____ No _____Please explain_____

49. Do you fast? Yes_____ No _____How often and for how long?_____

50. Are you on a special diet? Yes_____ No _____Please explain:_____

51. If you avoid any foods or follow a special dietary program, please explain:_____

_____

52. On the average night, what time do you go to bed? _____
What time do you usually arise? _____
How many hours do you sleep on the average night?_____

53. Do you feel well rested on awaking in the morning (i.e., ready to arise and get at things)?
Yes_____ No _____

54. Do you nap or rest horizontally through the day? Yes_____ No _____
If yes, for how long on the average? _____

55. On a scale of 1-10, how do you rate the quality of your sleep?
(1 being lousy, and 10 being perfectly restful)? _____

Note:_____

_____

This questionnaire is strictly confidential between you and the Doctor. Your accurate responses are vital to effective health care at this office. Please go back over your responses and consider their accuracy. Thank you!