Confidential Nutrition Patient Questionnaire

The doctors and staff of Cedars Chiropractic and Wellness Center welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another healthcare provider, if appropriate. Your visit to our office does not replace the need for you to receive care by your primary care physician or medical specialist(s). We always encourage you to seek the opinion of your medical doctor(s). It is often necessary to order standard or specialized lab tests to assess your symptoms and recommend a possible course of action. Insurance carriers do not typically cover this visit or specialized labs. We are happy to supply you with a receipt should you choose to submit it yourself and attempt reimbursement. You may be able to use flex spending account (FSA) or Health Savings Account to cover this visit and/or needed labs.

Patient information

Name (First, Middle, last) _____ Date of Birth_____ Age: _____

Address _____ City, State, Zip_____

Social Security #:_____ Sex: M / F Marital Status: __Single __Married __Widowed __Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Which number would you like our staff to use when contacting you? Home Cell Work

Would you like to receive appointment reminders? (You may choose all options)

___ By Email (Please provide your email address): _____

___ Would you like to receive our monthly calendar of events and announcements by email?

___ By Text message (Please provide the cell phone number to receive text messages on and the cell phone provider):

Employment Status

__ Employed __Unemployed __Retired __Part-time Student __Full time student __Other

Employer: _____ Occupation: _____

Does your employer offer a Corporate Wellness Program? Yes / No Name of Person at HR in charge of Wellness Program _____

Responsible Party Information

Name (if other than self): _____ Relationship to patient: _____

Address: _____ City, State, Zip: _____

Emergency Contact

Name: _____ Relationship to patient: _____

Phone #: _____

Is Your Illness or Injury Related to Any of the Following?

__Employment __Emergency __Accident __ Progressive/Chronic Other: _____

If employment related, has your employer been notified? __ Yes __ No

Who may we thank for your visit today?

__ Internet __Facebook __ Attorney __ Doctor __ Patient __ Magazine __Other

Please print the name of the person or source who referred you: _____

Acceptance as Patient

I understand and agree that the doctors of Cedars Chiropractic and Wellness center have the right to refuse to accept me as a patient at any time before treatment begins. I also understand that the doctors have the right to release me from care for non compliance or if they deem they are no longer able to help me with my condition. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. I also understand that a Quote of Eligibility and Coverage by my insurance is not a guarantee of payment and that I am responsible for paying any balance due.

Signature: _____ **Date**: _____

Please check (_) any conditions YOU have or have had in the past.
Place a C for Current, P for Past Condition or B for Both (past and present) adjoining each condition.

Current Symptoms: Please check all that apply.

C, P, B	GENERAL	C, P, B	HEENT	C, P, B	GI	C, P, B	MALE ONLY
	Cancer		Allergies		Anemia		Breast Lump
	Chills		Asthma		Appendicitis		Discharge from Penis
	Diabetes		Bleeding Gums		Bad Breath		Erection Difficulties
	Fever		Blurred Vision		Bloating		Lump in Testicle
	Goiter		Bronchitis		Bowel/Bladder		Sore on Penis
	Gout		Cataracts		Change in Appetite		Testicular Pain
	Hepatitis		Difficulty Swallowing		Constipation		Testicular Swelling
	Hernia		Double Vision		Diarrhea	C, P, B	FEMALE ONLY
	Liver Disease		Dry Eyes		Excessive Thirst		Abnormal Pap Smear
	Sleep Disturbance		Earache		Gallbladder Disease		Bleeding between Periods
	Sweats		Ear Discharge		Gas		Breast Lump or Thickening
	Thyroid Problems		Emphysema		Heartburn		Heavy Bleeding
C, P, B	EMOTIONAL		Hair Loss		Hemorrhoids		Hot Flashes
	Alcoholism		Headache		Indigestion		Nipple Discharge
	Anxiety		Hearing Loss		Nausea		Painful Intercourse
	Anorexia		Hoarseness		Rectal Bleeding		PMS
	Bulemia		Glaucoma		Stomach Pain		Vaginal Discharge
	Chemical Dependency		Gum Disease		Ulcers		Vaginal Dryness
	Depression		Migraine		Vomiting	_____	Last Menstrual Period
	Eating Disorder		Mouth Sores	C, P, B	HEART/LUNGS	_____	Last Pap Smear
	Fear/Panic		Nasal Congestion		Chest Pain		Have you had a
	High Strung		Nosebleeds		Heart Disease	Y/N	Mammogram
	Irritability		Persistent Cough		High Blood Pressure	C, P, B	URINARY
	Psychiatric Disorder		Postnasal Drip		High Cholesterol		Blood in Urine
	Suicidal		Ringing in Ears		Irregular Pulse		Difficult Urination
C, P, B	NEUROLOGICAL		Sinus Problems		Low Blood Pressure		Frequent Infections
	Carpal Tunnel		Swollen Lymph Nodes		Murmur		Frequent Urination
	Dizziness		Tonsillitis		Pacemaker		Kidney Disease
	Epilepsy		Visual Disturbance		Pain while Breathing		Lack of Bladder Control
	Fainting	C, P, B	MUSCULOSKELETAL		Palpitations		Painful Urination
	Forgetfulness		Arthritis		Pneumonia	C, P, B	SKIN
	Numbness/Tingling		Joint Pain		Poor Circulation		Bruise Easily
	Paralysis		Lack of Coordination		Rapid Heart Beat		Change in Moles
	Sciatica		Leg Cramps		Rheumatic Fever		Chicken Pox
	Seizures		Multiple Sclerosis		Short of Breath		Dry Skin
C, P, B	REPRODUCTIVE		Polio		Stroke		Itching
	AIDS		Stiffness		Suffocating Feeling		Measles
	Gonorrhea		Tremors		Swelling Ankles		Mumps
	Herpes		Weakness		Tuberculosis		Psoriasis/Eczema
	HIV Positive				Typhoid Fever		Rash
	Miscarriage(s)				Varicose Veins		Scarlet Fever
	Prostate Problems				Wheezing		Sores that won't heal
	Veneral Disease						Warts

Confidential Nutrition Patient Questionnaire

Current weight_____ Lbs Most Ever Weighed _____Lbs Desired Weight? _____ Lbs

Height: _____

Exercise – How many days/week? _____ Minutes/day? _____ Type? _____

Give the primary reason you are consulting with our doctor. Be sure to give a detailed account, including when and why the condition started, what has been done to date, the results you have had, and if the problem is getting better, worse, or staying the same.

_____
_____
_____
_____
_____

Give any secondary health problems you are experiencing. List the most severe first.

_____
_____
_____
_____

List all nutritional vitamins/supplement products you take. Include the name of the company, amount, why you are taking them, and how long you have been taking them. We ask that you bring all your bottles to your consultation.

Name	Amount	Company	How Long	Why Taking

List all drugs (prescription or not) you currently take. Include the reason you take them, amount, length of time taken, and results. List all other drugs you have taken in the past.

Name	Amount	Why Taking	How Long	Results

List all surgeries you have had, including the date, why it was done, and the results.

Surgery	Date	Why Done	Results

List all allergies you have to food, drugs, or other substances, along with the symptoms they produce. Indicate how long you have suffered from each allergy.

Allergy (s)	Symptom (s)

Allergy (s)	Symptom (s)

Answer the following questions to the best of your ability. If you don't know the answer, leave blank.

( )yes ( )no	My mother was healthy while pregnant with me. If no, describe
( )yes ( )no	Was your birth natural? If no, please check: () anesthesia () forceps () c-section
( )yes ( )no	Were you breast fed for at least (6) months?
( )yes ( )no	Were you fed anything other than breast or cow formula milk in the first (6) months?
	List Items:
( )yes ( )no	Were you a colicky baby? Until what age?
( )yes ( )no	Have you ever lived in a foreign country? List:
( )yes ( )no	Have you ever fainted or had a convulsion? Describe:

Mark if you have ever had:

( ) Measles	( ) Chicken Pox	( ) Hepatitis	( ) Shingles	( ) Scarlet Fever	( ) Lyme Disease	( ) Rheumatic Fever
( ) Herpes	( ) AIDS/HIV	( )German Measles	( ) Mumps	( ) Mononucleosis	( ) Venereal Disease:	

Diet History – Mark each one using an "0" or "none" when appropriate

Give the amount of each you consume

_____oz. water	_____day	_____not daily
_____oz. alcohol	_____day	_____not daily
_____oz. coffee/tea	_____day	_____not daily
_____oz. soda	_____day	_____not daily
_____oz. juice	_____day	_____not daily
oz. other _____		

List your 10 most favorite foods eaten most frequently:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Give a percentage of the following. Total for each line equaling 100%

Where daily diet is prepared:	home_____%	restaurant_____%	fast food_____%	vending machine _____%
How food is prepared:	baked steamed	broiled microwaved	boiled grilled	fried
Food is prepared from:	fresh	canned	frozen	prepackaged
My appetite is:	( ) normal	( ) excessive	( ) poor	( ) none
I crave:	( ) sweets	( ) salts	( )chocolate	( ) dirt ( ) other
The type of water used for drinking/cooking is:	( ) tap or city ( ) spring	( ) well ( ) rain	( )bottled distilled	( ) bottled filtered ( ) reverse osmosis
If purchase water, it is in:	( ) soft plastic	( ) hard plastic	( ) glass	
Foods that agree with you:	( ) raw veggies ( ) milk/dairy ( ) other	( ) raw fruit ( ) greasy	( ) fats ( ) eggs	( ) fried ( )beans ( ) sugar ( ) onions ( ) cabbage ( ) spices

What symptoms do you have from foods that disagree with you?

Do you fast? ( ) yes ( ) no If yes, how long?
Have you ever done a detoxification program before? ( ) yes ( ) no Explain:

Check any of the following diets you have tried:

( ) low cholesterol ( ) low salt ( ) low purine ( ) all energy ( ) low fat ( ) diabetic ( ) ulcer
( ) high fiber ( ) renal /kidney ( ) diverticulitis ( ) complex carbohydrate ( ) high protein
( ) herbalife ( ) advocare ( ) IDLife ( ) weight watchers ( ) atkins
(jenny craig ( ) nutrisystem ( ) south beach ( ) blood type ( ) zone
( ) other: _____

Energy Level & Sleep Patterns

Please rate the following areas of your health status on a scale of 1 to 10, with 1 being WEAK and 10 being STRONG.

	1	2	3	4	5	6	7	8	9	10
Energy Level										
Exercise										
Fun & Recreation										
Hydration										
Nutrition										
Prayer & Meditation										
Stress Management										
Unhealthy Habits										
Sleep										

At this phase in your life, is paying attention to your health important to you?
Always ***Sometimes*** ***Never***

Do you find the word diet and nutrition to be confusing and overwhelming?
Always ***Sometimes*** ***Never***

Do you feel confident about the absorption and the effectiveness of your vitamins / supplements?
Always ***Sometimes*** ***Never***

Do you take energy drinks to make it through the day? [ ] yes [ ] no
[ ]Red Bull [ ]Monster [ ] Sparks [ ] 5-hour energy [ ] Other_____

Continue to next page

Confidential Nutrition Patient Questionnaire

Please rate the following areas of your health status AS YOU WOULD LIKE THEM TO BE IN 3 MONTHS, with 1 being WEAK and 10 being STRONG.

	1	2	3	4	5	6	7	8	9	10
Energy Level										
Exercise										
Fun & Recreation										
Hydration										
Nutrition										
Prayer & Meditation										
Stress Management										
Unhealthy Habits										
Sleep										

How important is it for you to reach towards accomplishing these improvements in the next 3 months?

Extremely Important ***Very Important*** ***Somewhat Important*** ***Not Important***

Are you ready to discuss and initiate a Healthy Simplified plan that could help you achieve your goal(s)?

Yes [ ] ***No [ ]***

Sleep History

How many hours per night: _____

Please check if you have the following:

☐ Frequent Walking ☐ Nightmares ☐ Snoring ☐ Nap during the day ☐ Sleep Walk

Bowel Health **BM= Bowl movement or stool**

How many times do you have a BM? _____ times/day _____ times/week

Do you use laxatives? ( ) yes ( ) no **How often?** _____

Do you get the urge to have a BM? ( ) yes ( ) no **Do you have pain with BM?** ( ) yes ( ) no

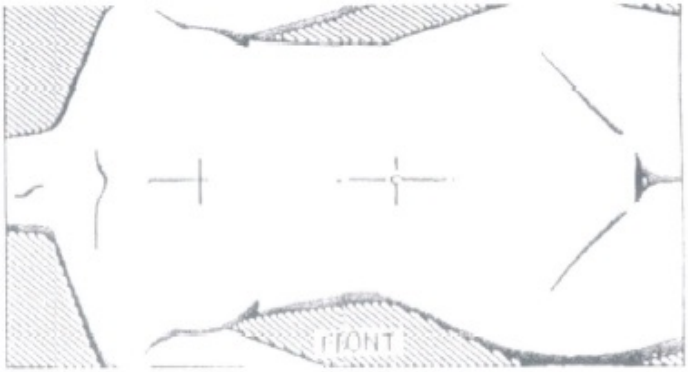
Answer key for the following: 0 = never 1 = rarely 2 = frequently 3 = always

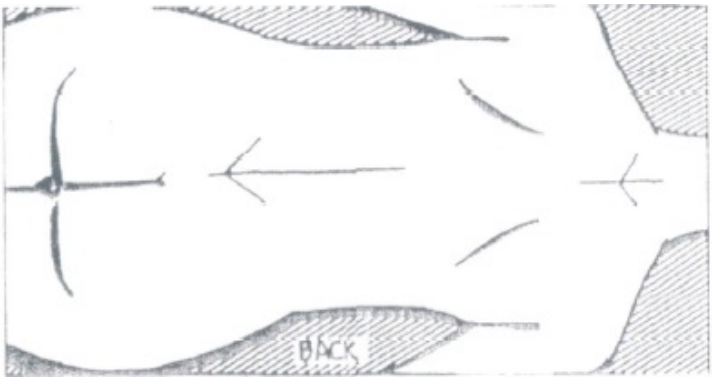
Stool Size	**Stool Consistency**	**Stool Color**
_____ 2" wide & 6+" length	_____ float like a submarine	_____ med/dark brown
_____ 1" wide & 4+" length	_____ float on top of water	_____ very dark/black
_____ thin, long, or narrow	_____ sink to bottom	_____ yellow/tan/clay
_____ small, hard	_____ loose but not watery	_____ greenish
_____ large, hard	_____ diarrhea	_____ blood is visible
_____ difficult to pass	_____ alternate hard/diarrhea	_____ mucous in/around

( ) yes ( ) no Have you ever had worms or parasites? How treated?_____

( ) yes ( ) no Do you presently have rectal itching? ( ) day ( ) night ( ) continuously

Digestion **Mark and area of distress associated with food intake on the diagrams.**





I get pain/heartburn: ( ) before eating ( ) after eating ( ) when lie down ( ) upon arising

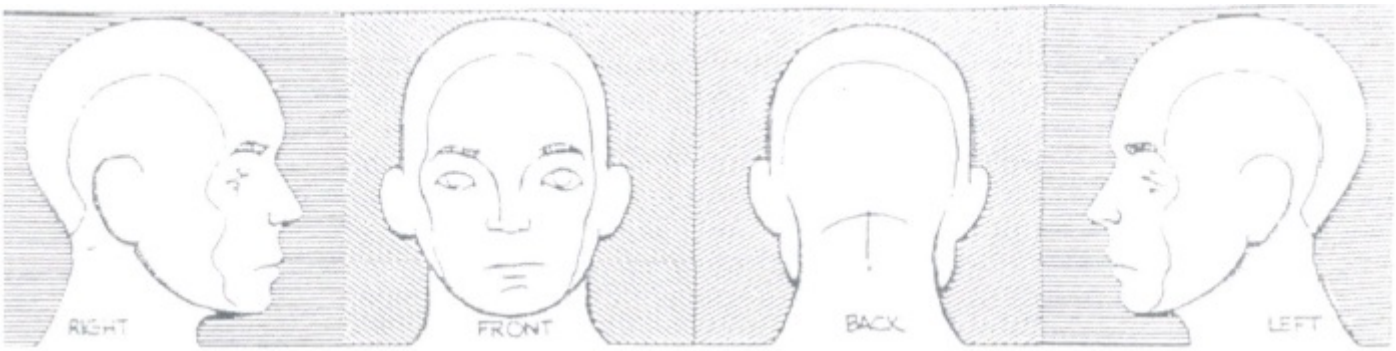
I have: ( ) indigestion ( ) belching ( )GERD ( ) intestinal gas ( ) bloating
( ) immediately after eating ( ) 1-2 hours ( ) 3-5 hours ( ) 6+ hours
( ) no odor ( ) some odor ( ) odor usually ( ) foul smelling
( ) hiatal hernia ( ) esophageal burning/reflux ( ) raise head of bed to sleep

List any drugs (prescription or not) or natural remedies you take for stomach or bowel symptoms.

Product	Dose	How Frequent	Results

Confidential Nutrition Patient Questionnaire

Head **Mouth** **Throat** **Mark any areas of headache or pain. Mark all that apply.**



My teeth are:	( ) good	( ) some fillings	( ) bad	( ) some missing
I wear dentures:	( ) upper	( ) lower	( ) partial	( ) crowns
My breath is:	( ) good	( ) slight odor	( ) odor on/off	( ) offensive odor usually
My tongue is:	( ) covered with taste buds	( ) sore	( ) furrowed	( ) coated_____color
My tongue color is:	( ) pink	( ) red	( ) red blotchy	( ) pink/red tip
My tonsils are:	( ) normal	( ) removed at age	( ) enlarged	( ) spotted
My sense of taste is:	( ) normal ( ) poor	( ) no taste	( ) over- salt foods	( ) canker sores
My lips are:	( ) normal ( ) dry	( ) peel a lot	( ) fever blisters often	( ) cracks in corner

I get headaches:	( ) daily ( ) weekly	( ) rarely	( ) never	
	( ) wake up with	( ) AM	( ) PM	
	( ) of different types	( ) with some food/drinks		
	( ) with aura	( ) with nausea/vomiting		

Muscle **Ligament** **Joint** **Nerve**

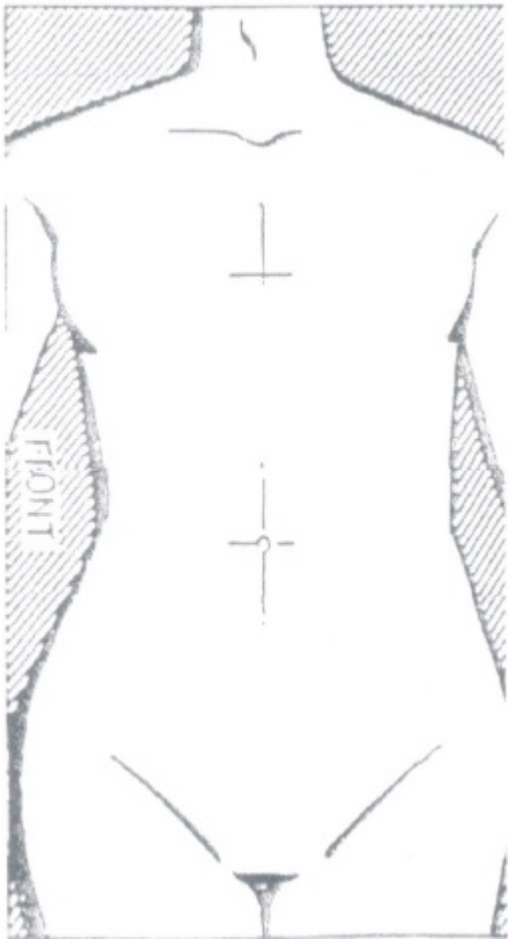
I have pain in:	( ) neck ( ) mid back	( ) low back	( ) hip	( ) knee
	( ) ankle ( ) feet	( ) shoulder	( ) elbow	( ) wrist
	( ) hands ( ) other_____			
I get:	( ) swollen joints	( ) sore joints	( ) joints pop/crack	( ) jaw pops
	( ) leg cramps at rest	( ) leg cramps w/ activity		( ) worse at night
	( ) tingling in hands/feet	( ) restless leg syndrome		
I have:	( ) nervous tick or twitching - where_____			( ) Bell's palsy
	( ) ringing in ears	( ) Parkinson's disease	( ) sciatic neuritis	( ) multiple sclerosis
	( ) spinal surgery - where_____		Results: _____	

Confidential Nutrition Patient Questionnaire

Hair Nails Skin

Hair:	( ) course	( ) fine	( ) falls out excessively _____	( ) turned grey	
Male Beard:	( ) heavy	( ) light or sparse	( ) none		
Female:	( ) facial hair always	( ) facial hair at age____	( ) hair on abdomen or breasts		
Fingernails:	( ) normal	( ) brittle or break	( ) soft	( ) ridged vertically	( ) white spots
	( ) grow fast	( ) ridged horizontally	( ) grow slow	( ) odd shape	( ) hangnails
Skin:	( ) normal ( ) oily	( ) dry	( ) flaky	( ) acne	( ) psoriasis
	( ) small bumps on upper arms		( ) skin cancer removed on _____		
	( ) antibiotics for acne – age_____		( ) How long taken? _____		
Spots on Skin:	( ) warts ( ) moles	( ) small red	( ) large red	( ) brown	( ) white
Hands and Feet:	( ) dry/cracked/bleeding areas on:		( ) hands	( ) heels	( ) feet
	( ) ingrown toenails	( ) fungus on feet/nails	( ) Althete's foot		

Chest and Heart **Mark any areas of pain or discomfort on diagram**



I have chest pain that:	( ) is sharp	( ) is dull	( ) is severe
	( ) radiates to arm, neck, or back		
	( ) worse at rest	( ) worse on exertion	
	( ) better w/ exercise	( ) no change w/exercise	
My pulse/heartbeat:	( ) is too fast	( ) too slow	( ) skips beats
I have:	( ) high blood pressure	( ) low blood pressure	
I am:	( ) on HBP medication	( ) on diuretics	
I have had:	( ) a heart attack	( ) bypass surgery	
	( ) angioplasty	( ) a stroke	
I have been told I have:	( ) heart disease	( ) lung disease	
	( ) clogged arteries		
I have:	( ) varicose veins	( ) spider veins	
	( ) hemorrhoids	( ) had vessel surgery	

Female Specific (Males, please continue on next page) Mark all that apply.

Age of first period_____

My periods are:
( ) normal ( ) painful first day ( ) painful before and during
( ) flow is excessive ( ) have clots or hemorrhage ( ) flow is scanty
( ) regular every____days ( ) irregular
( ) no period in_____months ( ) two or more per month
( ) abnormal since age_____
( ) menstrual problems before first child ( ) menstrual problems after first child
( ) weight gain after first child ( ) weight gain after 2nd or 3rd child

Menstrual Blood is: ( ) pink ( ) red ( ) brown ( ) black ( ) other

I have/have had: ( ) endometriosis ( ) constipation w/ periods ( ) diarrhea w/ periods

Organ Drop: ( ) uterus in position ( ) uterus out of position ( ) bladder prolapse

I am/have been:
( ) on birth control (type) _____ ( ) total years on BCP_____
( ) menopause at age _____ ( ) hysterectomy at age_____
( ) estrogen ( ) patch ( ) oral ( ) progestin ( ) implant

Hormone Replacement ( ) wild yam cream ( ) bio-identical formulation

I have breast soreness: ( ) before period ( ) during period ( ) after period ( ) all month long
I have: ( ) fibrocystic breasts ( ) had breast cancer ( ) produce milk - not pregnant/nursing
My breasts are: ( ) firm ( ) soft/saggy ( ) have implants ( ) had reduction

I:
( ) have____children ( ) been pregnant _____ times ( ) like children ( ) dislike children
( ) want more ( ) don't want more ( ) am sterile ( ) fear pregnancy

I get:
( ) bladder infections ( ) yeast infections ( ) yeast infections after antibiotics
( ) vaginal burning/itching ( ) inside ( ) outside

I urinate:
( )_____ times per day ( )_____ times per night ( ) more frequently than normal
( ) with pain ( ) difficulty starting/stopping ( ) itching or burning

My urine color is: ( ) pale yellow ( ) bright yellow ( ) dark yellow ( ) other_____
( ) clear ( ) cloudy ( ) w/mucous ( ) varies a lot

My urine has: ( ) odor describe_____

I have/had: ( ) venereal disease ( ) genital herpes ( ) herpes I ( ) HIV/AIDS

My libido is: ( ) normal ( ) excessive ( ) increased ( ) diminished ( ) absent
(libido means desire for sexual relations)

Continue at diagram on next page…

Male Specific

I am: ( ) overly tired ( ) exhausted ( ) getting too old for anything ( ) impotent

My prostate: ( ) normal ( ) enlarged ( ) had cancer ( ) removed
( ) date of last prostate exam _____ ( ) date of last PSA_____ Result/number _____

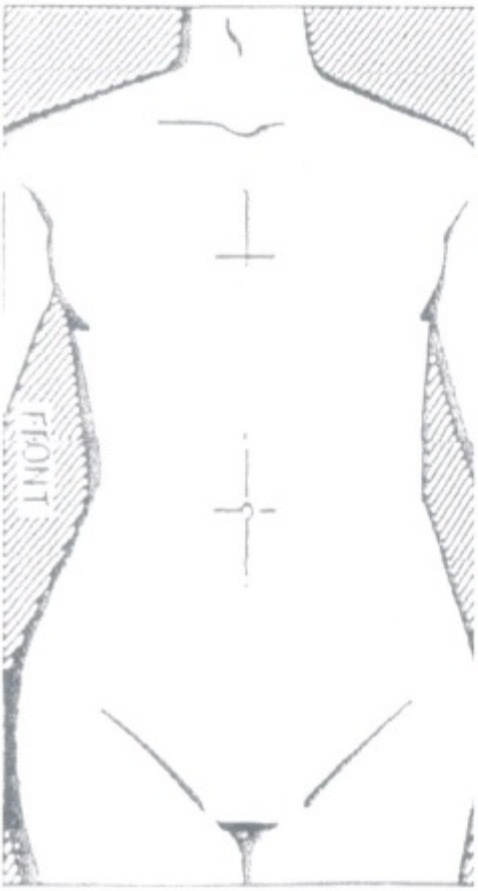
I have: ( ) pain w/urination ( ) difficulty starting flow ( ) difficulty stopping flow
( ) dribbling of urine ( ) decreased stream size ( ) pain/pressure after sex
( ) get up to urinate_____ times per night ( ) buring discharge

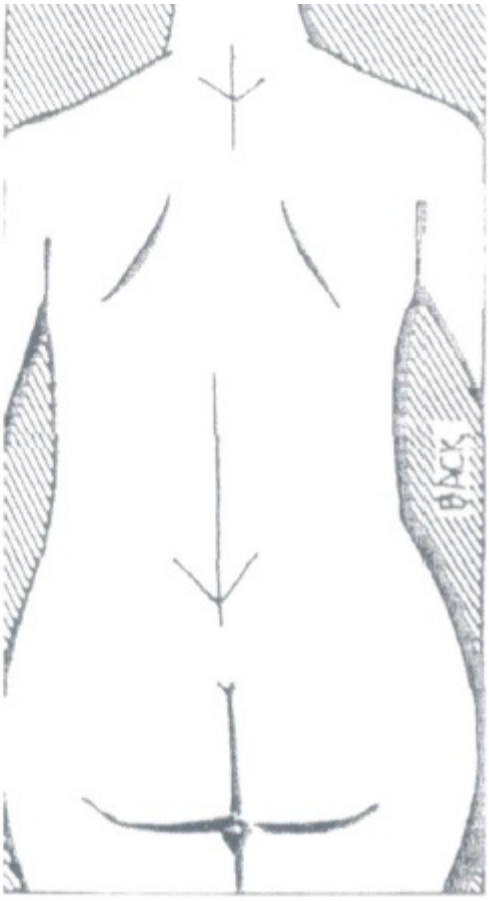
My urine color: ( ) pale yellow ( ) bright yellow ( ) dark yellow ( ) other _____
( ) clear ( ) cloudy ( ) w/mucous ( ) varies a lot
My urine has: ( ) odor, please describe _____

I have: ( )_____ hernia ( ) pain in testicles / scrotum
I have/had: ( ) venereal disease () genetal herpes ( ) herpes I ( ) HIV/AIDS

My libido is: ( ) normal ( ) excessive ( ) increased ( ) diminished ( ) absent
(libido means desire for sexual relations)

ALL PATIENTS: Use the diagrams below to mark all areas of pain or discomfort you have experienced in the past 90 days. Describe your pain/discomfort in the margins and connect with an arrow to each area the description applies to.





Are you currently seeing any other health care professional such as a medical doctor, dentist, massage therapist, acupuncturist, psychotherapist, etc? Please explain:

_____
_____
_____
_____

Please fill out your family health history on the chart below.
Put and "N" in the box if you have it now, or a "P" if had in the past

	Alcoholism	Allergies	Alzheimers Disease	Arthritis	Asthma	Atherosclerosis	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	High Blood Pressure	Kidney Disease	Obesity	Osteoporosis	Sinus Problems	Stroke	Thyroid Problems	Tuberculosis	Ulcers
You																				
Spouse																				
Children																				
Mother																				
Father																				
Maternal Grandparents																				
Paternal Grandparents																				
Sisters																				
Brothers																				

Use this space to add anything else you would like to share about your health concerns or that you think the doctor should know:

_____
_____
_____
_____

Please review this form to be sure your answers are accurate and sign below. Thank you for choosing our clinic. We look forward to working with you on your health goals.

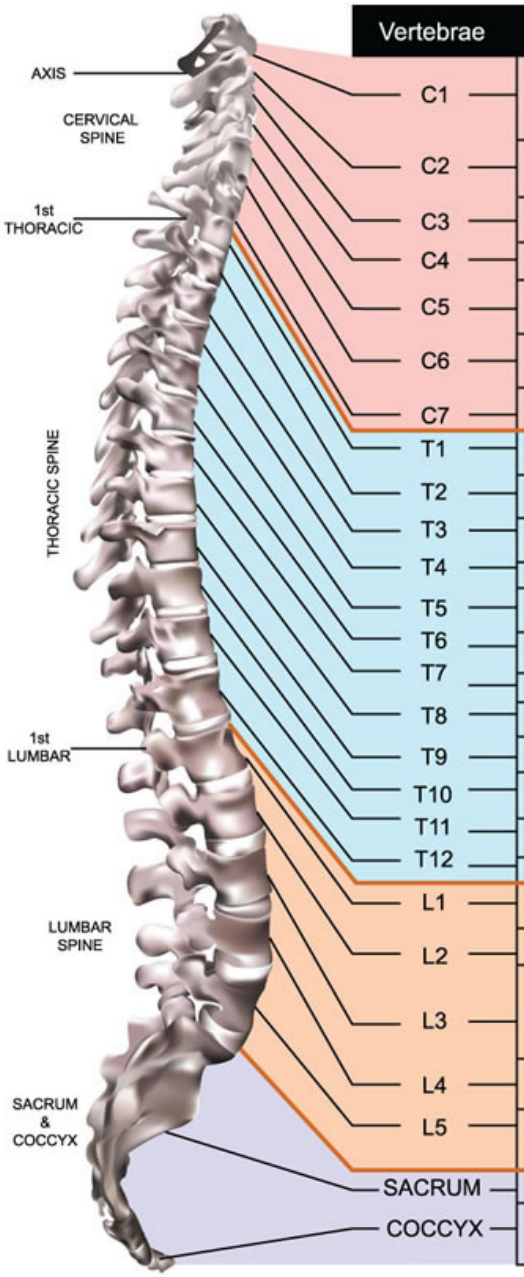
Signature_____ **Date**_____

Disclaimer: The Texas Board of Chiropractic Examiners has ruled that only MD's and DO's may treat (and "diagnose") internal disorders such thyroid issues and diabetes. As such, any treatment rendered is to treat subluxations via the viscerosomatic reflex as documented in the Meric chart. (see chart on next page). Complaints and comments should be directed to the TBCE: 800-821-3205

This is a chart of spinal nerves. It shows how they connect different parts of the body to the brain and associated symptoms when this connection is disturbed. This chart represents the Original Chiropractic Philosophy. Chiropractors aim at restoring the functions of the spine which enhances the connection between the Brain and the organs and systems of the body so the nervous system can do its job of maintenance and repair.

The term "Vertebral Subluxation" is used for the joints which are not moving properly, this makes them prone to inflammation and swelling and cause "pinched nerves" and premature "wear and tear". Chiropractors believe that this may affect the nerves causing the symptoms in corresponding organs and systems.

VERTEBRAL SUBLUXATION AND NERVE CHART



Vertebrae	Areas & Parts of Body		Possible symptoms
C1	Blood supply to the head,pituitary gland, scalp,bone of the face, brain, inner and middle ear,sympathetic nervous system.		❍ Headaches ❍ nervousness ❍ insomnia ❍ head colds ❍ high blood pressure ❍ migraine ❍ headaches ❍ nervous breakdowns ❍ amnesia ❍ chronic tiredness ❍ dizziness
C2	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	NECK REGION	❍ Sinus trouble ❍ allergies ❍ pain around the eyes ❍ earache ❍ fainting spells ❍ certain cases of blindness ❍ crossed eyes ❍ dealness
C3	Cheeks, outer ear, face bones, teeth, infacial nerve.		❍ Neuralgia ❍ neurites ❍ acne or pimples ❍ eczema
C4	Nose, lips, mouth, eustachian tube		❍ Hay fever ❍ runny nose ❍ hearing loss ❍ adenoids
C5	Vocal cords, neck glands, pharynx		❍ Laryngitis ❍ hoarseness ❍ throat conditions such as sore throat or guinsy
C6	Neck muscles, shoulders, tonsils.		❍ Stiff neck ❍ pain in upper arm ❍ tonsillitis ❍ chronic cough ❍ croup
C7	Thyroid gland, bursae in the shoulders, elbows.		❍ Bursitis ❍ colds ❍ thyroid conditions
T1	Arms from the elbows down, including hands, wrists, and fingers, esophagus and trachea.		❍ Asthma ❍ cough ❍ difficult breathing ❍ shortness of breath ❍ pain in lower arms and hands
T2	Heart, including its valves and covering, coronary and arteries.		❍ Functional hearth conditions and certain chest conditions
T3	Lungs, bronchial tubes, pleura, chest, breast.		❍ Bronchitis ❍ pleurisy ❍ pneumonia ❍ congestion ❍ influenza
T4	Gallbladder, common duct.		❍ Gallbladder conditions ❍ jaundice ❍ shingles
T5	Liver, solar plexus, circulation (general).	MID BACK	❍ Liver conditions ❍ fevers ❍ blood pressure problems ❍ poor circulations ❍ arthritis
T6	Stomach		❍ Stomach troubles including ❍ nervous stomach ❍ indigestion ❍ hearthburn ❍ dyspepsia
T7	Pancreas, duodenum		❍ Ulcers ❍ gastritis
T8	Spleen		❍ Lowered resistance
T9	Adrenai and suprarentai glands		❍ Allergies ❍ hives
T10	Kidneys		❍ Kidney troubles ❍ hardening of the arteries ❍ chronic tiredness ❍ nephritis ❍ pyelitis
T11	Kidneys, and kidney ureters		❍ Skin conditions such as acne ❍ pimples ❍ eczema ❍ boils
T12	Small Intestines, lymph circulation		❍ Rheumatism ❍ gas pains ❍ certain types of sterility
L1	Large intestines, inguinal rings.		❍ Constipation ❍ colitis ❍ dysentery ❍ diarrhea ❍ some rupture of hernias
L2	Appendix, abdomen, upper leg.		❍ Cramps ❍ difficulty breathing ❍ minor varicose veins
L3	Sex organs, uterus, bladder, knees.	LOW BACK	❍ Bladder troubles ❍ menstrual troubles such as painful ❍ or irregular periods ❍ miscarriages ❍ bed wetting ❍ importency ❍ changes of life symptoms ❍ many knee pains
L4	Prostate gland, muscles of the lower back, sciatic nerve.		❍ Sciatica ❍ lumbago ❍ difficult painful or too ❍ frequent urination ❍ backaches
L5	Lower legs, ankies, feet.		❍ Poor circulation in the legs ❍ swollen ankies ❍ weak ankles and arches ❍ cold feet ❍ weakness in the legs ❍ leg cramps
SACRUM	Hip bones, buttocks.	PELVIS	❍ Sacroiliac conditions ❍ spinal curvatures
COCCYX	Rectum, anus.		❍ Hemorrhoids (piles) ❍ pruritus (itching) ❍ pain at end of spine on sitting