

CLINICAL APPRAISAL INDICATOR

Client Name _____

Date _____

INSTRUCTIONS

Please **Circle the number** next to the symptom in the **GROUPS** below that are **applicable to you**

1) *Mild Symptoms* - symptoms occurring once or twice a month

2) *Moderate Symptoms* - symptoms occurring once or twice a week

3) *Severe Symptoms* - symptoms occurring daily

GROUP ONE

- | | | | | | |
|-----------------------------|-------|--------------------------------|-------|--------------------------|-------|
| 1) "Nervous" Stomach | 1 2 3 | 5) Mental alert, quick | 1 2 3 | 9) Fever easily raised | 1 2 3 |
| 2) Dry Mouth-Eyes-Nose | 1 2 3 | 6) Extremities cold, clammy | 1 2 3 | 10) Cold sweats often | 1 2 3 |
| 3) Pulse speeds after meals | 1 2 3 | 7) Heart pounds after retiring | 1 2 3 | 11) Neuralgia-like pains | 1 2 3 |
| 4) Keyed up – fail to calm | 1 2 3 | 8) Acid foods upset | 1 2 3 | | |

ARE YOUR SYMPTOMS MADE WORSE BY EMOTIONAL STRESS? Yes / No

GROUP TWO

- | | | | | | |
|------------------------------------|-------|--|-------|--|-------|
| 12) Perspire easily | 1 2 3 | 16) Digestion rapid | 1 2 3 | 20) Joint stiffness after rising | 1 2 3 |
| 13) Muscle-leg-toe cramps at night | 1 2 3 | 17) Vomiting frequent | 1 2 3 | 21) Circulation poor, sensitive to cold | 1 2 3 |
| 14) Eyelids swollen, puffy | 1 2 3 | 18) Difficulty swallowing | 1 2 3 | 22) Subject to colds, asthma, bronchitis | 1 2 3 |
| 15) Indigestion soon after meals | 1 2 3 | 19) Constipation, diarrhea-alternating | 1 2 3 | | |

ARE YOUR SYMPTOMS MADE WORSE BY EMOTIONAL STRESS? Yes / No

GROUP THREE

- | | | | | | |
|--------------------------------|-------|--|-------|---|-------|
| 23) Afternoon headaches | 1 2 3 | 26) Heart palpitates if meals are missed | 1 2 3 | 28) Awaken after few hours of sleep | 1 2 3 |
| 24) Get "shaky" if hungry | 1 2 3 | or delayed | | difficult to get back to sleep | |
| 25) Faintness if meals delayed | 1 2 3 | 27) Eat when nervous | 1 2 3 | 29) Crave candy or coffee in afternoons | 1 2 3 |
| | | | | 30) Abnormal craving for sweets or snacks | 1 2 3 |

GROUP FOUR

- | | | | | | |
|--|-------|---|-------|---|-------|
| 31) Bruise easily "black and blue" spots | 1 2 3 | 36) Swollen ankles, worse at night | 1 2 3 | 40) Hands and feet go to sleep easily, numbness | 1 2 3 |
| 32) Sigh frequently, "air hunger" | 1 2 3 | 37) Muscle cramps, worse during exercise | 1 2 3 | 41) Tendency to anemia | 1 2 3 |
| 33) Aware of "breathing heavily" | 1 2 3 | 38) Shortness of breath on exertion | 1 2 3 | 42) Tension under the breastbone, or feeling of | 1 2 3 |
| 34) Opens window in closed rooms | 1 2 3 | 39) Dull pain in chest or radiating into left | 1 2 3 | "tightness", worse on exertion | |
| 35) Susceptible to colds and fevers | 1 2 3 | arm, worse on exertion | | | |

GROUP FIVE

- | | | | | | |
|--|-------|----------------------------------|-------|--|-------|
| 43) Dry Skin | 1 2 3 | 47) Bilioussness | 1 2 3 | 51) Laxatives used often | 1 2 3 |
| 44) Skin rashes frequent | 1 2 3 | 48) Greasy foods upset | 1 2 3 | 52) History of gallbladder attacks or gallstones | 1 2 3 |
| 45) Bitter metallic taste in mouth in the mornings | 1 2 3 | 49) Stools light colored | 1 2 3 | 53) Sneezing attacks | 1 2 3 |
| 46) Bowel movements painful or difficult | 1 2 3 | 50) Pain between shoulder blades | 1 2 3 | | |

GROUP SIX

- | | | | | | |
|---|-------|--|-------|-------------------------------------|-------|
| 54) Lower bowel gas several hours after eating | 1 2 3 | 56) Coated tongue | 1 2 3 | 58) Gas shortly after eating | 1 2 3 |
| 55) Burning stomach sensations, eating relieves | 1 2 3 | 57) Indigestion ½ to 1 hour after eating; may be up to 3 – 4 hours | 1 2 3 | 59) Stomach "bloating" after eating | 1 2 3 |

CLINICAL APPRAISAL INDICATOR

GROUP SEVEN

(A)		(B)		(E)	
60) Pulse fast at rest	1 2 3	76) Slow pulse, below 65	1 2 3	91) Hot flashes	1 2 3
61) Nervousness	1 2 3	77) Increase in weight	1 2 3	92) Headaches	1 2 3
62) Can't gain weight	1 2 3			93) Dizziness	1 2 3
63) Intolerance to heat	1 2 3	(C)		94) Increased blood pressure	1 2 3
64) Highly emotional	1 2 3	78) Low blood pressure	1 2 3	95) Sugar in urine (not diabetes)	1 2 3
65) Flush easily	1 2 3	79) Failing memory	1 2 3	96) Masculine tendencies (female)	1 2 3
66) Night sweats	1 2 3	80) Increased sex desire	1 2 3		
67) Inward trembling	1 2 3	81) Headaches, "splitting or rending" type	1 2 3	(F)	
68) Heart palpitates	1 2 3	82) Decreased sugar tolerance	1 2 3	97) Low blood pressure	1 2 3
69) Insomnia	1 2 3			98) Chronic fatigue	1 2 3
		(D)		99) Weakness, fatigue	1 2 3
		83) Bloating of intestines	1 2 3	100) Tendency to hives	1 2 3
(B)		84) Abnormal thirst	1 2 3	101) Arthritic tendencies	1 2 3
70) Impaired hearing	1 2 3	85) Weight gain around hips or waist	1 2 3	102) Perspiration increases	1 2 3
71) Decrease in appetite	1 2 3	86) Sex desire reduced or lacking	1 2 3	103) Crave salt	1 2 3
72) Ringing in ears	1 2 3	87) Tendency to ulcers colitis	1 2 3	104) Brown spots or bronzing of skin	1 2 3
73) Constipation	1 2 3	88) Increased sugar tolerance	1 2 3	105) Allergies – tendency to asthma	1 2 3
74) Mental sluggishness	1 2 3	89) Women: menstrual disorders	1 2 3	106) Exhaustion – muscular and nervousness	1 2 3
75) Headaches upon arising - wears off during the day	1 2 3	90) Young girls: lack of menstrual	1 2 3	107) Respiratory disorders	1 2 3

GROUP EIGHT

Female Only

108) Painful menses	1 2 3
109) Premenstrual tension	1 2 3
110) Very easily fatigued	1 2 3
111) Depressed feeling before period	1 2 3
112) Menstruation excessive / prolonged	1 2 3
113) Painful breasts	1 2 3
114) Menstruate too frequently	1 2 3

Male Only

115) Vaginal discharge	1 2 3	122) Pain on inside of legs or heel	1 2 3
116) Menopause, hot flashes, etc.	1 2 3	123) Feeling of incomplete bowel	1 2 3
117) Menses scanty	1 2 3	124) Prostate trouble	1 2 3
118) Acne, worse at menses	1 2 3	125) Leg nervousness at night	1 2 3
119) Tire too easily	1 2 3	126) Diminished sex desire	1 2 3
120) Urination difficult	1 2 3		
121) Night urination frequent movement	1 2 3		

GROUP NINE

127) Chronic cough	1 2 3	131) Difficulty breathing	1 2 3	134) Bronchitis (frequent)	1 2 3
128) Pain around ribs	1 2 3	132) Coughing up phlegm	1 2 3	135) Infections settle in lungs	1 2 3
129) Shortness of breath	1 2 3	133) Coughing up blood	1 2 3	136) Sensitive to smog	1 2 3
130) Chest pain	1 2 3				

GROUP TEN

137) Frequent urination	1 2 3	141) Cloudy urine	1 2 3	144) Painful/burning when passing urine	1 2 3
138) Rose colored (bloody) urine	1 2 3	142) Rarely need to urinate	1 2 3	145) Urination when you cough or sneeze	1 2 3
139) Dripping after urination	1 2 3	143) Frequent bladder infections	1 2 3	146) Strong smelling urine	1 2 3
140) Difficulty passing urine	1 2 3				

GROUP ELEVEN

(A)

147) Throat infections	1 2 3	150) Gets boils or styes	1 2 3	153) Bumpy skin on back of arms	1 2 3
148) Poor wound healing	1 2 3	151) Swollen lymph glands	1 2 3	154) Inflamed or bleeding gums	1 2 3
149) Slow to recover from cold or flu	1 2 3	152) Catch colds or flu too easily	1 2 3		

(B)

155) Poor wound healing	1 2 3	157) Swollen lymph glands	1 2 3	159) Hyperactivity	1 2 3
156) Post nasal drip	1 2 3	158) Swollen tongue	1 2 3	160) Food sensitivity or allergy	1 2 3

CLINICAL APPRAISAL INDICATOR



IMPORTANT - Please list below your four main health complaints in order of importance:

1) _____

2) _____

3) _____

4) _____



PLEASE FILL IN BELOW:

Name: _____ Phone No: _____

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

Birthdate: _____ Weight: _____ Height: _____ Married: Yes / No Gender: Male / Female Email _____

Address: _____ Occupation: _____

History of Illnesses and Treatments: _____

Operations, Accidents, or Injuries: _____

Present Diagnosed Illnesses: _____

Please List any Family History of Illness or Disease: _____

Please List any Medications or Supplements you are presently taking: _____

Client Signature

Date


Technician Signature


Date





 **DISCLAIMER** 


The Asyra system provides a completely non-invasive method for gaining valuable information about your body's vital functions. The primary objective of the screening is to disclose patterns of stress and provide feedback that will assist in developing a program to restore each system and meridian to balance.


-  I understand that the Asyra survey does not provide medical diagnosis and that my testing technician may recommend further medical testing. If I suspect I need further medical intervention, I understand I should consult MY physician. I give my permission for the testing technician to evaluate me on the Asyra. I understand in doing so my testing technician is NOT becoming my primary care physician. I understand that the testing technician will give me information about myself and make recommendations based on the Asyra screening. I understand that the testing technician will not pass judgements on prescribed medications and it is the responsibility of my primary care physician to make any adjustments on prescribed medications. Any decision to follow through with the recommended program is my own decision and I hold the testing technician harmless.


-  I understand that I am here to learn about natural health and better lifestyle practices and I will be offered information about food supplements and herbs as a guide to general health.


-  I understand that I should continue to see any medical doctors I am currently under the care of, and that any Prescribed medications should not be altered without first consulting the physician who recommended it.


-  I fully understand that those who counsel me are not medical doctors, medical practitioners, licensed nutritionalists, or licensed naturopaths. I am not here for any medical diagnostic purposes or treatment procedures.


-  Information about the traditional uses of supplements that may create a healthy balance in the body may be discussed. This is not intended to be interpreted as a substitute for a licensed physician's treatment. Nothing said, done, typed, printed, or reproduced by us is intended to diagnose, prescribe, treat, or take the place of a licensed physician.

-  The intent is to provide educational information for the purpose of assisting you with lifestyle changes necessary to regain and maintain an environment needed to produce a healthy balanced body.

-  I am not on this visit, or any subsequent visit, acting as an agent for the federal, state, county, local law enforcement or news media on a mission of entrapment or investigation.

-  I understand that all information and conversations will be kept confidential, and that information concerning myself can be released to another health professional only with my written consent.

-  I understand that the Asyra screening will only identify energetic imbalances and does not diagnose any diseases in the body. The Balancing Item refers to energetic frequency needed to restore balance to the body. Balancing Items are defined differently from medical terms and are not a cure for any disease.

-  I recognize that the Asyra screening is an unorthodox approach to balancing my health. Being of sound mind, I have chosen this screening to assist in balancing my health of my own free will and in exercise of my constitutional right for the attainment of life, liberty, and the pursuit of happiness.

**HOMEOPATHIC
RECOVERY
CENTER**

Client Signature

Date

Guardian Signature (if under 18 years of age)

Relationship