

VANCOUVER NATUROPATHIC CLINIC

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Energy Enhancement System

Patient Questionnaire #1

Name: _____

Date: _____

Before your first session in the Energy Enhancement System, please answer the following questions based on how you feel right now.

Physical

Please rate the severity of the following symptoms, using the extra space to enter specifics (location or type of pain, etc.).

	None	Mild	Moderate	Severe		
Headache	0	1	2	3	4	5
Joint pain	0	1	2	3	4	5
Muscle pain	0	1	2	3	4	5
Back pain	0	1	2	3	4	5
Swelling	0	1	2	3	4	5
Nasal/sinus congestion	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Skin problems	0	1	2	3	4	5
Menstrual problems	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5
Sleep disturbances	0	1	2	3	4	5
Nausea, vomiting	0	1	2	3	4	5
Bowel disturbances (diarrhea, constipation, gas)	0	1	2	3	4	5
Urinary problems	0	1	2	3	4	5
Numbness or tingling	0	1	2	3	4	5
Dizziness/vertigo	0	1	2	3	4	5
Infection	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5

Additional comments: _____

Energy/Sleep

	Worst	Best				
How energetic do you usually feel?	0	1	2	3	4	5
How well do you sleep?	0	1	2	3	4	5
How easily do you fall asleep?	0	1	2	3	4	5
How is your energy level when you wake up?	0	1	2	3	4	5
How much do you rely on coffee or stimulants?	0	1	2	3	4	5

Mental

	None	Low	Moderate	High		
Concentration	0	1	2	3	4	5
Mental clarity	0	1	2	3	4	5
Short-term memory	0	1	2	3	4	5
Long-term memory	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5

Additional comments: _____

Emotional & Spiritual

	None	Low	Moderate	High		
Anger	0	1	2	3	4	5
Fear	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5
Sadness/grief	0	1	2	3	4	5
Shame	0	1	2	3	4	5
Guilt	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Love	0	1	2	3	4	5
Self-acceptance	0	1	2	3	4	5
Trust	0	1	2	3	4	5
Connection with others/intimacy	0	1	2	3	4	5
Hopefulness/optimism	0	1	2	3	4	5
Joyfulness	0	1	2	3	4	5
Peacefulness/calmness	0	1	2	3	4	5
Contentment	0	1	2	3	4	5
Confidence	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5
Other: _____	0	1	2	3	4	5

Additional comments: _____
