

Name: _____

Date: _____

Clinical Appraisal Indicator

Instructions:

Indicate the symptoms that apply to you (**LEAVE BLANK, THE BOXES THAT DO NOT APPLY TO YOU!**):

- (1) = *Mild* Symptoms (Occurs 1-2 times/year)
(2) = *Moderate* Symptoms (Occurs several times/month)
(3) = *Severe Symptoms* (Aware of it constantly)

Group One:

- | | | |
|---|---|--|
| <input type="checkbox"/> 1. Nervous Stomach | <input type="checkbox"/> 5. Mentally Alert, Quick | <input type="checkbox"/> 9. Cold Sweats Often |
| <input type="checkbox"/> 2. Dry Mouth/Eyes/Nose | <input type="checkbox"/> 6. Extremities Cold, Clammy | <input type="checkbox"/> 10. Fever Easily Raised |
| <input type="checkbox"/> 3. Pulse Speeds After Meal | <input type="checkbox"/> 7. Heart Pounds After Retiring | <input type="checkbox"/> 11. Neuralgia-like Symptoms |
| <input type="checkbox"/> 4. Keyed Up, Fail to Calm | <input type="checkbox"/> 8. Acid Foods Upset | |

Are Your Symptoms Made Worse By Emotional Stress?

Group Two:

- | | | |
|---|---|---|
| <input type="checkbox"/> 12. Perspire Easily | <input type="checkbox"/> 16. Digestion Rapid | <input type="checkbox"/> 20. Joint Stiffness After Rising |
| <input type="checkbox"/> 13. Muscle-Leg-Toe Cramps At Night | <input type="checkbox"/> 17. Vomiting Frequent | <input type="checkbox"/> 21. Circulation Poor, Sensitive to Cold |
| <input type="checkbox"/> 14. Eyelids Swollen, Puffy | <input type="checkbox"/> 18. Difficulty Swallowing | <input type="checkbox"/> 22. Subject to Colds, Asthma, Bronchitis |
| <input type="checkbox"/> 15. Indigestion Soon After Meals | <input type="checkbox"/> 19. Constipation, Diarrhea Alternating | |

Are Your Symptoms Made Worse by Physical Stress?

Group Three:

- | | | |
|---|--|--|
| <input type="checkbox"/> 23. Afternoon Headaches | <input type="checkbox"/> 26. Heart Palpitates if Meals Missed Or Delayed | <input type="checkbox"/> 29. Crave Candy or Coffee in Afternoons |
| <input type="checkbox"/> 24. Get "Shaky" if Hungry | <input type="checkbox"/> 27. Eat When Nervous | <input type="checkbox"/> 30. Abnormal Craving for Sweets or Snacks |
| <input type="checkbox"/> 25. Faintness if Meals Delayed | <input type="checkbox"/> 28. Awaken After a Few Hours Of Sleep/Hard to Get Back to Sleep | |

Group Four:

- | | | |
|--|---|---|
| <input type="checkbox"/> 31. Bruise Easily, "Black and Blue" Spots | <input type="checkbox"/> 35. Susceptible to Colds and Fevers | <input type="checkbox"/> 40. Hands and Feet Go to Sleep Easily, Numbness |
| <input type="checkbox"/> 32. Sigh Frequently, "Air Hunger" | <input type="checkbox"/> 36. Swollen Ankles, Worse at Night | <input type="checkbox"/> 41. Tendency to Anemia |
| <input type="checkbox"/> 33. Aware of "Breathing Heavily" | <input type="checkbox"/> 37. Muscle Cramps, Worse During Exercise | <input type="checkbox"/> 42. Tension under the Breastbone of the Feeling of Tightness, Worse on Exertion. |

Group Five:

- | | | |
|---|---|---|
| <input type="checkbox"/> 43. Dry Skin | <input type="checkbox"/> 47. Bilioussness | <input type="checkbox"/> 51. Laxatives Used Often |
| <input type="checkbox"/> 44. Skin Rashes Frequent | <input type="checkbox"/> 48. Greasy Foods Upset | <input type="checkbox"/> 52. History of Gall-Bladder Attack or Gallstones |
| <input type="checkbox"/> 45. Bitter Metallic Taste in Mouth In Mornings | <input type="checkbox"/> 49. Stools Light-Colored | <input type="checkbox"/> 53. Sneezing Attacks |
| <input type="checkbox"/> 46. Bowel Movements Painful or Difficult | <input type="checkbox"/> 50. Pain Between Shoulder Blades | |

Group Six:

- | | | |
|--|---|--|
| <input type="checkbox"/> 54. Lower Bowel Gas Several Hours After Eating | <input type="checkbox"/> 56. Coated Tongue | <input type="checkbox"/> 58. Gas Shortly After Eating |
| <input type="checkbox"/> 55. Burning Stomach Sensation, Relieved by Eating | <input type="checkbox"/> 57. Indigestion ½ to 1 Hour After Eating; May be up to 3-4 Hours | <input type="checkbox"/> 59. Stomach “Bloating” After Eating |
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Group Seven:

- | | | |
|--|---|---|
| <input type="checkbox"/> 60. Pulse Fast At Rest | <input type="checkbox"/> 64. Highly Emotional | <input type="checkbox"/> 68. Heart Palpitates |
| <input type="checkbox"/> 61. Nervousness | <input type="checkbox"/> 65. Flush Easily | <input type="checkbox"/> 69. Insomnia |
| <input type="checkbox"/> 62. Can't Gain Weight | <input type="checkbox"/> 66. Night Sweats | |
| <input type="checkbox"/> 63. Intolerance to Heat | <input type="checkbox"/> 67. Inward Trembling | |
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B.

- | | | |
|---|---|---|
| <input type="checkbox"/> 70. Impaired Hearing | <input type="checkbox"/> 73. Constipation | <input type="checkbox"/> 76. Slow Pulse, Below 65 |
| <input type="checkbox"/> 71. Decrease in Appetite | <input type="checkbox"/> 74. Mental Sluggishness | <input type="checkbox"/> 77. Increase in Weight |
| <input type="checkbox"/> 72. Ringing in Ears | <input type="checkbox"/> 75. Headaches Upon Arising
Wears Off During Day | |
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C.

- | | | |
|---|--|--|
| <input type="checkbox"/> 78. Low Blood Pressure | <input type="checkbox"/> 80. Increased Sex Drive | <input type="checkbox"/> 82. Decreased Sugar Tolerance |
| <input type="checkbox"/> 79. Failing Memory | <input type="checkbox"/> 81. Headaches,
“Splitting/Rending” | |
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D.

- | | | |
|--|--|--|
| <input type="checkbox"/> 83. Bloating of Intestines | <input type="checkbox"/> 86. Sex Desire Reduced/Lacking | <input type="checkbox"/> 89. Women: Menstrual Disorders |
| <input type="checkbox"/> 84. Abnormal Thirst | <input type="checkbox"/> 87. Tendency to Ulcers, Colitis | <input type="checkbox"/> 90. Young Girls: Lack of Menstrual Function |
| <input type="checkbox"/> 85. Weight Gain Around Hips/Waist | <input type="checkbox"/> 88. Increased Sugar Tolerance | |
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E.

- | | | |
|--|---|--|
| <input type="checkbox"/> 91. Hot Flashes | <input type="checkbox"/> 93. Dizziness | <input type="checkbox"/> 95. Sugar in Urine (Not Diabetes) |
| <input type="checkbox"/> 92. Headaches | <input type="checkbox"/> 94. Increased Blood Pressure | <input type="checkbox"/> 96. Masculine Tendencies (Female) |
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F.

- | | | |
|--|---|--|
| <input type="checkbox"/> 97. Low Blood Pressure | <input type="checkbox"/> 101. Arthritic Tendencies | <input type="checkbox"/> 105. Allergies: Tendency to Asthma |
| <input type="checkbox"/> 98. Chronic Fatigue | <input type="checkbox"/> 102. Perspiration Increases | <input type="checkbox"/> 106. Exhaustion: Muscular and Nervousness |
| <input type="checkbox"/> 99. Weakness, Dizziness | <input type="checkbox"/> 103. Crave Salt | <input type="checkbox"/> 107. Respiratory Disorders |
| <input type="checkbox"/> 100. Tendency to Hives | <input type="checkbox"/> 104. Brown Spots/Discoloring of Skin | |
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Group Eight:

Female Only:

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|---|--|--|
| <input type="checkbox"/> 108. Painful Menses | <input type="checkbox"/> 112. Menstruation Excessive and Prolonged | <input type="checkbox"/> 116. Menopause, Hot Flashes, Etc. |
| <input type="checkbox"/> 109. Premenstrual Tension | <input type="checkbox"/> 113. Painful Breasts | <input type="checkbox"/> 117. Menses Scanty |
| <input type="checkbox"/> 110. Very Easily Fatigued | <input type="checkbox"/> 114. Menstruate Too Frequently | <input type="checkbox"/> 118. Acne, Worse at Menses |
| <input type="checkbox"/> 111. Depressed Feeling Before Menstruation | <input type="checkbox"/> 115. Vaginal Discharge | |
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Male Only:

- | | | |
|--|--|--|
| <input type="checkbox"/> 119. Tire Too Easily | <input type="checkbox"/> 122. Pain on Inside Legs or Heel | <input type="checkbox"/> 125. Leg Nervousness at Night |
| <input type="checkbox"/> 120. Urination Difficult | <input type="checkbox"/> 123. Feeling of Incomplete Bowel Evacuation | <input type="checkbox"/> 126. Diminished Sex Drive |
| <input type="checkbox"/> 121. Night Urination Frequent | <input type="checkbox"/> 124. Prostate Trouble | |

Group Nine:

- | | | |
|---|---|--|
| <input type="checkbox"/> 127. Chronic Cough | <input type="checkbox"/> 131. Difficulty Breathing | <input type="checkbox"/> 135. Infections Settle in Lungs |
| <input type="checkbox"/> 128. Pain Around Ribs | <input type="checkbox"/> 132. Coughing Up Phlegm | <input type="checkbox"/> 136. Sensitive to Smog |
| <input type="checkbox"/> 129. Shortness of Breath | <input type="checkbox"/> 133. Coughing Up Blood | |
| <input type="checkbox"/> 130. Chest Pain | <input type="checkbox"/> 134. Bronchitis (Frequent) | |
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Group Ten:

- | | | |
|---|---|--|
| <input type="checkbox"/> 137. Frequent Urination | <input type="checkbox"/> 141. Cloudy Urine | <input type="checkbox"/> 144. Painful/Burning When Passing Urine |
| <input type="checkbox"/> 138. Rose-Colored/Bloody Urine | <input type="checkbox"/> 142. Rarely Need to Urinate | <input type="checkbox"/> 145. Urination When you Cough/Sneeze |
| <input type="checkbox"/> 139. Dripping After Urination | <input type="checkbox"/> 143. Frequent Bladder Infections | <input type="checkbox"/> 146. Strong-Smelling Urine |
| <input type="checkbox"/> 140. Difficulty Passing Urine | | |
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Group Eleven:

Section A:

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|---|--|--|
| <input type="checkbox"/> 147. Throat Infections | <input type="checkbox"/> 150. Gets Boils/Cysts | <input type="checkbox"/> 153. Bumpy Skin on Back of Arms |
| <input type="checkbox"/> 148. Poor Wound Healing | <input type="checkbox"/> 151. Swollen Lymph Nodes | <input type="checkbox"/> 154. Inflamed/Bleeding Gums |
| <input type="checkbox"/> 149. Slow to Recover from Cold/Flu | <input type="checkbox"/> 152. Catch Colds/Flu too Easily | |
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Section B:

- | | | |
|---|---|--|
| <input type="checkbox"/> 155. Chronic Lung Congestion | <input type="checkbox"/> 157. Breathe Through Mouth | <input type="checkbox"/> 159. Hyperactivity |
| <input type="checkbox"/> 156. Post-Nasal Drip | <input type="checkbox"/> 158. Swollen Tongue | <input type="checkbox"/> 160. Food Sensitivity/Allergy |
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IMPORTANT: Please list below your four main health complaints, in order of importance:

1. _____
2. _____
3. _____
4. _____

PLEASE FILL IN BELOW:

AGE: _____ MARRIED? YES/NO _____ SEX: M/F _____

OCCUPATION _____

NOTES:

Linda D. Potts, DCRC, RN, BSN, MBA
Certified Bioenergetic Technician

WAIVER AND CONSENT

In consideration of receiving services of value from Linda D. Potts I hereby declare:

1. I have been informed that Linda D. Potts is not licensed to practice medicine.
2. She has stated that she will neither diagnose nor prescribe for any condition that I may have.
3. She has encouraged me to consult a licensed medical practitioner for any physical or mental complaints that I may have.
4. My signature below also signifies my consent for Biofeedback Screening performed by Linda D. Potts, DCRC, RN, BSN, MBA

Signature: _____

Date: _____