

THE VERVE CLINIC

Consultation Form

Name _____

Date _____

**Please mark any of the following conditions/symptoms you experience.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Often Fatigued | <input type="checkbox"/> Very light periods | <input type="checkbox"/> Difficulty falling asleep |
| <input type="checkbox"/> Knee Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Dry flakey skin | <input type="checkbox"/> Heartburn or bitter taste |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Low energy after a meal | <input type="checkbox"/> Prone to chapped lips | <input type="checkbox"/> Thick dark period blood |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bloating after meals | <input type="checkbox"/> Brittle toe/finger nails | <input type="checkbox"/> Pupils dilated |
| <input type="checkbox"/> Premature greying hair | <input type="checkbox"/> Crave Sweet things | <input type="checkbox"/> losing hair | <input type="checkbox"/> Raised prolactin |
| <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Loose stools or ab pain | <input type="checkbox"/> Dry/brittle hair | <input type="checkbox"/> Pulse rate rapid |
| <input type="checkbox"/> Dark Circles under eye | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Dizzy around period | <input type="checkbox"/> Mouth/throat often dry |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Frequent cold hands & feet | <input type="checkbox"/> reduced nighttime vision | <input type="checkbox"/> Often thirsty for cold drinks |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Frequent Cold Nose | <input type="checkbox"/> Period blood brown/black | <input type="checkbox"/> Usually warmer than others |
| <input type="checkbox"/> Afraid a lot | <input type="checkbox"/> Prone to feeling heavy/sluggish# | <input type="checkbox"/> Pain around ovulation | <input type="checkbox"/> Wake up sweating |
| <input type="checkbox"/> Low back pain - premenstrual | <input type="checkbox"/> Grogginess in head | <input type="checkbox"/> Numb hands/feet | <input type="checkbox"/> Acne before period |
| <input type="checkbox"/> Cold feet (esp @ night) | <input type="checkbox"/> Bruises easily | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Short cycle |
| <input type="checkbox"/> Usually colder than others | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Chronic hemorrhoids | <input type="checkbox"/> Vaginal rashes or irritation |
| <input type="checkbox"/> Low Libido | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Clotty period blood | <input type="checkbox"/> Cold abdomen compared to the rest of your trunk |
| <input type="checkbox"/> Often fearful | <input type="checkbox"/> Reluctancy to exercise | <input type="checkbox"/> Endometriosis/fibroids | <input type="checkbox"/> Tired or sluggish after a meal |
| <input type="checkbox"/> Urinate more frequently | <input type="checkbox"/> Prone to worry | <input type="checkbox"/> Tender lower abs | <input type="checkbox"/> Cysts - breasts/ovaries |
| <input type="checkbox"/> Early morning loose stools | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Benign lumps breast/abs | <input type="checkbox"/> Cystic or pustular acne |
| <input type="checkbox"/> Profuse Vaginal discharge | <input type="checkbox"/> Light headed if stand up too fast | <input type="checkbox"/> Stabbing period pain | <input type="checkbox"/> Urgent/foul smelling stool |
| <input type="checkbox"/> Heat helps menstrual cramps | <input type="checkbox"/> Sweat when not exerting yourself | <input type="checkbox"/> Prone to depression | <input type="checkbox"/> Stringy/mucus in period |
| <input type="checkbox"/> Wake up early without alarm | <input type="checkbox"/> Thin/watery period blood | <input type="checkbox"/> Prone to anger/rage | <input type="checkbox"/> Prone to yeast infections |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Spotting before period | <input type="checkbox"/> Uterine prolapse | <input checked="" type="checkbox"/> Sore breasts @ ovulation |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Uterine prolapse | <input type="checkbox"/> Period cramps that bear down | <input type="checkbox"/> Vaginal/rectal itching pre period |
| <input type="checkbox"/> Often agitated | <input type="checkbox"/> Period cramps that bear down | <input type="checkbox"/> Low immune system or allergies | <input type="checkbox"/> Foul smelling/green or yellow vaginal discharge |
| <input type="checkbox"/> Often fidgety/restless | <input type="checkbox"/> Low immune system or allergies | <input type="checkbox"/> Hyperthyroidism | |
| <input type="checkbox"/> Low in spirit | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Anemia | |
| | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hemorrhoids or polyps | |
| | <input type="checkbox"/> Hemorrhoids or polyps | <input type="checkbox"/> Sore breasts @ ovulation or pre menstrually | |