avalon laser health
live without pain

Questionnaire

Chills and Fevers

- Do you experience any chills or fevers? Yes No

If yes, when do they occur? _____

- Do you feel cold or hot in general? Cold Hot

Where do you experience your cold or hot? _____

Perspiration

- Do you sweat? Yes No
- After heavy or slight exertion? Heavy Slight
- Do you sweat at night? Yes No
- Do you sweat spontaneously? Yes No

Food and Drink/Appetite, Thirst, and Taste

- How is your appetite? _____
- Are there any changes recently with your appetite? Yes No

What? _____

- Any weight gain or loss? Gain Loss
- How is your thirst? _____
- Do you prefer hot or cold drinks? Hot Cold
- Any food cravings? Yes No

Like what? _____

- Any feelings of fullness after meals? Yes No

If so, where? _____

- Any unusual tastes in your mouth? Yes No

If so, what? _____

Defecation and Urination

- Do you get constipation or have diarrhea? Yes No
- How many times a day do you? Urinate: _____ Bowel Movement? _____
- Is your urine scanty or profuse? Scanty (Small) Profuse
- Is the color of your urine: Clear Yellow
  Dark Cloudy
- Do you experience pain or difficulty with: Urination Bowel Movement
- What is the consistency of your bowel movement? Normal Loose Dry
- Any undigested food, mucous, or blood in your stool? Yes No

If so, what? _____

Sleep

- Do you sleep well? Yes No
- How many hours of sleep do you get? _____
- Do you have trouble getting to sleep? Yes No
- Do you have trouble staying asleep? Yes No
- Do you have trouble getting out of bed in the morning? Yes No
- Do you have recurring dreams or nightmares? Yes No

Emotions

- Do you or have you suffered from: Depression Anxiety/Stress Irritability Anger
  Worry Over thinking Sadness Grief

Pain (Head/Body, Chest/Abdomen, Eyes/Ears

• Do you have pain?	Yes	No
If so, where?		
_____		
_____		
• Is your pain sharp or dull/achy?	Sharp	Dull
• Is your pain fixed or does it move?	Fixed	Moves
•Is your pain relieved or aggravated by pressure?	Relieved	Aggreviated
• Is your pain relieved by hot or cold?	Hot	Cold
• Does it come and go or is it constant?	Come/go	Constant
• Is your pain better with movement or rest?	Movement	Rest
• Any time of day it is better or worse? _____		
• Do you have any headaches?	Yes	No
If so, where are they located? _____		
• Is the headache pain sharp, dull, or heavy?	Sharp Dull	Heavy
• Is there any time of day that your headaches are better or worse?	Yes	No
If so, when? _____		
• Any triggers for your headaches? _____		
• Do you experience ringing in your ears?	Yes	No
If so, is it high or low pitched?	High	Low
• Do you experience vertigo or dizziness?	Vertigo	Dizziness
• Do you have floaters/spots in your eyes?	Yes	No
• Any blurry vision?	Yes	No

Menses and Leukorrhea

• Is your period the same time each month?		Yes	No
• How far apart is your cycle? _____			
• How long does your flow last? _____			
• Is your flow heavy or light?		Heavy	Light
• Is your blood flow dark or bright red?		Dark	Bright
• Do you have any clots?		Yes	No
• Is there any pain with your periods?		Yes	No
If so, when do you experience pain?	Before	During	After
• Do you experience PMS?		Yes	No
• Do you have or have you have vaginal discharge?		Yes	No
If yes, what is the consistency and color?		Thick	Thin
		White	Yellow
• Is there any odor with your discharge?		Yes	No

Other

- Poor Memory
- Eczema
- Rashes/Hives