



**McCAFFREY**<sup>TM</sup>

HEALTH CENTER

*revolutionizing*  *healthcare*

# Signs & Symptoms

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LIKE US ON FACEBOOK-WE POST GREAT HEALTH TIPS OFTEN  
WATCH US ON GOOD DAY MARKETPLACE-MONDAY AND WEDNESDAY MORNINGS AT 8:00AM  
LISTEN TO US ON "HOUSE CALL WITH DR SEAN MCCAFFREY" 1450AM SATURDAY MORNINGS 8:00AM

This document is to be used as a screening for nutritional health. It is not intended to diagnose specific medical condition, disease or illness or to replace an evaluation by a health care professional.



## PERSONAL HISTORY .....

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Referred By: (person, FB, radio, tv) \_\_\_\_\_

Sex \_\_\_\_\_ D.O.B. \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**Chief Complaint**- primary reason you are seeking help:

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Please complete the following. This document will help us to understand your current health condition. If you have any questions please call or email us, we will be happy to help.





# MEDICAL HISTORY .....

## **Surgeries** (and age at time of surgery)

1. \_\_\_\_\_ age \_\_\_\_\_      2. \_\_\_\_\_ age \_\_\_\_\_  
3. \_\_\_\_\_ age \_\_\_\_\_      4. \_\_\_\_\_ age \_\_\_\_\_

## **Prescriptions** (currently taking)

1. \_\_\_\_\_      2. \_\_\_\_\_  
3. \_\_\_\_\_      4. \_\_\_\_\_

## **Supplements or Over-the-Counter Meds** such as Vitamins, Tylenol (currently taking)

1. \_\_\_\_\_      2. \_\_\_\_\_  
3. \_\_\_\_\_      4. \_\_\_\_\_

## **Habits** (Please circle all that apply):

Alcohol    Chocolate    Cigarettes    Coffee    Laxatives    Tea    Sugar or Sugar Substitute

**Do you consider yourself:** overweight    average    underweight

**Your activity level:** sedentary    light    moderate    heavy

**Are you primarily responsible for preparing your own meals?** Yes    No

**How many meals do you eat out per week?** \_\_\_\_\_

**How many glasses of water do you drink per day?** \_\_\_\_\_

**List foods you crave:**

\_\_\_\_\_  
\_\_\_\_\_

**List foods you avoid:**

\_\_\_\_\_  
\_\_\_\_\_

**Any special diet or dietary restrictions?** \_\_\_\_\_

**Are you following a dietary regimen (weight watchers, etc)?**    yes                      no

# FAMILY HISTORY *(check all that apply)* .....



	<b>Mother</b>	<b>Father</b>	<b>Siblings</b>
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Heart Disease	_____	_____	_____
Cancer	_____	_____	_____
Arthritis	_____	_____	_____
Kidney Disease	_____	_____	_____
Diabetes	_____	_____	_____
Stomach Disorders	_____	_____	_____
Other (please list)	_____	_____	_____

## DIETARY PREFERENCES .....



What you usually eat & drink 5 days a week, not including weekends. Please record your dietary habits below and please be specific when indicating your food choices.

### MORNING MEAL

Do you usually eat breakfast?	yes	no
Do you eat breakfast at home?	yes	no
Do you use a meal substitute (slim fast, etc)?	yes	no

**Mid-Morning Snack:** \_\_\_\_\_

### LUNCH

Do you usually eat lunch?	yes	no
Do you eat lunch at home?	yes	no
Do you use a meal substitute (slim fast, etc)?	yes	no

**Mid-Afternoon Snack:** \_\_\_\_\_

### EVENING MEAL

Do you usually eat evening meal?	yes	no
Do you eat evening meal at home?	yes	no
Do you use a meal substitute (slim fast, etc)?	yes	no

**Evening Snack:** \_\_\_\_\_

### OTHER DIETARY ITEMS

Do you chew gum?	yes	no
Do you use breath mints?	yes	no

Additional food items not listed: \_\_\_\_\_

**PLEASE complete each question; some may be repeated. Please score each as follows: 3 = if this is a MAJOR problem (severe or happens frequently)  
1 = if this is a MINOR problem (not severe or happens infrequently)  
Blank = if you never have this problem  
If you do not understand a question, please circle it and we will discuss it. J**



## SECTION 1

### Group A

- 1. History of speech impediment, stuttering or stammering
- 2. Dry, itchy eyes or dry mouth
- 3. Poor memory
- 4. Unable to relax, become serene, or meditate
- 5. Frequent sore or irritated throat

### Group B

- 1. History of diabetes in yourself or family
- 2. Functional or reactive hypoglycemia
- 3. Uncontrollable appetite (eating when not hungry)
- 4. Desire to lose weight
- 5. In need of a meal replacement

### Group C

- 1. History of spinal disc problems or back surgery
- 2. Unable to tolerate stress (i.e., unable to make decisions)
- 3. Irritated or receding gums, loose teeth
- 4. Cold hands and feet
- 5. Clicking jaw or TMJ discomfort

### Group D

- 1. History of having difficulty healing after athletic injuries, surgery or trauma
- 2. Swelling of soft tissue
- 3. Cold hands and feet
- 4. Hot flashes, menopausal symptoms
- 5. Chronic low back discomfort

### Group E

- 1. History of frequent canker sores, cold blisters, or boils
- 2. Muscle & tendon weakness, discomfort in lower back and buttocks
- 3. Slow morning starter, writer's cramp or stiffness after sitting
- 4. Dry skin, dandruff, hair falling out
- 5. Discomfort in the shoulders & rib cage

### Group F

- 1. History of spontaneous abortion, inability to conceive or to induce labor; low sperm count
- 2. Tremors, stiffness after rest
- 3. Dry skin, skin manifestations or eruptions
- 4. Hair loss
- 5. Chronic shoulder problems



## SECTION 2

### Group A

- 1. History of lactose intolerance or gluten intolerance
- 2. Craving or thirst for cold liquids or foods
- 3. Intolerance of dairy products, grains or sugars
- 4. Sensitive to air pollutants (i.e., perfumes, smoke)
- 5. Discomfort or soreness under the left rib cage after eating

### Group B

- 1. History of food sensitivity
- 2. Bloating after eating dairy or grains
- 3. Loose stools after eating dairy or grains

### Group C

- 1. History of gallbladder stones or gallbladder surgery
- 2. Loss of appetite especially for meat
- 3. Frequent sour taste in the mouth, intolerance of fats and spicy foods
- 4. Frequent constipation with light colored stool
- 5. Discomfort or soreness under right rib cage or in lower right abdomen after eating

### Group D

- 1. History of diabetes in yourself or family
- 2. Excessive appetite
- 3. Tongue coated with thick yellow film
- 4. Frequent bitter taste in mouth
- 5. Discomfort or soreness in temporal area on side of head

### Group E

- 1. History of ulcers or gastritis
- 2. Frequent heartburn or indigestion with nausea and discomfort
- 3. Acid reflux after eating
- 4. Frequent use of antacids
- 5. Stomach discomfort that is relieved by eating

### Group F

- 1. History of chronic gas, bloating and distention
- 2. Unusual fullness after eating
- 3. Rapid ingestion of food without chewing food completely
- 4. Avoidance of raw foods, especially vegetables
- 5. Discomfort or soreness in the upper abdominal midline

### Group G

- 1. History of pernicious anemia
- 2. Loss of taste for meat
- 3. Strong desire to eat when not hungry
- 4. Indigestion, particularly 2-3 hours after eating
- 5. Lower bowel gas





#### Group H

- 1. History of chronic indigestion
- 2. Unusual fullness after eating
- 3. Lower bowel gas, unaware of what foods cause the problem
- 4. Undigested food, capsules or tablets found in the stool
- 5. Frequent abdominal cramping or discomfort after eating

### SECTION 3

#### Group A

- 1. History of chronic frequent yeast infections
- 2. Foul odor to stool, urine and/or breath
- 3. Unusually large appetite (i.e., cannot control the urge to eat)
- 4. Frequent or prolonged use of antibiotics
- 5. Discomfort or soreness around naval

#### Group B

- 1. History of constipation with infrequent bowel movements
- 2. Frequent use of laxatives
- 3. Hard, uncomfortable stools
- 4. Less than 1 bowel movement a day
- 5. Lower abdominal discomfort

#### Group C

- 1. History of colitis or other disease of the large intestine
- 2. Loose stools with mucous or blood in the stool
- 3. Frequent bowel movements
- 4. Discomfort with bowel movements
- 5. Left lower bowel discomfort

#### Group D

- 1. Always tired (i.e., unable to meet daily requirements)
- 2. Loss of appetite or feel better when you don't eat
- 3. Restless sleep, grinding of teeth
- 4. Thin, difficult to gain weight
- 5. Itching around rectum and groin

### SECTION 4

#### Group A

- 1. History of muscular weakness and/or atrophy
- 2. Inability to tolerate potassium-rich foods (i.e., olives, vegetable juices, bananas)
- 3. Frequent writer's cramp, stiffness especially after rest
- 4. Muscle soreness and discomfort resulting from exercise
- 5. Loss of joint range of motion, discomfort when stretching

#### Group B

- 1. History of food sensitivity and non-specific digestive symptoms
- 2. Frequent raised skin eruptions or hives in response to foods or chemicals
- 3. Strong reactions to mosquito or insect bites
- 4. Frequent histamine reactions (i.e., sneezing attacks)
- 5. Discomfort associated with skin irritations



### Group C

- 1. History of deep bone or joint discomfort
- 2. Frequent use or need for tranquilizers
- 3. Frequent infections, need for antibiotics
- 4. Symptoms of swelling of feet and ankles
- 5. Any type of acute traumatic incidents/accidents

### Group D

- 1. History of osteoarthritis or gout
- 2. Musculoskeletal discomfort, difficulty walking, etc.
- 3. Bone and joint discomfort in the spine, hips, knees, feet or hands
- 4. Irritation from overuse or excessive exercise
- 5. Discomfort or soreness in the knees

### Group E

- 1. History of tuberculosis or COPD
- 2. Skin problems
- 3. Being treated for psoriasis
- 4. Frequent ear infections
- 5. Discomfort or soreness in the temporal area

### Group F

- 1. History of lymphatic congestion
- 2. Enlarged lymph nodes
- 3. Localized swelling
- 4. Congestion, soft tissue
- 5. Discomfort or soreness in the shoulders and neck

### Group G

- 1. History of poor immune response or poor ability to heal
- 2. Lack of appetite
- 3. Decreased sense of taste
- 4. Problems with foot odor
- 5. Discomfort or soreness in the hip joint(s)

## SECTION 5

### Group A

- 1. History of reactive hypoglycemia
- 2. Suffer from airborne allergies
- 3. Dark circles under the eyes
- 4. Nausea or vomiting-type indigestion, morning sickness
- 5. Muscular lower back discomfort

### Group B

- 1. History of frequent bladder infections
- 2. Frequent urination, urgency or loss of control
- 3. Pass small amounts of urine at each voiding
- 4. Dry skin, flaking, dandruff
- 5. Discomfort or soreness in the lower abdomen or genital area



### Group C

- 1. History of anemia or other blood disorder
- 2. Fatigued, tired most of the time
- 3. Pale skin, lips and nails
- 4. Low resistance (i.e., frequent colds and infections)
- 5. Discomfort or soreness in the left flank area of the abdomen

### Group D

- 1. History of skin disorders, such as acne
- 2. Frequent skin rashes or eruptions
- 3. Have many warts or moles
- 4. Excessive perspiration or lack of perspiration
- 5. Muscular discomfort or soreness in the lower back

### Group E

- 1. History of hepatitis, jaundice, other liver disorder
- 2. History of high blood pressure or medication
- 3. Water retention, swelling of hands and feet
- 4. Suffer from varicose veins, hemorrhoids
- 5. Discomfort or soreness in the right flank area of the abdomen

## SECTION 6

### Group A

- 1. Type A personality (driven and aggressive)
- 2. Tend to have problems with indigestion and constipation
- 3. Stiff joints, especially after rest
- 4. Sensitive to sudden sounds (startle easily)
- 5. Headaches in back of head and neck

### Group B

- 1. History of gallbladder stones or sugar
- 2. Being treated for high blood pressure
- 3. Frequent problems with dizziness or vertigo
- 4. Frequent episodes of fearfulness and sleeplessness
- 5. Frequent migraine-type headaches

### Group C

- 1. History of cataracts, glaucoma, poor vision
- 2. Frequent head colds, runny nose, watery eyes
- 3. Bruise easily, slow healing of cuts, sore or bleeding gums
- 4. Frequent redness in the eyelids, "sand in your eyes"
- 5. Frequent headaches associated with eye strain, discomfort when moving eyes

### Group D

- 1. History of chronic sinus problems
- 2. Loss of sense of smell or an obstruction to nasal breathing
- 3. Bothered by thick mucus discharge from the nose
- 4. Frequent nosebleeds
- 5. Facial discomfort or paralysis



### Group E

- 1. History of or taking medication for heart disease
- 2. Irregular heartbeat, skipped beats
- 3. Dryness of skin or hair, itching due to dryness
- 4. Suffer from varicose veins, hemorrhoids
- 5. Shoulder or chest discomfort on exertion

### Group F

- 1. History of asthma, emphysema, bronchitis, pneumonia
- 2. Difficulty breathing, shortness of breath
- 3. Frequent cough (dry or productive)
- 4. Wheezing or having difficulty breathing when lying on back
- 5. Difficult shoulder movement

### Group G

- 1. History of bone disorders, spurs, osteoporosis
- 2. Muscle soreness and weakness
- 3. Loose teeth or poor fitting dentures
- 4. Restlessness, hyperirritability, or restless legs at night
- 5. Low back discomfort, weak joints or ligaments, fallen arches

### Group H

- 1. History of injury to the tailbone
- 2. Restlessness or difficulty sleeping
- 3. Inability to concentrate, frequent daydreaming or nightmares
- 4. Unresolved health problems
- 5. Discomfort in the area of the tailbone (i.e., hurts to sit down)

## SECTION 7

### Group A

- 1. History of taking medication for thyroid gland disorders
- 2. Fast heartbeat (i.e., can feel heart racing)
- 3. Swollen or uncomfortable breasts
- 4. Moist warm skin (i.e. sweat easily)
- 5. Neck, shoulder, arm, hand discomfort

### Group B

- 1. History of low blood pressure problems
- 2. Awake after a few hours of rest and cannot go back to sleep
- 3. Suffer from frequent periods of sadness or the inability to think clearly
- 4. Become light-headed when meals are missed
- 5. Suffer from frequent nightmares or panic attacks

### Group C

- 1. History of prostate disorders or medication
- 2. Frequent night urination
- 3. Dribbling
- 4. Loss of sexual urge
- 5. Discomfort radiating into the groin or testes



**Group D**

- 1. History of hysterectomy or estrogen replacement therapy
- 2. Vaginal discharge
- 3. Excessive menstrual flow
- 4. Lack of menstruation, scanty flow, irregular periods
- 5. Symptoms of PMS

**Group E**

- 1. Generally tired and lacking ambition or purpose
- 2. Frequent lack of motivation, inability to get started
- 3. Fatigued, easily tired
- 4. Failure to meet ordinary requirements of daily activities
- 5. Discomfort or soreness in calf muscles when climbing stairs

Thank you for filling this document out accurately. Your replies will help us to identify your health issues and develop a customized treatment plan to restore normal body function.