Spiritual Physics Institute Questionnaire

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you married? Please circle one: Married Widowed Single Divorced

I am thinking about leaving my current relationship

1. How often do you feel tired? Please circle one:

All of the time Often Regularly Sometimes Occasionally Never

2. I often have muscle cramps and pain? Yes No Sometimes

3. I feel like I have cold intolerance. Yes No Sometimes

4. I have had changes in hair growth recently. Yes No Sometimes

5. My skin is pale and dry. Yes No Sometimes Just pale Just dry

6. I am having trouble losing weight. Yes No A little bit

7. I have gained weight and can’t lose it. Yes No Somewhat

8. I would like to talk to one of your nutritionists about losing weight. Yes No

9. I feel constipated many times in the week Yes No Sometimes

10. Are your menstrual cycles regular? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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11. My libido is healthy. Yes No I don’t know It feels lacking

12. I have some childhood trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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13. Do you have breathing issues? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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14. Do you have itchy eyes, wheezing, a rash, sneezing, or nasal congestion? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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15. Have you had a cough recently? If so, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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16. Have you had a sore throat, stuffy nose, runny nose, fever, etc? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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17. Have you taken anything to lessen your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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18. Have you had any phlegm? Yes No

19. Have you felt any chest tightness or chest congestion? Yes No

20. Have you experienced shortness of breath? Yes No

21. Have you had a low-grade fever? Yes No

22. Have you had swollen lymph nodes? Yes No

23. Do you have headaches? Yes No Sometimes

22. Do you have fatigue and low energy most of the time? Yes No Sometimes

23. Have you had any appetite loss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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24. I have seen blood in my stool: Yes No

25. Have you had night sweats? Yes No

26. Have you had any skin changes, such as discoloration, a sore that doesn’t heal, skin that looks bigger or thicker, changes color, has an oddly shaped boarder, etc? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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27. Have you had trouble swallowing? Yes No

28. Have you lost weight without trying? Yes No

29. Do you have any lumps or a lump on your testicle? Yes No

30. Do you have pain during ejaculation or urination? Yes No

31. Have you had any breast pain or nipple changes? Yes No

32. Have you had bleeding between periods or menopause? Yes No

33. Have you been sad recently? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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34. Do you feel like you are looking to find your purpose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

35. Have you had persistent sadness? Yes No

36. Have you had feelings of hopelessness? Yes No

37. Have you felt feelings of worthlessness? Yes No

38. Do you feel guilty or do you have feelings of guilt? Yes No Sometimes Often

Rarely Always

39. Have you experienced a loss of interest in activities? Yes No

40. Have you been experiencing sleep disturbances? Yes No Sometimes

41. I have difficulty remembering things and concentrating: Yes No Explain:\_\_\_\_\_\_

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

42. I feel overwhelmed: Yes No Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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43. I have been having thoughts of suicide or hurting myself Yes No Sometimes

44. I think about harming others. Yes No Sometimes

45. I feel like I need to talk to someone. Yes No

46. I have digestive issues. Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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47. I have pain, gas, bloating, etc when I eat: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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48. I have itching on my skin or in my private areas: Yes No Sometimes

49. My stools are: painful hard loose pellets diarrhea liquid

bloody painful regular irregular other

50. How many times do you have a bowel movement per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

51. I have fatigue and dizziness often: yes no

52. I experience joint pain often: yes no

53. I feel nauseous often: yes no sometimes

54. I frequently get headaches, even if they are minor: yes no

55. I crave sugary foods, alcohol, breads, sweets, coffee, or other similar things that are unhealthy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

56. How many times per week do you drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

57. I frequently have allergies: yes no

58. I have yeast infections that I have noticed: yes no I don’t know

59. I occasionally or frequently get mouth sores: yes no

60. I have a skin condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

61. Are there any other issues or things that you would like to include before our session begins: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature (not computer signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_