



# Plant Wisdom Within

Herbs, Nutrition, Wellness

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ADULT

## INSTRUCTIONS FOR YOUR FIRST CONSULTATION

I invite you to enjoy this period of focus & reflection while you turn your attention to completing this New Client Questionnaire. Any areas of concern which arise during its completion will be given ample time for exploration during our appointments together.

### REQUIRED FOR YOUR FIRST VISIT:

- Completed New Client Questionnaire -- to receive optimized care, please return completed form two days prior to initial appointment. *Please allow 30-45 minutes to complete this questionnaire.*

### PLEASE ALSO BRING THE FOLLOWING

- Any labs, blood tests, or other pertinent medical information you think may be helpful.
- If you are taking any pharmaceuticals, over-the-counter drugs, herbs, &/or supplements, please bring them in their original containers for accurate assessment of ingredients, dosage, & form by your practitioner.

**If you have any questions, please contact me:**

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# Plant Wisdom Within

## New Client Questionnaire, Adult

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Please answer the questions below as thoroughly as possible so that we may make the best possible clinical assessment and develop a realistic and workable plan for supporting you in comfortably living the life which wants to live in you! Your answers to personal questions are important as they provide helpful context for establishing a productive partnership with you. That said, please answer only the questions you are comfortable answering.

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TODAY'S DATE:

### BASIC INFORMATION

#### CONTACT INFORMATION:

NAME:

ADDRESS:  
CITY, STATE, ZIP:

WORK PHONE:

HOME PHONE:

MOBILE PHONE:

EMAIL:

PREFERRED CONTACT METHOD:

ANYTHING HELPFUL TO KNOW ABOUT CONTACTING YOU:

#### EMERGENCY CONTACT:

NAME:

RELATIONSHIP:

PHONE:

#### PHYSICAL:

AGE:                      DATE OF BIRTH:

GENDER:                      ANCESTRAL DESCENT:

HEIGHT:

WEIGHT:                      LBS

HIGHEST ADULT WEIGHT:    LBS/YR:

LOWEST ADULT WEIGHT:    LBS/YR:

#### PERSONAL INFORMATION:

STATUS:

PARTNER'S NAME:

PARTNER'S GENDER:

SPIRITUALITY/RELIGION:

EDUCATION:

WITH WHOM (PERSONS/ANIMALS) DO YOU SHARE YOUR HOME?

OCCUPATION:

HOW LONG?

SATISFIED?

WHAT ARE YOUR INTERESTS/PASSIONS?

#### WHAT ARE YOUR PRIMARY REASONS FOR COMING TO PLANT WISDOM WITHIN?

1.

2.

3.

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## MEDICAL INFORMATION

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WITH WHAT TYPES OF HEALTH PRACTITIONERS ARE YOU CURRENTLY WORKING?

PRACTITIONER TYPE	NAME	REASON FOR SEEING	CITY, STATE	PHONE NUMBER
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IS THERE ANYTHING THAT SURFACED DURING A RECENT MEDICAL TEST, LAB WORK, OR DOCTOR'S VISIT THAT YOU WOULD LIKE TO REPORT?

WHAT HEALTH CONCERNS DID YOU EXPERIENCE AS A CHILD?

WHAT HEALTH CONCERNS HAVE YOU EXPERIENCED AS AN ADULT?

ARE YOU PART OF A RECOVERY PROGRAM? Y/N IF SO, WHICH ONE?

ARE YOU CURRENTLY BREASTFEEDING? Y/N IF SO, HOW OLD IS THE CHILD? HOW OFTEN?

WHICH ALLERGIES TO FOODS, MEDICATIONS, CHEMICALS, &/OR OTHER ENVIRONMENTAL SUBSTANCES DO YOU HAVE?

WHAT IS YOUR TYPICAL REACTION, AND HOW SEVERE IS IT?

ALLERGEN	TYPICAL REACTION	SEVERITY
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WHAT, IF ANY, SURGERIES/OPERATIONS/HOSPITALIZATIONS HAVE YOU UNDERGONE, & WHEN?

PROCEDURE(S)	REASON(S)	DATE
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HAVE YOU EVER HAD A MAJOR CHEMICAL EXPOSURE?  
IF SO, WHEN, AND TO WHAT?

WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE OF THE U.S. & CANADA?

WHERE	DATE
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## REVIEW OF BODY SYSTEMS

Please indicate if you are currently experiencing any of the following. Also, kindly provide detail wherever there's a "?".

(Click boxes to create checkmarks & fill in the blanks where questions are asked.)

### HEAD

- SEIZURE
  - HEADACHE
  - MIGRAINES
- ### EYES
- VISION LOSS
  - TEARING
  - DISCHARGE
  - REDNESS
  - PAIN
  - CORRECTIVE LENSES

### EARS

- HEARING LOSS
- RINGING IN THE EARS
- DISCHARGE
- ITCHING
- HISTORY OF INFECTION

### NOSE

- DISCHARGE
- BLOOD
- CONGESTION
- SNORING/BLOCKAGE

### NECK & THROAT

- PAIN
- LUMP
- ENLARGED THYROID
- STIFFNESS
- TONSILLITIS

### URINARY

- URINATIONS PER DAY?*
- COLOR OF URINE?*
- HISTORY OF URINARY TRACT INFECTION
- HISTORY OF BLADDER INFECTION
- HISTORY OF KIDNEY INFECTION
- KIDNEY STONES
- SWELLING OF ANKLES OR LEGS
- INCONTINENCE
- URGENCY
- FREQUENCY
- PAIN ON URINATION
- BLOOD IN URINE
- LOWER BACK PAIN
- DARK CIRCLES UNDER EYES

### MUSCULOSKELETAL

- MYALGIA (MUSCLE PAIN)
- ARTHRITIS
- STIFFNESS
- JOINT PAIN
- GOUT
- BACKACHE — *UPPER/LOWER?*
- MOBILITY RESTRICTIONS
- HISTORY OF BROKEN BONES

### RESPIRATORY

- CONGESTION
- SINUS
- PAIN/INFLAMMATION
- DIFFICULTY BREATHING
- COUGH
- WHEEZING
- TUBERCULOSIS
- EMPHYSEMA

### CARDIOVASCULAR

- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- HEART PALPITATIONS
- RAPID HEART BEAT
- CHEST PAIN
- HIGH CHOLESTEROL
- VARICOSE VEINS
- SPIDER VEINS
- COLD HANDS & FEET
- CLOTTING TENDENCY
- STROKE

### LYMPHATICS

- CONGESTION - *WHERE?*
- SWOLLEN NODES-  
*WHERE?*
- PAINFUL NODES -  
*WHERE?*
- INFECTION - *WHERE?*
- DRAINAGE - *WHERE?*

### ENDOCRINE

- LOW ENERGY LEVEL
- HYPOTHYROID (LOW)
- HYPERTHYROID (HIGH)
- LOW BLOOD SUGAR
- DIABETES
- HORMONE IMBALANCE

### ALLERGIC &

- ### IMMUNOLOGIC
- RESPIRATORY ALLERGY
  - FREQUENT COLD/ FLU
  - FOOD ALLERGIES
  - FOOD SENSITIVITIES
  - IMMUNE DISORDER

### NEUROPSYCHIATRIC

- PHOBIAS
- STRESS
- INSOMNIA
- DEPRESSION
- ANXIETY
- ATTENTION DEFICIT/  
HARD TO CONCENTRATE
- MENTALLY SLUGGISH
- SHINGLES
- OTHER MENTAL DISORDER?*
- ABNORMAL MOVEMENT (TREMORS, ETC.)

### GASTROINTESTINAL

- BAD BREATH
- MOUTH ULCERS
- BLOATING
- PAIN/CRAMPING
- GAS
- NAUSEA
- ACID REFLUX/GERD
- CONSTIPATION
- DIARRHEA
- UNDIGESTED FOOD IN STOOLS
- BLOOD IN STOOLS
- ULCERS
- POLYPS
- HEMORRHOIDS
- GALL STONES
- LIVER/GALLBLADDER ISSUES

### BOWEL MOVEMENTS

- # PER DAY?*
- # PER WEEK?*
- QUALITY? PEBBLY/  
FULLY FORMED/SOFT &  
LARGELY UNFORMED/  
LOOSE & UNFORMED  
FLOAT OR SINK?  
COLOR? BROWN /  
GREEN / YELLOWISH /  
DARK OR BLACK /  
OTHER?*

### SKIN/ INTEGUMENTARY

- RASH
- DRY SKIN
- ITCHING
- ACNE
- ROSACEA
- ECZEMA
- CHANGING MOLES
- NAIL GROWTH
- HAIR LOSS
- HAIR QUALITY CHANGE
- BRUISE EASILY
- SLOW WOUND HEALING

### MALE REPRODUCTIVE

- URINATION DIFFICULTY
- BPH
- GENITAL MASSES
- PENILE DISCHARGE
- PROSTATE PAIN
- PAIN/SWELLING IN TESTES
- VASECTOMY
- ERECTILE INSUFFICIENCY
- PAINFUL SEX/ORGASM
- BURNING ON EJACULATION
- BLOOD IN SEMEN
- LOW SPERM COUNT
- POOR SPERM MOBILITY

- LOW LIBIDO
- STDs
- BIRTH CONTROL, *WHAT FORM?* \_\_\_\_\_

### FEMALE REPRODUCTIVE

#### BREASTS

- TENDERNESS
- LUMPS
- DISCHARGE
- CHANGES IN SHAPE
- PERFORM BREAST SELF-EXAMS?
- ABNORMALITIES
- MAMMOGRAMS / THERMOGRAPHY

#### GENITALS

- VAGINAL DISCHARGE
- REDNESS
- RECURRENT YEAST INFECTIONS
- STDs
- PELVIC PAIN OR MASSES
- PAINFUL INTERCOURSE/ORGASM
- LOW LIBIDO
- ABNORMAL PAP SMEAR, *RESULTING ACTION?*

#### MENSES

- AGE AT ONSET OF MENSES? \_\_\_\_\_*
- BLEEDING STARTS APPROX EVERY \_\_\_ DAYS*
- BLEED FOR \_\_\_ DAYS?*
- AMOUNT OF BLEEDING? LIGHT MODERATE HEAVY*
- QUALITY OF BLEEDING? BRIGHT RED/ BROWN/ CLOTTING*
- PAINFUL CRAMPS
- BLEEDING BETWEEN CYCLES
- MOOD SWINGS AROUND CYCLE
- ABSENCE OF MENSTRUAL CYCLES
- BIRTH CONTROL, *CURRENT? \_\_\_\_\_ PAST HORMONAL CONTRACEPTIVE TYPE? \_\_\_\_\_ #YRS \_\_\_\_\_*

#### MENOPAUSAL WOMEN

- AGE OF MENOPAUSE?*
- MENOPAUSAL SYMPTOMS
- VAGINAL BLEEDING
- VAGINAL DRYNESS
- HORMONE REPLACEMENT THERAPY
- OSTEOPOROSIS

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**FOR WOMEN: PREGNANCIES** *(please include losses/terminations)*

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VAGINAL/C SECTION/ LOSS/TERMINATION	COMPLICATIONS/OTHER THINGS YOU WANT TO MENTION	SEX	YEAR
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ARE YOU CURRENTLY PREGNANT? Y/N    ARE YOU ACTIVELY TRYING TO CONCEIVE Y/N  
ARE YOU AWARE THAT IT'S IMPORTANT TO INFORM YOUR PRACTITIONER IF YOU DECIDE TO CONCEIVE OR  
IF YOU BECOME PREGNANT?

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**FAMILY HISTORY**

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RELATION	DECEASED(D) LIVING (L)?	PRESENT HEALTH OR CAUSE OF DEATH
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MATERNAL GRANDMOTHER

MATERNAL GRANDFATHER

PATERNAL GRANDMOTHER

PATERNAL GRANDFATHER

MOTHER

FATHER

BROTHER(S)

SISTER(S)

CHILDREN/AGES

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**MEDICATIONS & SUPPLEMENTS**

MEDICATIONS (Over-the-Counter &amp; Prescription)

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DOSE (IU/MG/CAPS)	#TIMES/ DAY	NAME	LENGTH OF USE	REASON FOR TAKING
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ARE YOU SENSITIVE TO LOW LEVELS OF MEDICATIONS &/OR CAFFEINE?

VITAMINS, MINERALS, &amp; HERBAL SUPPLEMENTS

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DOSE (IU/MG/CAPS)	#TIMES/ DAY	NAME	LENGTH OF USE	REASON FOR TAKING
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## LIFESTYLE ACTIVITIES

	FREQUENCY				COMMENTS
	NEVER OR RARELY <1X/MONTH	OCCASION - ALLY <1X/WEEK	REGULARLY >2-3X/WK	MOST DAYS OF THE WEEK	
EXERCISE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
DAILY HOURS SPENT SITTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEXUAL ACTIVITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SOCIALIZING W/ FRIENDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
RELAXATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
SELF-PAMPERING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
RECREATIONAL DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)

## SLEEP

AT WHAT TIME ARE YOU TYPICALLY IN BED?	WHAT TIME DO YOU FALL ASLEEP?	TYPICAL HOURS ASLEEP?
#OF TIMES YOU AWAKEN DURING THE NIGHT?	REASON?	
DO YOU WAKE TO AN ALARM CLOCK?	DO YOU FEEL RESTED UPON RISING?	

## NOURISHMENT

	FREQUENCY				COMMENTS
	NEVER OR RARELY <1X/MONTH	OCCASION - ALLY <1X/WEEK	REGULARLY >2-3X/WK	MOST DAYS OF THE WEEK	
CAFFEINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
SODA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
RED MEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
WHITE MEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
EGGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
SEAFOOD/FISH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
NUTS & SEEDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
FRUITS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
VEGETABLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S) <input type="checkbox"/> CANNED <input type="checkbox"/> FROZEN <input type="checkbox"/> FRESH
PLANT OILS (OLIVE, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S) <input type="checkbox"/> CANNED <input type="checkbox"/> FROZEN <input type="checkbox"/> FRESH
DAIRY PRODUCTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE <input type="checkbox"/> MILK <input type="checkbox"/> BUTTER <input type="checkbox"/> CHEESE <input type="checkbox"/> YOGURT
SOY PRODUCTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
BREAD/GRAINS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
JUNK/FAST FOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)
FRIED FOODS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TYPE(S)

HOW MANY TIMES EACH WEEK DO YOU EAT EACH MEAL AT HOME (VS. OUT)?

\_\_\_ BREAKFAST \_\_\_ LUNCH \_\_\_ DINNER

HOW MANY OUNCES OF WATER DO YOU DRINK PER DAY? \_\_\_ OZ  TAP  BOTTLED  FILTERED



## CONSTITUTIONAL ASSESSMENT

The following section provides an overview of your personal constitutional tendencies, which is helpful in determining which herbs and nutritional guidance are most appropriate for you. For this reason, please evaluate yourself as accurately & honestly as you can, based on how you have reacted in general throughout your lifetime, not how you react at present. Avoid the temptation to see yourself as you would like to be rather than as you are. There are no right/wrong or better/worse answers. There is only feedback which informs how to personalize your care. Your answers may primarily appear in one column or they may cross multiple columns. Enjoy the process!

### BODY FRAME & WEIGHT

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> NARROW SHOULDERS, HIPS                                      | <input type="checkbox"/> MEDIUM SHOULDERS, HIPS                 | <input type="checkbox"/> BROAD SHOULDERS, HIPS                                       |
| <input type="checkbox"/> LOSE WEIGHT WITHOUT DIFFICULTY, GAIN WEIGHT WITH DIFFICULTY | <input type="checkbox"/> LOSE OR GAIN WEIGHT WITHOUT DIFFICULTY | <input type="checkbox"/> LOSE WEIGHT WITH DIFFICULTY, GAIN WEIGHT WITHOUT DIFFICULTY |

### SKIN, NAILS, & HAIR

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> SKIN COLD TO THE TOUCH (ESP. HANDS & FEET) | <input type="checkbox"/> SKIN WARM TO THE TOUCH      | <input type="checkbox"/> SKIN IS COOL TO THE TOUCH      |
| <input type="checkbox"/> SKIN DRY, ROUGH                            | <input type="checkbox"/> SKIN OILY                   | <input type="checkbox"/> SKIN IS MOIST & SUPPLE OR OILY |
| <input type="checkbox"/> SWEAT IS SCANTY, EVEN IN HEAT              | <input type="checkbox"/> SWEAT PROFUSE, EVEN IN COLD | <input type="checkbox"/> SWEAT IS MODERATE, CONSISTENT  |
| <input type="checkbox"/> HAIR BRITTLE, DRY, OR KINKY                | <input type="checkbox"/> SOFT & STRONG               | <input type="checkbox"/> THICK & STRONG                 |
|   | <input type="checkbox"/> HAIR EARLY GRAY OR REDDISH  |   |

### APPETITE

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> VARIABLE APPETITE & THIRST    | <input type="checkbox"/> APPETITE STRONG, SHARP, THIRST EXCESSIVE | <input type="checkbox"/> APPETITE SLOW BUT STEADY                 |
| <input type="checkbox"/> VARIABLE INTEREST IN FOOD     | <input type="checkbox"/> ENJOY EATING                             | <input type="checkbox"/> MODERATE INTEREST IN FOOD                |
| <input type="checkbox"/> DIZZY OR FAINT WITHOUT SNACKS | <input type="checkbox"/> IRRITABLE IF MEALS ARE MISSED            | <input type="checkbox"/> CAN MISS MEALS WITHOUT PHYSICAL DISTRESS |

### DIGESTION & EVACUATION

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> DEFECATE 1-FEW TIMES/WEEK    | <input type="checkbox"/> DEFECATE MULTIPLE TIMES/DAY     | <input type="checkbox"/> DEFECATE ONCE DAILY                                  |
| <input type="checkbox"/> STOOLS OFTEN DRY, HARD, DARK | <input type="checkbox"/> STOOLS SOFT TO LOOSE, YELLOWISH | <input type="checkbox"/> STOOLS THICK, WELL-FORMED, RARELY HARD, MEDIUM BROWN |
| <input type="checkbox"/> STOOLS MOVE WITH STRAIN      | <input type="checkbox"/> STOOLS MOVE EASILY              | <input type="checkbox"/> STOOLS MOVE SLOWLY                                   |
| <input type="checkbox"/> RESPOND TO LAXATIVES         | <input type="checkbox"/> NO NEED FOR LAXATIVES           | <input type="checkbox"/> RESPOND ONLY TO STRONG LAXATIVE                      |

### PHYSICAL STRENGTH & ENDURANCE

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> ENERGY COMES IN SPURTS/BURSTS; PREFER TO EXPEND IT WHEN AVAIL. | <input type="checkbox"/> CONSTANT SUPPLY OF ENERGY; DRIVE TO BE ACTIVE CAN CAUSE OVERLOAD | <input type="checkbox"/> PREFER NOT TO EXPEND ENERGY, BUT FEEL GOOD WITH REGULAR ACTIVITY |
| <input type="checkbox"/> LIKE VIGOROUS EXERCISE, BUT IT EVENTUALLY EXHAUSTS YOU         | <input type="checkbox"/> LIKE VIGOROUS EXERCISE & CAN ENDURE IF PACED WELL                | <input type="checkbox"/> ENDURE VIGOROUS EXERCISE WELL, BUT PREFER NOT TO PARTAKE         |

### SLEEP

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> DIFFICULT TO FALL ASLEEP  | <input type="checkbox"/> EASILY FALL ASLEEP UNLESS WORRIED                   | <input type="checkbox"/> EASY & QUICK TO FALL ASLEEP              |
| <input type="checkbox"/> LIGHT OR VARIABLE SLEEPER; HARD TO RETURN TO SLEEP WHEN WAKENED | <input type="checkbox"/> LIGHT SLEEPER; RETURNS TO SLEEP EASILY WHEN WAKENED | <input type="checkbox"/> SLEEP SOUNDLY, RARELY WAKENED            |
| <input type="checkbox"/> RARELY ACHIEVE ADEQUATE SLEEP                                   | <input type="checkbox"/> GET BY ON MINIMAL SLEEP                             | <input type="checkbox"/> TOUGH TO ROUSE                           |
| <input type="checkbox"/> RISE FEELING UNRESTED   | <input type="checkbox"/> RISE FEELING ALERT                                  | <input type="checkbox"/> PREFER MANY HOURS OF SLEEP               |
| <input type="checkbox"/> DREAMS: FLYING, JUMPING, RUNNING, FEARFUL                       | <input type="checkbox"/> DREAMS FIERY, ANGRY, PASSIONATE, COLORFUL           | <input type="checkbox"/> RISE FEELING RESTED & ALERT              |
|  |  | <input type="checkbox"/> DREAMS WATERY, OCEAN, SWIMMING, ROMANTIC |

### VOICE

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> TALKATIVE; SPEAK QUICKLY       | <input type="checkbox"/> CONCISE & DIRECT IN SPEAKING | <input type="checkbox"/> CAUTIOUS, TALK WHEN THERE'S SOMETHING TO SAY |
| <input type="checkbox"/> TENDENCY TO STRAY FROM SUBJECT | <input type="checkbox"/> SPEAKING IS PURPOSEFUL       | <input type="checkbox"/> SPEAKING IS SLOW,                            |
| <input type="checkbox"/> UNINTERRUPTED CHATTER          | <input type="checkbox"/> SHARP, CLEAR, CUTTING        | <input type="checkbox"/> VOICE MELODIOUS OR MONOTONOUS                |
| <input type="checkbox"/> SPEECH CHAOTIC AT TIMES        |   |   |

### PERSONALITY TRAITS

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> SENSITIVE                                     | <input type="checkbox"/> STRONG & FORCEFUL                              | <input type="checkbox"/> CALM & QUIET                            |
| <input type="checkbox"/> HIGHLY STRUNG/ ANXIOUS                        | <input type="checkbox"/> DOMINEERING, OPINIONATED                       | <input type="checkbox"/> PATIENT, COMPASSIONATE                  |
| <input type="checkbox"/> RARELY SEE PROJECT THROUGH                    | <input type="checkbox"/> SEE PROJECTS THROUGH                           | <input type="checkbox"/> SEE PROJECTS THROUGH STUBBORNLY         |
| <input type="checkbox"/> FRIENDSHIPS SHORT TERM, WAVERING, CHANGEABLE  | <input type="checkbox"/> FRIENDSHIPS ACTIVE & DISCERNINGLY SELECTED     | <input type="checkbox"/> FRIENDSHIPS LONG-TERM, LOYAL            |
| <input type="checkbox"/> FEARFUL, INSECURE, OR ANXIOUS WHEN UNBALANCED | <input type="checkbox"/> AGGRESSIVE, IRRITABLE, JEALOUS WHEN UNBALANCED | <input type="checkbox"/> GREEDY, ATTACHED, STUCK WHEN UNBALANCED |
| <input type="checkbox"/> HABITS DIFFICULT TO FORM                      | <input type="checkbox"/> HABITS MADE OR BROKEN EASILY                   | <input type="checkbox"/> HABITS ARE ENJOYABLE                    |

### MIND & MEMORY

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> RESTLESS, ACTIVE, CURIOUS              | <input type="checkbox"/> AGGRESSIVE, INTELLIGENT, DETERMINED                    | <input type="checkbox"/> CALM, SLOW, RECEPTIVE,   |
| <input type="checkbox"/> WAVERING, CHANGEABLE                   | <input type="checkbox"/> MEMORY SHARP; REMEMBER EASILY & FORGET WITH DIFFICULTY | <input type="checkbox"/> MEMORY SLOW TO CATCH HOLD, BUT ONCE YOU'VE GOT IT, IT STAYS FOR GOOD |
| <input type="checkbox"/> RECENT MEMORY GOOD; REMOTE MEMORY POOR | <input type="checkbox"/> DESIGN-FOCUSED (PLANNER)                               | <input type="checkbox"/> PROCESS-FOCUSED (IMPLEMENTER)  |
| <input type="checkbox"/> IDEA-FOCUSED (THEORIST)                |   |   |

### MENSTRUATION

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> IRREGULAR CYCLES                | <input type="checkbox"/> REGULAR, LONG LENGTH CYCLES | <input type="checkbox"/> REGULAR, AVERAGE LENGTH CYCLES |
| <input type="checkbox"/> SCANTY FLOW, SOMETIMES CLOTTING | <input type="checkbox"/> HEAVY FLOW                  | <input type="checkbox"/> MODERATE FLOW                  |
| <input type="checkbox"/> BLOOD DARK IN COLOR             | <input type="checkbox"/> BRIGHT RED BLOOD            | <input type="checkbox"/> BLOOD LIGHT IN COLOR           |
| <input type="checkbox"/> CONSTIPATION BEFORE PERIOD      | <input type="checkbox"/> LOOSE STOOLS BEFORE PERIOD  | <input type="checkbox"/> PRONE TO WATER RETENTION       |
| <input type="checkbox"/> SHARP, INTENSE CRAMPS           | <input type="checkbox"/> MEDIUM INTENSITY CRAMPS     | <input type="checkbox"/> DULL, ACHY CRAMPS              |