Northern Natural Medicine
www.northernnaturalmedicine.com
(701) 314-9904

_____ _____

Client Name Date

INSTRUCTIONS:

Please circle the number next to the symptom in the GROUPS below that are applicable to you

1) Mild Symptoms – symptoms occurring once or twice a month
2) Moderate Symptoms – symptoms occurring once or twice a week
3) Severe Symptoms – symptoms occurring daily

GROUP ONE

1) "Nervous" Stomach	1 2 3	5) Mental alert, quick	1 2 3	9) Fever easily raised	1 2 3
2) Dry Mouth/Eyes/Nose	1 2 3	6) Extremities cold, clammy	1 2 3	10) Cold sweats often	1 2 3
3) Pulse speeds up after meals	1 2 3	7) Heart pounds lying down	1 2 3	11) Neuralgia0like pains	1 2 3
4) Keyed up – unable to calm	1 2 3	8) Acid foods upset	1 2 3		

ARE YOUR SYMPTOMS MADE WORSE BY EMOTIONAL STESS? Yes / No

GROUP TWO

12) Perspire easily	1 2 3	16) Diarrhea	1 2 3	20) Morning joint stiffness	1 2 3
13) Muscle/leg cramps at night	1 2 3	17) Vomiting frequently	1 2 3	21) Poor circulation, cold	1 2 3
14) Eyelids swollen/puffy	1 2 3	18) Difficulty swallowing	1 2 3	22) Frequent colds	1 2 3
15) Indigestion after meals	1 2 3	19) Constipation, diarrhea-alternating	1 2 3		

ARE YOUR SYMPTOMS MADE WORSE BY EMOTIONAL STESS? Yes / No

GROUP THREE

23) Afternoon headaches	1 2 3	26) Palpitations if meals are missed	1 2 3	29) Crave afternoon caffeine	1 2 3
24) Get "shaky" when hungry	1 2 3	27) Eat when nervous	1 2 3	30) Crave sweets often	1 2 3
25) Faintness if meals delayed	1 2 3	28) Wake often at night	1 2 3		

GROUP FOUR

31) Bruise easily	1 2 3	36) Swollen ankles, worse night	1 2 3	40) Hands and feet numb often	1 2 3
32) Sigh frequently	1 2 3	37) Muscle cramps, worse exercise	1 2 3	41) Tendency to anemia	1 2 3
33) Breathing heavily	1 2 3	38) Short of breath with exertion	1 2 3	42) Tightness under breastbone	1 2 3
34) Opens windows often	1 2 3	39) Dull pain in chest/arm	1 2 3		

GROUP FIVE

43) Dry skin	1 2 3	47) Biliousness	1 2 3	51) Use laxatives often	1 2 3
44) Frequent rashes	1 2 3	48) Greasy foods upset	1 2 3	52) Gallstones or pain	1 2 3
45) Bitter/metallic taste	1 2 3	49) Stools light colored	1 2 3	53) Sneezing attacks	1 2 3
46) Bowel movements difficult	1 2 3	50) Pain between shoulder blades	1 2 3		

GROUP SIX

54) Gas hours after eating	1 2 3	57) Indigestion soon after eating	1 2 3
55) Burning in stomach	1 2 3	58) Gas shortly after eating	1 2 3
56) Coated tongue	1 2 3	59) Bloating after eating	1 2 3

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GROUP SEVEN

(A)

60) Pulse fast at rest 1 2 3
61) Nervousness 1 2 3
62) Can't gain weight 1 2 3
63) Intolerance to heat 1 2 3
64) Highly emotional 1 2 3
65) Flush easily 1 2 3
66) Night sweats 1 2 3
67) Inward trembling 1 2 3
68) Heart palpitations 1 2 3
69) Insomnia 1 2 3

(B)

70) Impaired Hearing 1 2 3
71) Low appetite 1 2 3
72) Ringing in ears 1 2 3
73) Constipation 1 2 3
74) Mental sluggishness 1 2 3
75) Headache upon waking 1 2 3

(B)

76) Slow pulse below 65 1 2 3
77) Weight gain 1 2 3

(C)

78) Low blood pressure 1 2 3
79) Memory issues 1 2 3
80) Increased sex desire 1 2 3
81) Headaches "splitting" 1 2 3
82) Low sugar tolerance 1 2 3

(D)

83) Intestinal bloating 1 2 3
84) Abnormal thirst 1 2 3
85) Weight gain hips or waist 1 2 3
86) Low libido 1 2 3
87) Ulcerative colitis 1 2 3
88) High sugar tolerance 1 2 3
90) Female: missed periods 1 2 3

(E)

91) Hot flashes 1 2 3
92) Headaches 1 2 3
93) Dizziness 1 2 3
94) High blood pressure 1 2 3
95) Sugar in urine 1 2 3

(F)

96) Low blood pressure 1 2 3
97) Chronic fatigue 1 2 3
98) Weakness 1 2 3

99) Hives 1 2 3
100) Arthritis 1 2 3
101) increased perspiration 1 2 3
102) Crave salt 1 2 3
103) Brown spots on skin 1 2 3
104) Allergies, asthma 1 2 3
105) Exhaustion - muscular 1 2 3
106) Respiratory disorders 1 2 3

GROUP EIGHT

Female Only:

107) Painful periods 1 2 3
108) PMS 1 2 3
109) Easily fatigued 1 2 3
110) Depressed before period 1 2 3
111) Periods heavy or long 1 2 3
112) Breast tenderness 1 2 3
113) Frequent periods 1 2 3

114) Vaginal discharge 1 2 3
115) Menopause symptoms 1 2 3
116) Periods light 1 2 3
117) Tire too easily 1 2 3
118) Urination difficult 1 2 3
119) Frequent urination at night 1 2 3

Male Only:

121) Pain on inside of legs 1 2 3
122) Incomplete BM 1 2 3
123) Prostate problems 1 2 3
124) Restless legs 1 2 3
125) Low libido 1 2 3

GROUP NINE

126) Chronic cough 1 2 3
127) Pain around ribs 1 2 3
128) Shortness of breath 1 2 3
129) Chest pain 1 2 3

130) Difficulty breathing 1 2 3
131) Coughing up phlegm 1 2 3
132) Coughing up blood 1 2 3

133) Frequent bronchitis 1 2 3
134) Infections tend to lungs 1 2 3
135) Sensitive to smog 1 2 3

GROUP TEN

136) Frequent urination 1 2 3
137) Blood in urine 1 2 3
138) Dripping after urination 1 2 3
139) Difficulty passing urine 1 2 3

140) Cloudy urine 1 2 3
141) Rarely need to urinate 1 2 3
142) Frequent UTI 1 2 3
143) Painful/burning urination 1 2 3

144) Urination with coughing 1 2 3
145) Strong smelling urine 1 2 3

GROUP ELEVEN

(A)

146) Frequent throat infection 1 2 3
147) Poor wound healing 1 2 3
148) Slow to recover from illness 1 2 3

149) Tend to boils or styes 1 2 3
150) Swollen lymph nodes/glands 1 2 3
151) Catch cold/flu easily 1 2 3

152) Bumps on back of arms 1 2 3
153) Bleeding gums 1 2 3

(B)

154) Post nasal drip 1 2 3
155) Food sensitivity/allergy 1 2 3

156) Swollen tongue 1 2 3

157) Hyperactivity 1 2 3

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IMPORTANT – Please list below your four main health complaints in order of importance:

1. _____
2. _____
3. _____
4. _____

PLEASE FILL IN BELOW:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Weight: _____ Height:_____ Married: _____ Gender: _____

Email: _____ Occupation: _____

History of Illness and Treatments: _____

_____

_____

Surgeries, Accidents, Injuries: _____

_____

_____

Present Diagnosed Illnesses: _____

_____

_____

Please list any family history of illness/disease: _____

_____

_____

Please list any medications or supplements you are taking: _____

_____

_____

_____

_____

Client Signature: _____ Date: _____

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DISCLAIMER:

The Qest system provides a completely non-invasive method for gaining valuable information about your body's vital functions. The primary objective of the screening is to disclose patterns of stress and provide feedback that will assist in developing a program to restore each system to balance.

I understand that the Qest survey does not provide medical diagnosis and that my testing technician may recommend further medical testing. If I suspect I need further medical intervention, I understand I should consult MY physician. I give my permission for the testing technician to evaluate me on the Qest. I understand in doing so my testing technician is NOT becoming my primary care physician. I understand that the testing technician will give me information about myself and make recommendations based on the Qest screening. I understand that the testing technician will not pass judgements on prescribed medications and it is the responsibility of my primary care physician to make any adjustments on prescribed medications. Any decision to follow through with the recommended program is my own decision and I hold the testing technician harmless.

I understand that I am here to learn about natural health and better lifestyle practices and I will be offered information about food supplements and herbs as a guide to general health.

I understand that I should continue to see any medical doctors I am currently under the care of, and that any prescribed medications should not be altered without first consulting the physician who recommended it.

I fully acknowledge that I am not seeking any medical diagnostics or treatment procedures with this method alone.

Information about the traditional uses of supplements that may create a healthy balance in the body may be discussed. This is not intended to be interpreted as a substitute for a licensed physician's treatment. Nothing said, done, typed, printed, or reproduced by us is intended to diagnose, prescribe, treat, or take the place of a licensed physician.

The intent is to provide educational information for the purpose of assisting you with lifestyle changes necessary to regain and maintain an environment needed to produce a healthy balanced body.

I understand that all information and conversations will be kept confidential, and that information concerning myself can be released to another health professional only with my written consent.

I understand that the Qest screening will only identify energetic imbalances and does not diagnose any diseases in the body. The Balancing Item refers to energetic frequency needed to restore balance to the body. Balancing Items are defined differently from medical terms and are not a cure for any disease.

I recognize that the Qest screening is an unorthodox approach to balancing my health. Being of sound mind, I have chosen this screening to assist in balancing my health of my own free will and in exercise of my constitutional right for the attainment of life, liberty, and the pursuit of happiness.

Client signature: _____ Date:_____

Guardian Signature (if under 18 years): _____ Relationship: _____