Radiant Energy Health & Wholeness
Jennifer Cappabianca
jennifer@radenergy.live
www.radenergy.live

Deep Dive Questionnaire

Name_____

DOB_____ Age_____ Male/Female_____

Blood Pressure: Rt Arm_____ Lt Arm _____

Basil Axillary(under arm) Temperature_____

THYROID/PARATHYROID

Are you over weight?	Yes_____	No_____
Do you get cold hands and feet ?	Yes_____	No_____
Do you have hair loss or are you bald?	Yes_____	No_____
Is it easy to put on weight and hard to loose it?	Yes_____	No_____
Are your fingernails ridged, brittle or weak ?	Yes_____	No_____
Do you have varicose or spider veins ?	Yes_____	No_____
Do you have, or have you had hemorrhoids ?	Yes_____	No_____
Do you get cramping in your muscles ?	Yes_____	No_____
Is your bladder strong or weak ?	Strong____	Weak_____
Do you have an irregular heartbeat ?	Yes_____	No_____
Do you have mitral valve prolapse (heart murmur)	Yes_____	No_____
Do you get headaches or migraines ?	Yes_____	No_____
Do you have, or have you ever had, a hernia?	Yes_____	No_____

Have you had an aneurysm ? Yes_____ No_____

Do you have osteoporosis ? Yes_____ No_____

Do you have scoliosis ? Yes_____ No_____

Do you get irritable easily? Yes_____ No_____

Do you have low energy levels? Yes_____ No_____

Do you suffer from symptoms of depression? Yes_____ No_____

Did you score low on your bone density tests? Yes_____ No_____

Do your test come back showing low calcium levels? Yes_____ No_____

Do you have, or have you had a goiter? Yes_____ No_____

Do you have spine deterioration or herniated disk? Yes_____ No_____

Have you or any family member been diagnosed with Hashimoto's or Reidel disease? Yes_____ No_____

Do you sweat profusely or hardly at all? Yes_____ No_____

ADRENAL GLANDS
Medulla (Adrenal)

Do you have Parkinson's or palsy? Yes_____ No_____

Do you have anxiety attacks, or feel overly anxious? Yes_____ No_____

Do you feel excessive shyness, or inferior to others? Yes_____ No_____

Do you have low blood pressure (below 118 systolic)? Yes_____ No_____

Do you have tremors, nervous legs, etc.? Yes_____ No_____

Do you have tinnitus (ringing in the hear)? Yes_____ No_____

Do you have shortness of breath or is it hard to take a deep breath? Yes_____ No_____

Do you have heart arrhythmia? Yes_____ No_____

Do you have a hard time sleeping? Yes_____ No_____

Do you have Chronic Fatigue Syndrome? Yes_____ No_____

Do you get tired easily? Yes_____ No_____

Have you ever been diagnosed with Addison's Disease or with congenital adrenal hyperplasia? Yes_____ No_____

CORTEX (Adrenal)

Do you have elevated cholesterol levels? Yes_____ No_____

Do you have lower back weakness? Yes_____ No_____

Do you have, or have you had, sciatica? Yes_____ No_____

Do you have arthritis or bursitis? Yes_____ No_____

Do you have any "itis's"(inflammatory conditions)? Yes_____ No_____

Explain_____

_____

_____

FEMALE ONLY

Are you menstruation irregular? Yes_____ No_____

Do you have excessive bleeding? Yes_____ No_____

Do you have ovarian cyst? Yes_____ No_____

Do you have Fibroids? Yes_____ No_____

Do you have or have you had endometriosis or A-typical cells? Yes_____ No_____

Are you fibrocystic ? Yes_____ No_____

Do you have fibromyalgia or scleroderma? Yes_____ No_____

Do you get sore breast, especially during menstruation? Yes_____ No_____

Do you have a low or excessive sex drive? Yes_____ No_____

Have you had a hysterectomy? Yes_____ No_____

Partial_____ Complete_____ When_____

Did they take any other organs out at the same time?
(such as gallbladder) Yes_____ No_____

Have you had a D&C? Yes_____ No_____

Have you had a miscarriage? Yes_____ No_____

Have you had difficulty in conceiving children? Yes_____ No_____

Other_____

_____

MALE ONLY

Do you have prostatitis(frequent urination, especially
at night)? Yes_____ No_____

If yes how often?

Do you have prostate cancer? PSA counts: Yes_____ No_____

Do you have testicular hypertrophy (enlargement)? Yes_____ No_____

Do you have a low or excessive sex drive? Yes_____ No_____

Do you have erection problems? Yes_____ No_____

Do you have premature ejaculation? Yes_____ No_____

Other_____

_____

PANCREAS

Do you get gas after you eat? Yes_____ No_____

Do you feel your foods just sit in your stomach? Yes_____ No_____

Do you have acid reflux? Yes_____ No_____

Do you see undigested foods in your stools? Yes_____ No_____

Do you have hypoglycemia (low blood sugar)? Yes_____ No_____

Type I_____ Type II_____

Are you thin and have a hard time putting on weight? Yes_____ No_____
Do you have gastritis or enteritis? Yes_____ No_____

Do your foods pass right through you (diarrhea)? Yes_____ No_____

Do you have moles on your body? Yes_____ No_____

GASTROINTESTINAL TRACT

Is your tongue coated (white, yellow, green or brown) especially in the morning? Yes_____ No_____

Do you have a hiatal hernia? Yes_____ No_____

Do you have gastritis? Yes_____ No_____

Do you have enteritis? Yes_____ No_____

Do you have colitis? Yes_____ No_____

Do you have diverticulitis? Yes_____ No_____

Do you get or have diarrhea? Yes_____ No_____

Do you get or have constipation? Yes_____ No_____

How often do you have a bowel movement? _____

Have you ever had a stomach or intestinal ulcer? Yes_____ No_____

Do you have, or have you had, any type of gastrointestinal cancer: stomach, colon, rectal, etc. Yes_____ No_____

Explain_____

_____

_____

Do you have Crohn's Disease? Yes_____ No_____

Do you have "gas" problems? Yes_____ No_____

Other GI problems_____

LIVER/GALLBLADDER

Do you have a problem digesting fats ? Yes_____ No_____

Do fats or dairy foods cause bloating and/or pain in the stomach area? Yes_____ No_____

Are your stools white or very light brown in color ? Yes_____ No_____

Do you get pain in the middle of your back (especially after eating ? Yes_____ No_____

Do you get pain behind the right, lower rib area? Yes_____ No_____

Do you have "liver" spots on your skin?(not freckles) Yes_____ No_____

Do you have skin problems? if so, what type? Yes_____ No_____

Are you anemic? Yes_____ No_____

Do you have, or have you ever had, hepatitis? Yes_____ No_____

A_____ B_____ C_____

HEART & CIRCULATION

Do you have any grey hair? Yes_____ No_____

Do you have have a hard time remembering things? Yes_____ No_____

Do your legs get tired when you walk? Yes_____ No_____

Do you bruise easily? Yes_____ No_____

Do you get chest pain or angina? Yes_____No_____

Have you ever had a heart attack (Myocardial Infarction)?
Yes_____No_____

Have you ever had open-heart surgery? Yes_____No_____

Do you have heart arrhythmia? Yes_____No_____

What kind?_____

Do you have a heart murmur or mitral valve prolapse? Yes_____No_____

Do you ever feel pressure on your chest? Yes_____ No_____

Do you get “prickly pains anywhere, especially in the heart area ? Yes_____No_____

Where?_____

Do you have, or have you had you ever had high blood pressure? Yes_____No_____

Your average blood pressure is_____ over_____

SKIN

Do you get skin rashes? Yes_____No_____

Do you have blemishes? Yes_____No_____

Do you have eczema or dermatitis? Yes_____No_____

Do you have psoriasis? Yes_____No_____

Do you itch anywhere? Where? Yes_____No_____

Is your skin dry? Yes_____No_____

Is your skin excessively oily? Yes_____No_____

Do you get dandruff? Yes_____No_____

LYMPHATIC SYSTEM

Are you allergic to anything? Yes_____ No_____ What?_____

Do you ever get colds or flu like systems? Yes_____No_____

Do you have sinus problems? Yes_____No_____

Do you have or get sore throat? Yes_____No_____

Do you have, or have you had, tumors? Yes_____No_____

Do you have swollen lymph nodes? Yes_____No_____
What type? fatty_____ benign_____ cancerous_____

Where?_____

Do you have low platelet count (blood)? Yes_____No_____

Is your immune system low or sluggish? Yes_____No_____

Have you had your appendicitis or an appendectomy? Yes_____No_____

When?_____

Do you get pimples, boils, and the like? Yes_____No_____

Do you have allergies? Yes_____No_____

Have you ever had an abscess? Yes_____No_____

Have you had toxemia? Yes_____No_____

Do you have, or have you had, cellulitis? Yes_____No_____

Have you ever had gout? Yes_____No_____

Do you get blurred vision? Yes_____No_____

Do you have mucus in your eyes when you wake up
in the morning? Yes_____No_____

Do you snore? Yes_____No_____

Do you have sleep apnea? Yes_____No_____

Have you had your tonsils out? Yes_____No_____
What age?_____

KIDNEYS & BLADDER

Have you ever had a urinary tract infection? Yes_____No_____

Have you had “burning” upon urination? Yes_____No_____

Do you have a problem holding your bladder(parathyroid) Yes_____No_____

Have you ever had kidney stones? Yes_____No_____

Do you have bags under your eyes(especially in the morning)? Yes_____No_____

Is your urine restricted? Yes_____No_____

Do you get cramping or pain on either side of your mid to low back ? Yes_____No_____

Do you have, or did you ever have, nephritis? Yes_____No_____

Do you have, or did you have, cystitis? Yes_____No_____

LUNGS

Do you have, or have you had bronchitis? Yes_____No_____

Emphysema? Yes_____No_____

Asthma? Yes_____No_____

C.O.P.D.? Yes_____No_____

Are you on inhalers or nebulizers? Yes_____No_____

How often?_____

What type?_____

What is your oxygen saturation?_____

_____

Do you get pain when you breathe? Yes_____No_____

Do you get pain when you take in a deep breathe? Yes_____No_____

Did you ever have, or do you now have, lung cancer? Yes_____No_____

Do you have a collapsed lung? Yes_____No_____

Are you a smoker? If yes, how often do you smoke? Yes_____No_____

Have you ever had pneumonia? Yes_____No_____

Have you ever worked around toxic chemicals,
coal mines or around asbestos? Yes_____No_____

Do you cough a lot? Yes_____No_____

Do you get any mucus when you cough? Yes_____No_____
What color is the mucus?_____

DENTAL:
Did you have your wisdom teeth out? Yes_____No_____

Was there any complications? Dry socket? Explain

_____

Do you have any root canals? Yes_____No____

Do you have amalgams? Yes_____No____

Do you have any gold filling? Yes_____No____

Have you had any teeth extracted? Yes_____No____

ELECTROMAGNETIC FIELD:EMF

Do you hold your cell phone up to your hear when using? Yes_____No____

Do you sleep with your phone on? Yes_____No___

Is your phone next to you while you sleep? Yes_____No___

Do you keep your cell on you and on? Where?_____ Yes_____No___

Do you sleep with a TV in your room ? Yes_____No____

Do you sleep with WiFi on? Yes_____No____

Do you have a smart meter on your house? Yes_____No____

Do you have smart appliances in your home? Yes_____ No____

Do you have electronics plugged in your bedroom at night? Yes_____No____

Do you live near power lines? Yes_____No____

Do you live in a multi unit home ? Yes_____No___

Do you work on computers all day? Yes_____No____

Are you on your computer or phone until you fall asleep? Yes_____No____

Do you trouble falling asleep? Yes_____No____

Do you have trouble waking up in the morning? Yes_____No___

WORK:

Do you work a night shift? Yes____No___

Do you work with chemicals? Yes____No____

Do you work with building materials? Yes____No____

Do you have a long commute? Yes____No___

What do you do for work?

_____

OTHER (What are your main health concerns and complaints?)
Please list and elaborate on any conditions or symptoms that this questionary has not covered.

_____

_____

_____

_____

_____

_____

PAST SURGERIES

Please list any past surgeries you had (tonsils removed, gallbladder, hysterectomy, etc)

Surgery and year of surgery.

_____

_____

_____

CHEMICAL MEDICATIONS
Please list any chemical medications that you are presently taking.

Medication Reason

_____

_____

_____

_____

_____

NATURAL SUPPLEMENTS
Please list any natural supplements you are currently taking.

Supplements

_____

_____

_____

_____

Vitamins & Minerals

_____

_____

_____

_____

ALLERGIES
Please list anything that you are allergic to.

_____

_____

_____

_____

GENETIC HISTORY: List major diseases or conditions.

Mother_____

Father_____

(Maternal) Grandfather_____

(Maternal) Grandmother_____

(Fraternal)Grandfather_____

(Fraternal) Grandmother_____

Siblings_____

_____

_____

_____

_____

_____

_____

Other

_____

_____