Name____Age_________Date_______________________________________

Please tell me why you're here ____

____

What have you already done to address this situation? ____

____

Do you have a major adult love relationship? _______________ Do you tend to be hot or cold? ______________

Are you thirsty? __________________________ What do you drink ____

Do you sweat at night? _________________________________ In the daytime?______________________________

What are your symptoms / signs? ____

Do you get headaches? _______ Experience dizziness? _______ Disturbances in vision? ___________________

How many bowel movements per day? _______________ Are they formed? ________________________________

Do you urinate during the day? _____________ At night? __________ Frequency at night?____________________

Do you breathe with difficulty upon slight exercise? ____

Do you exercise? ___________________ Describe ____

Do you sleep well and easily? ______________ # Hours _______ Bedtime at ________________________________

Do you feel you have strong immune system? ____

Do you cough up sputum? _______________ What color and texture? ______________________________________

List all medical drugs you are presently taking____

____

List all herbs / remedies / supplements you are presently taking ____

____

Do you have a history of may drugs taken during childhood? ____

Do you drink alcohol? If yes, how much / how often? ____

Do you smoke? ______ Amount __________ Have you had hepatitis? ________ STDs? _________PID_________

Do you eat sugar / caffeine / salt? ___________________________________ How often? ________________________

List all severe illnesses; give dates ____

List all chronic illnesses ____

List and date any surgeries ____

Have you declined any suggested surgeries? ________ If yes, what and when? _____________________________

Any history of mental illness? ____

What negative emotion best suits you? (circle choice) anger fear grief overthinking excess joy depression

Low back pain ________ Ringing in ears ________ Dry eyes ________ Sore joints ________

For Women: Onset of menses at age _____ Normal cycle is ____ days Color of blood ______ Clots? _____

Cramps? _____ Moodiness? _____ Backache? _____ Breasts tender? _____ Midcycle spotting? ________

Vaginal discharge? Birth control history: ____________________________Are you/might you be pregnant? ____

Irregular menses _____ When _______ Breast lumps _____Menopause? _______ Decreased sexual energy

Positive Pap Smears ________# pregnancies: ______ Which years? ________________ # of full term babies: _____

Miscarriages? __________ Years ________ Therapeutic abortions? ______ Years _________

Other concerns? Continue on back if necessary ____