name:	date: file #:
address:	phone:
	e-mail:
occupation: birth date: age:	height: weight:
primary care physician:	phone:

All information gathered on this form is held in the utmost confidence and released only with your written permission. Though aspects of these questions may seem to be unrelated to your main issues, they are clinically significant in order to make an accurate diagnosis and provide you with the best possible care and results. Thank you for filling this out carefully and completely.

Main Issues (please list in order of greatest to least priority):

1. 3.

2. 4.

Date main issue(s) first started:
How often does this problem bother you (frequency)?
How long does an episode last (duration)?
How severe is the intensity on a scale of 0-10: (0=least intense, 10=worst):
When symptom is at its best:___/10_ When symptom is at its worst:___/10_ Today:___/10_

If there is pain involved, what is the **pain quality**? (circle all that apply):
dull, achy gripping ache sharp/stabbing cold hot/inflamed/burning numb
throbbing radiating fixed location(s) wandering locations other:

What makes the pain **better**? (circle all that apply):
heat/cold/wind damp/humid weather work/exercise/movement rest/sitting-lying
touch/pressure steroids/thyroid meds. stress other:

What makes the pain **worse**? (circle all that apply):
heat/cold/wind damp/humid weather work/exercise/movement rest/sitting-lying
touch/pressure steroids/thyroid meds. stress other:

family health history (circle all that apply):
asthma allergies cancer diabetes digestive problems
emotional problems heart disease high blood pressure seizures stroke
substance abuse other:____________________

allergies (drugs, chemicals, foods, environmental, herbs, etc.):____________________
____
____

injuries/hospitalizations/surgeries (please include dates):____________________
____
____
____

past medical history (circle all that apply):
asthma/pneumonia allergies anemia cancer diabetes
digestive issues emotional issues heart disease hepatitis high blood pressure
seizures stroke substance abuse thyroid disease
infectious disease (measles, chicken pox, mononucleosis, etc.) other:____________________

Have you ever been prescribed **steroidal medications** (corticosteroids, Prednisone, etc.) for any medical issues? ___
____

current medications (please include dietary supplements, herbs, etc.):____________________
____
____

Patient name: date:

Please answer the following questions and indicate in the tables below any symptoms you have experienced. Check ☑ those manifesting within the past 6 months and circle those which occurred at any time in the past.

Please describe the amounts of the following items you consume on a daily/weekly/monthly basis. Include past usage where applicable:

☐ tobacco (chew, smoke or snuff):	☐ alcohol:
☐ recreational drugs:	☐ caffeine/chocolate:
☐ sugar-free sweeteners:	☐ other:

other:

CHILLS, FEVER, SWEATING

☐ general body temperature: runs warm/cool	☐ Are you thirsty? For hot or cold drinks?
☐ cold hands/feet	☐ cold limbs
☐ feverishness or chills: _____x/day intensity -____/10 (time of day this occurs – AM/PM)	☐ aversion to wind/cold/heat/humidity intensity -____/10
☐ excessive/spontaneous sweating: intensity -____/10 (time of day this occurs – AM/PM)	☐ night sweats: frequency -____x/__________. intensity -____/10
☐ lack of/difficulty sweating:	

other:

SKIN, HAIR & NAILS

☐ rashes or hives (dry/itchy/oozing/hot)	☐ psoriasis/eczema (dry/itchy/oozing/hot)	☐ acne or eruptions (cystic/inflamed/draining)	☐ edema/swelling
☐ dryness/itching	☐ easy bruising	☐ spider veins	☐ large scars
☐ premature graying	☐ falling hair	☐ weak or brittle nails	☐ moles/lumps

other:

HEAD & NECK

☐ headaches: severity of pain _______/10 time of occurrence:________________________
frequency:________x/day/week/month duration:_______________ location:______________________

accompanying symptoms (circle all that apply): auras/lights/eye pain light/noise sensitivity before/after period worse w/stress worse w/humidity better/worse w/eating better/worse w/pressure

pain quality (circle all that apply): dull/achy sharp/ stabbing throbbing "empty head" head heaviness

☐ dizziness	☐ vertigo	☐ fainting
☐ neck or shoulder tension	☐ enlarged lymph nodes	☐ TMJ, tooth grinding, clenching

other:

EARS

☐ infection or pain	☐ wax build-up or discharge	☐ decreased hearing/deafness
☐ sensitive to loud sounds	☐ aversion to wind	☐ ear feels empty/wet/cold

☐ tinnitus (circle all that apply): high/low pitch loud/soft worse with: stress anger fatigue after sex in AM/PM

other:

EYES

☐ blurred vision, floaters or spots	☐ visual changes	☐ red, dry, tearing, or painful eyes
☐ poor night vision	☐ sensitivity to light	Do you wear corrective lenses? **Y N**

other:

Patient name: date:

NOSE, THROAT & MOUTH

☐ nasal discharge or nosebleeds	☐ allergies	☐ sinus problems
☐ sore throats or hoarseness	☐ canker sores or oral ulcers	☐ dental problems

other:

CARDIOVASCULAR SYSTEM

☐ palpitations/rapid heartbeat	☐ chest pain	☐ tightness/heaviness in the chest
☐ poor circulation	☐ swelling in extremities	☐ blood clots/bleeding disorders
☐ poor memory	☐ blood pressure: high low	☐ "fuzzy" feeling in head or chest

other:

RESPIRATORY SYSTEM

☐ frequent colds	☐ shortness of breath	☐ sighing/"air hunger"
☐ acute/chronic cough	☐ coughing up phlegm or blood	☐ ever been a smoker?

other:

DIGESTIVE SYSTEM

☐ excessive thirst	☐ thirst with little desire to drink	beverage preference – hot cold
☐ excessive appetite	☐ reduced appetite	☐ food cravings = _______________
☐ heartburn or reflux	☐ nausea or vomiting	☐ sluggish digestion
☐ gas or bloating	☐ stomach pain	☐ gallbladder disease
☐ recent change in weight: +/-	☐ loss of taste	☐ bad taste in the mouth

Which of the following flavors do you crave or eat frequently? (circle all that apply): Sweets Sour Spicy Salty Greasy/Fried Hot Bitter Crunchy Cold/Iced/Frozen

other:

DIET (circle all that apply): omnivore carnivore vegetarian vegan Atkins raw foods other:____________________

AM	Noon	PM

other:

ELIMINATION

stools: dry soft loose pellets	☐ constipation	☐ diarrhea
Bowel movement frequency = _____x/day	☐ blood in stools	☐ abdominal pain
☐ hemorrhoids	☐ sensation of "incompleteness"	☐ ineffectual urging
☐ loose stools with strong odor	☐ anal itching or burning	☐ undigested food in stools

other:

URINATION

urinary frequency = _____x/day	☐ urinary tract infections	☐ urinary discomfort or pain
☐ incontinence	☐ night urination (waking to urinate)	☐ blood in the urine
☐ bladder or kidney stones	☐ dark or concentrated urine	☐ pale or cloudy urine

other:

Patient name: date:

MUSCULOSKELETAL & NEUROLOGICAL SYSTEMS

☐ muscle or joint pain	☐ back ache/back pain	☐ muscle or joint weakness
☐ joint changes/"arthritis"	☐ pain is chronic/acute	☐ heavy limbs
☐ stiffness	☐ cracking in joints	☐ muscle spasms/cramps
☐ numbness or paralysis	☐ seizures, tics, or tremors	☐ Bell's Palsy

If there is pain involved, what is the **pain quality**? (circle all that apply):

dull, achy gripping ache sharp/stabbing cold hot/inflamed/burning numb
throbbing radiating fixed location(s) wandering locations other:

What makes the pain **better**? (circle all that apply):

heat/cold/wind damp/humid weather work/exercise/movement rest/sitting-lying touch/pressure
steroids/thyroid meds. stress other:

What makes the pain **worse**? (circle all that apply):

heat/cold/wind damp/humid weather work/exercise/movement rest/sitting-lying touch/pressure
steroids/thyroid meds. stress other:

other:

SLEEP & ENERGY

morning person/night owl	bedtime_______ wake time________	☐ fatigue - constant/episodic
☐ insomnia - difficulty falling asleep	☐ insomnia - frequent waking	☐ dream disturbed sleep
☐ amount of sleep - hours/night	☐ do you take naps?	☐ hyperactivity or restlessness
☐ anger or irritability	☐ poor memory	☐ depression

Energy level - (please rate 1-10): overall________ when symptoms flare up_________

Sexual energy - (1-10): libido/interest________ arousal ability________ orgasm ability________

better: in AM/PM after work/exercise after eating after bowel movement with damp/cold/hot weather

worse: in AM/PM after work/exercise after eating after bowel movement with damp/cold/hot weather

Emotional stress levels - (please rate 1-10): spouse/partner relationship_____ family_____ job_____ finances_____

other:

MALE

☐ pain, dryness, itching of genitalia	☐ genital lesions/discharge	☐ impotence/erectile dysfunction
☐ weak urinary stream	☐ enlarged prostate	☐ hernias/testicular lumps

other:

FEMALE

☐ vaginal infections/discharge	☐ painful periods	☐ irregular periods
☐ abnormal bleeding	☐ Premenstrual Syndrome	☐ painful ovulation
☐ pain, dryness, itching of genitalia	☐ genital lesions/discharge	☐ abnormal PAP smear
☐ breast lumps	☐ uterine fibroids	☐ menopausal symptoms

other:

INFECTION SCREENING

☐ HIV risk: self or partner	☐ Tuberculosis risk: self or household	☐ Hepatitis risk: self or household

☐ sexually transmitted disease: self/partner gonorrhea chlamydia syphilis genital warts herpes: oral/genital

other:

Patient name: date:

GYNECOLOGICAL & REPRODUCTIVE HEALTH HISTORY

age at menarche (first period):__________ 1st menses painful? Y N 1st menses irregular? Y N

date of last period:_______ length of cycle (from day 1-day 1):_________ duration of flow:___________

# of pregnancies:_______ # of births:_______ # of abortions:________ # of miscarriages:______

Did you ever have any difficulty getting pregnant? Y N date of last PAP:_____ results:______

Did you breastfeed?_______ If yes, how many children and for how long?____________________________________

Are you sexually active?______ type of birth control practiced:__________________

Have you ever used oral contraceptives or Hormone Replacement Therapy (HRT)?______________________________

"Premenstrual Syndrome"

☐ Mood (circle all that apply):	angry	irritable	changeable	weepy	depressed	vulnerable
☐ Breasts:	masses (soft & gummy, firm or hard)	tenderness	distention/swelling	inflammation		
☐ pain:	low back	hips	abdomen	womb	thighs/legs	
other:						

Menstrual Blood

Color of menstrual blood (circle all that apply): brown purple red wine red bright red pale watery

☐ heavy flow	☐ spotting	☐ flow is slow to start
☐ flooding	☐ trickling	☐ clots in blood

Please describe each day's flow re: amount, color and clots.

Day 1	Day 2	Day 3	Day 4	Day 5

other:

Menstrual Pain

location of pain (circle all that apply):	low back	hips	abdomen	womb	thighs/legs
time in cycle (circle all that apply):	before flow begins	once flow starts	during heaviest flow	after flow ends	

What is the pain quality? (circle all that apply): dull, achy sharp/stabbing cold hot/inflamed/burning numb heavy or downbearing throbbing radiating fixed location(s) wandering locations
other:

What makes the pain **better**? (circle all that apply): heat/cold/wind damp/humid weather stress work/exercise/movement rest/sitting-lying touch/pressure steroids/thyroid meds. passage of clots
other:

What makes the pain **worse**? (circle all that apply): heat/cold/wind damp/humid weather stress work/exercise/movement rest/sitting-lying touch/pressure steroids/thyroid meds. passage of clots
other:

How long does the pain last (duration)?

How severe is the intensity on a scale of 0-10: (0=least intense, 10=worst):

other:

"Menopausal Syndrome"

age of menopause:

☐ hot flashes: x/day______	☐ weight gain	☐ headaches
☐ impaired memory	☐ disturbed sleep	☐ impaired thinking

☐ mood swings (circle all that apply): anger frustration frequent crying depression emotional numbness

other:

Patient name: date:

How would you describe your emotional self-expression? ____________________

____

How might others describe you? ____________________

____

How do you handle anger? (Repressed expression/busting out, Irritability, rib/side pain, abdominal pain, digestive upset, bowel upset, headache, etc.): ____________________

Are you comfortable expressing anger? Y N

Are you currently experiencing any significant family stress? Y N

In the past year have you experienced any significant loss? (i.e. death of a loved one or pet, job loss, miscarriage, divorce or separation, significant move, etc.) ____________________

____

What was going on in your life when the problem began? ____________________

____

What is your intuitive sense as to what caused/is causing the main issues? ____________________

____

Do you feel actively supported by your family and friends? ____________________

____

What are your expectations for your course of treatment? ____________________

____

How long do you expect it to take to get results and what is your goal? ____________________

____

Do you think your healing will require lifestyle changes and do you believe you will be able to make them? ________

____

Please include any other information you wish to share or feel is relevant to your case: ____________________

____

____

____