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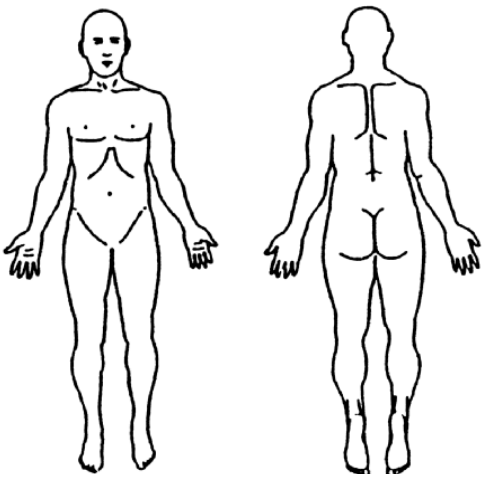
Name_____Date_____

Date of Birth_____Age_____Height _____Weight_____

Please complete this form to the best of your ability.

Please mark areas of pain



Chief complaint_____
_____

Other Health Concerns_____
_____

Medical History: Cancer_____Seizures_____Heart Disease_____
Other_____

Previous Treatment _____

Current Medications_____
_____

Allergies_____

Shortness of Breath_____Palpatations____Dizziness_____Sensory Changes_____

Diet: Breakfast_____
Lunch_____
Dinner_____

Cravings_____Avoidence_____

Amount of: Water_____Alcohol_____Caffeine_____Cigs_____

Exercise_____

Digestion: Gas_____Bloating_____Heartburn_____Nausea_____Pain_____

Urination: Times/day_____Color_____Difficulty_____Pain_____

Bowels: Movements how often_____Form_____Color_____Pain____
Tendency to Diarrhea_____or Constipation_____

Sleep: Hours/day_____Difficulty getting to_____Difficulty staying_____
Difficulty rising_____Dream quality/themes_____

	Pain	Congestion	Dryness	Discharge	Itching	
Ear	_____	_____	_____	_____	_____	Ringing
Eye	_____	_____	_____	_____	_____	Floaters
Nose	_____	_____	_____	_____	_____	Snoring
Throat	_____	_____	_____	_____	_____	

Skin: Dryness_____Itching_____Acne_____Moles_____Rashes_____

Temperature: Chill easily_____Cold hands & feet_____Overheat easily_____
Night Sweats_____Hot Flashes_____Sweat Easily_____

Menses: Age began_____Cycle Length_____Flow Length_____Clots_____

PMS_____If yes list symptoms_____

Pregnancies_____Births_____Birth Control_____What type_____
Perimenopause or Menopause_____Symptoms_____