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Name: ____

Chief Complaint: ____

Date of onset (when you first noticed your problem): ____

How long have you had this condition? ____

Have you had this in the past? ☐ Yes ☐ No When: _________________

Pain is: ☐ Minimal ☐ Moderate Scale of 1-10 ______
☐ Slight ☐ Severe

What makes it better? ____

What makes it worse? ____

Your condition is: ☐ Getting worse ☐ Constant ☐ Comes and goes

Medications/drugs/herbs you are currently taking: ____

List surgeries/operations you have had and dates: ____

____

Family History

	Father	**Mother**	**Sibling**	**Children**	**Self**
Arthritis					
Asthma					
Cancer					
Allergies					
Heart trouble					
High blood pressure					
Stroke					
Diabetes					

Energy level	**Stress**
☐ High (time of day)_______ ☐ Low (time of day)________	☐ None ☐ Moderate ☐ Severe What causes it? ____

Sweating	Circulation
☐ Night sweats ☐ Rarely sweat ☐ Excess sweating ☐ Spontaneous sweating	Feelings of ☐ Hot ☐ Cold What area? ______________________ Hands and feet get easily cold: ☐ Yes ☐ No

General

☐ Chills ☐ Low energy ☐ Dizziness ☐ Allergies	☐ Fatigue ☐ Excess thirst ☐ Weight loss ☐ Weight gain	☐ Aversion to heat ☐ Aversion to cold ☐ Low back pain ☐ Joint disorders

Skin

☐ Dry ☐ Itchy ☐ Moist, clammy ☐ Burning ☐ Blood not clotting ☐ Hives	☐ Changing moles/lumps (cysts/tumors) ☐ Boils ☐ Frequent rashes ☐ Acne ☐ Bruises easily (black & blue spots)	☐ Hair loss/thinning ☐ Dry scalp ☐ Skin puffy/wrinkled ☐ Dark circles under eyes ☐ Other:______________________

Sleep Problems

☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful	☐ Insomnia ☐ Excess dreaming ☐ Other:______________________	How many hours do you sleep each night?_______

Head & Neck

☐ Dizziness ☐ Memory loss ☐ Eye pain ☐ Dry eyes	☐ Blurred vision ☐ Double vision ☐ Floaters ☐ Loss of balance ☐ Darkness under eyes	☐ Headaches:__________________ (list area) ☐ Other:______________________

Ears & Nose

☐ Poor hearing ☐ Earaches ☐ Ear discharge/infections	☐ Ringing/buzzing in ears ☐ Frequent nose bleeds ☐ Sinus trouble	☐ Congestion/allergies ☐ Frequent colds ☐ Other:______________________

Chest

☐ Hard to breathe ☐ Wheezing ☐ Shortness of breath ☐ Pain/pressure in chest ☐ Palpitations	☐ Mucous rattles when breathing ☐ Trouble breathing at night ☐ Persistent cough ☐ Chest pain ☐ Coughing Blood	☐ Swollen ankles ☐ Coughing phlegm Color_______________ ☐ Other:______________________

Genitourinary

☐ Frequent urination ☐ Daytime ☐ At night ☐ Hard to urinate	☐ Strong smelling urine ☐ Pain or burning on urination ☐ Blood in urine	☐ Frequent infections ☐ Water retention ☐ Other:______________________

Gastrointestinal (check those that apply)

	Often	Seldom	Severe	Mild	None
Poor appetite					
Excessive appetite					
Nausea					
Vomiting					
Belching					
Indigestion					
Stomach pain					
Lower abdominal pain					
Bloody Stools					
Black Stools					
Mucus in stools					
Hemorrhoids					
Lower bowel gas					
Stools have foul odor					
Colon problems					
Diarrhea					
Constipation					

Neurological

- ☐ Tremors
- ☐ Numbness
- ☐ Tingling
- ☐ Pain
- ☐ Paralysis
- ☐ Seizures
- ☐ Poor coordination
- ☐ Stroke
- ☐ Other:________________________

Emotional & Mental

- ☐ Nervousness
- ☐ Depressed
- ☐ Easily angered
- ☐ Easily irritated
- ☐ Frequent crying
- ☐ Disoriented
- ☐ Moody
- ☐ Mind not clear
- ☐ Manic
- ☐ Obsessive
- ☐ Compulsive
- ☐ Anxiety
- ☐ Fearful
- ☐ Terrors
- ☐ Difficulty expressing emotions

Other:________________________

Lifestyle Habits

(please state how much, how many and how often)

Cigarettes (packs): ____________________________ Coffee/Tea (cups): ______________________

Alcohol (type/per week): ____

Prescription drugs: ____

Over-the-counter drugs: ____

Recreational drugs: ____

Vitamins/Herbs: ____

Dietary restrictions: ____

Food cravings: ____

Exercise (type and frequency): ____

Briefly describe your diet: ____