Date: _____

Name: _____

Date of Birth: ____/____/_____ Age: _____ Preferred Pronoun: He / She / Other _____

Address: _____ City: _____

State: _____ Zip: _____ Telephone:_____

Email: _____

Occupation: _____How did you hear of us? _____

What are you coming in for today? _____

_____

How long have you had this condition? _____

Date of last physical exam: ____/___/___ Physician: _____

Medical Diagnosis (if any): _____

Please list any medications and supplements you are currently taking or have taken in the past year. Please include the condition for which they are treating.	**Please list any allergies (food, pharmaceuticals, seasonal, etc)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgeries/Hospitalizations	
Date _____	Condition treated _____
_____	_____
_____	_____
_____	_____

Patient Name: _____
Date: _____

Past Medical History: Please circle all that apply						
AIDS/HIV	Alcoholism	Allergies	Asthma	Anemia	Cancer	Diabetes
Emphysema	Heart Disease	Hepatitis A / B / C	Herpes	Lyme Disease		
Multiple Sclerosis	Organ Transplant	Pacemaker	Seizures	Stroke		
Thyroid Disorder	Latex Allergy	Lymph Node Removal	Other _____			

CHECK current symptoms. CIRCLE symptoms that have affected you in the past

Gastrointestinal		
□ Belching	□ Severe stomach pain	□ Blood in stool
□ Nausea	□ Diarrhea / Loose stools	□ Incomplete bowel movements
□ Vomiting	□ Gas	□ Itchiness and/or burning
□ Vomiting blood	□ Bloating after meals	□ Painful bowel movements
□ Acid Regurgitation	□ Hemorrhoids	□ Irregular bowel movements
□ Heartburn	□ Poor appetite	□ Frequent Thirst
□ Constipation	□ Undigested food in stool	□ Crave: sweet
□ Indigestion	□ Excessive hunger	□ Crave: salty

Urinary		
I urinate approximately _____ times per day.		
Color: □ pale yellow □ dark yellow □ brown □ orange		
□ Trouble starting stream	□ Frequent UTIs	□ Dribbling
□ Frequent urination	□ Incontinence	□ Painful urination
□ Wake to urinate	□ Blood in urine	□ Kidney stones

Cardiovascular		
□ Chest pain	□ Irregular heartbeat	□ Hypertension
□ Phlebitis	□ Varicose veins	□ Hypotension
□ Palpitations	□ Poor circulation	

Patient Name: _____
Date: _____

Respiratory		
□ Chronic cough/wheezing	□ Pain inhaling	□ Asthma
□ Chronic runny nose	□ Frequent sore throat	□ Frequent colds
□ Coughing blood	□ Bleeding gums	(3 or more per yr)
□ Nose bleeds	□ Shortness of breath	□ Cold Sores
□ Changes in taste / smell	□ Difficulty swallowing	
□ Coughing phlegm	□ Dry mouth	

Muscular-skeletal		
□ Swollen joints	□ Bone pain	□ Shaking limbs
□ Tendonitis	□ Muscle cramps / pain	□ Heavy limbs
□ Arthritis / joint pain	□ Weak muscles	□ Numbness Where? _____
□ Rheumatism	□ Spinal curvature	

Ears, Eyes, Head		
□ Ear pain	□ Poor vision	□ Frequent headaches:
□ Pain red eyes	□ Clogged / popping ears	Where? _____
□ Itchy eyes	□ See spots (floaters)	□ Poor Memory
□ Cloudy vision	□ Decreased hearing	□ Cloudy head/unable to think
□ Ringing in ears	□ Dizziness	□ Hot flashes

Skin and Hair		
□ Always feeling cold	□ Bruise easily	□ Eczema
□ Always feeling hot	□ Skin rashes	□ Hair loss
□ Cold hands and feet	□ Psoriasis	□ Acne
□ Dry skin	□ Premature graying	□ Night sweating
□ Hives	□ Itching	□ Excess sweating

Patient Name: _____
Date: _____

Emotions and Sleep		
□ Panic attacks	□ Obsessive thoughts	□ Disturbed sleep
□ Nervousness	□ Suicidal thoughts	□ Fatigue
□ Anxiety	□ Anger, irritability	□ Low libido
□ Depression	□ Nightmares	Relationship Status:
□ Fearfulness	□ Difficulty staying asleep	Married/Partnered / Divorced /
□ Frequent sighing	□ Difficulty falling asleep	Single / Other _____

Reproductive (if applicable)	
□ Erectile difficulties	□ Prostate trouble
Date of last period _____	Children's Ages: _____
# days of bleeding _____	□ Previous miscarriage
# days from 1st day of period to 1st day of next	□ Heavy bleeding
period? _____	□ Clots
Could you be pregnant? Y / N	□ Mood changes during cycle
□ Have you been pregnant in the past? Y/N	□ Cramping
□ How many children do you have? _____	□ Breast tenderness

Signature	The information on this form is correct to the best of my knowledge.
Signature:	Date:

Practitioner Use Only	
Tongue/Pulse	**Treatment**

Practitioner Signature: _____ **Date:** _____