Name _____ Date _____

Pain

l r b = left, right, both

past	current			past	current			past	current			past	current		
❑	❑	head		❑	❑	lower arm	l r b	❑	❑	upper back		❑	❑	shin	l r b
❑	❑	jaw		❑	❑	wrist	l r b	❑	❑	mid-back		❑	❑	ankle	l r b
❑	❑	neck		❑	❑	hand	l r b	❑	❑	lower back		❑	❑	foot	l r b
❑	❑	throat		❑	❑	fingers	l r b	❑	❑	hip		❑	❑	heel	l r b
❑	❑	shoulder	l r b	❑	❑	chest		❑	❑	thigh	l r b	❑	❑	toes	l r b
❑	❑	upper arm	l r b	❑	❑	rib/flank	l r b	❑	❑	knee	l r b				
❑	❑	elbow	l r b	❑	❑	abdomen		❑	❑	calf	l r b				

Other current related symptoms_____

Immune Function

past	current		past	current		past	current	
❑	❑	frequent colds or flu	❑	❑	production of phlegm	❑	❑	kidney stone
❑	❑	fevers	❑	❑	hay fever or allergies	❑	❑	gallstone
❑	❑	chills	❑	❑	enlarged lymph glands	❑	❑	HIV
❑	❑	frequent infections	❑	❑	edema / swelling	❑	❑	TB
❑	❑	recurring sore throat	❑	❑	arthritis	❑	❑	hepatitis
❑	❑	sinus infection	❑	❑	cancer or tumors	❑	❑	sexually transmitted disease
❑	❑	cough	❑	❑	low energy / fatigue			

Other current related symptoms or diseases _____

The Senses & Emotions

past	current		past	current		past	current	
❑	❑	dry eyes	❑	❑	decreased hearing	❑	❑	concussion
❑	❑	red eyes	❑	❑	ear ringing	❑	❑	poor coordination
❑	❑	eye inflammation	❑	❑	ear infections	❑	❑	dizziness
❑	❑	blurred vision	❑	❑	insomnia	❑	❑	fainting
❑	❑	poor night vision	❑	❑	anxiety / stress	❑	❑	seizures
❑	❑	floaters/spots in visual field	❑	❑	depression	❑	❑	localized weakness
❑	❑	visual changes	❑	❑	irritability	❑	❑	numbness or tingling
❑	❑	glasses / contact lenses			psychological problems	❑	❑	tremors
❑	❑	cataracts	❑	❑	often feel angry	❑	❑	paralysis
❑	❑	grinding teeth	❑	❑	treated for emotional /	❑	❑	muscular disorder
❑	❑	poor memory			psychological problems	❑	❑	nervous system disorder

Other current related symptoms_____

Circulatory System

past	current		past	current		past	current	
❑	❑	high blood pressure	❑	❑	chest pain or pressure	❑	❑	blood clotting disorders
❑	❑	low blood pressure	❑	❑	jaw, neck, shoulder or arm pain	❑	❑	phlebitis
❑	❑	palpitations	❑	❑	nausea	❑	❑	poor memory
❑	❑	irregular heart beat	❑	❑	swollen hands or feet	❑	❑	circulation problems
						❑	❑	headache / migraine

Other current related symptoms_____

Name _____ Date _____

GI System

past	current		past	current		past	current	
❑	❑	gas	❑	❑	vomiting	❑	❑	diarrhea
❑	❑	abdominal bloating	❑	❑	belching	❑	❑	constipation
❑	❑	abdominal pain	❑	❑	ulcers	❑	❑	unusual stools
❑	❑	indigestion	❑	❑	change in appetite	❑	❑	urine / bowel incontinence
❑	❑	heartburn	❑	❑	excessive appetite	❑	❑	difficulties with urination
❑	❑	nausea	❑	❑	decreased appetite	❑	❑	diabetes

Other current related symptoms_____

Women's Health

past	current		past	current		past	current	
❑	❑	irregular periods	❑	❑	night sweats	❑	❑	tumors or cysts
❑	❑	premenstrual syndrome	❑	❑	hot flashes	❑	❑	hysterectomy
❑	❑	painful menstrual periods	❑	❑	frequent vaginal infections	❑	❑	decreased libido
❑	❑	abnormal bleeding	❑	❑	pelvic inflammatory disease	❑	❑	genital itching / pain
❑	❑	menopause symptoms	❑	❑	abnormal PAP smear	❑	❑	genital lesions / discharges

Total Pregnancies _____ Living _____ Ectopic _____ Miscarriages _____ Induced Abortions _____

Other current related symptoms_____

Men's Health

past	current		past	current		past	current	
❑	❑	prostatitia	❑	❑	genital lesions / discharges	❑	❑	impotence
❑	❑	testicular lumps	❑	❑	genital pain	❑	❑	decreased libido

Other current related symptoms_____

Family History

Complete for each family member placing an X in the appropriate box:

	Self	Mother	Father	Sister	Brother	Spouse	Child	
Allergies								
Blood Disorder / Anemia								
Diabetes								
Cancer or Tumors								
Seizures								
High Blood Pressure								
Kidney or Bladder Disorder								
Stomach or Intestinal Disorder								
Drug Abuse								
Tuberculosis								
Heart Disease								
Stroke								
Depression / Mental Illness								
Other								

Name _____ Date _____

Major Hospitalizations
Please list any hospitalizations or surgeries you have undergone

Year	Operation or Illness	Name of Hospital	City and State

_____

_____

_____

_____

_____

Medicines, Herbs and Supplements
Check any medications you are currently taking

- ❑ aspirin
- ❑ ibuprofen
- ❑ acetaminophen (Tylenol)
- ❑ oral contraceptives
- ❑ antacids
- ❑ fiber or other laxatives
- ❑ diet pills
- ❑ allergy medication
- ❑ blood thinners
- ❑ blood pressure pills
- ❑ anti-depressants
- ❑ sleeping pills
- ❑ tranquilizers
- ❑ insulin

Other, please list:

Western Drugs	Herbs	Supplements

_____

_____

_____

_____

_____

_____

Habits
Please check any habits which apply to you now or in the past

Coffee	❑ yes ❑ no	# per day / week _____	age started _____	age quit _____
Tobacco	❑ yes ❑ no	# per day / week _____	age started _____	age quit _____
Marijuana	❑ yes ❑ no	# per day / week _____	age started _____	age quit _____
Alcohol	❑ yes ❑ no	# per day / week _____	age started _____	age quit _____
Crack / Cocaine	❑ yes ❑ no	# per day / week _____	age started _____	age quit _____
Heroin	❑ yes ❑ no	# per day / week _____	age started _____	age quit _____
Other	❑ yes ❑ no	# per day / week _____	age started _____	age quit _____

Name _____ Date _____

Please describe any restricted diet you follow(ed) now or in the past.

Please describe any regular program of exercise.

Do you have any religious or spiritual practice? If so, please describe.

What are the top priorities in your life?

What are your goals for your health?

What is your main concern today?

Please provide any additional information about yourself or your condition not covered by the above questions.