

Name _____ Sex: M / F DOB ___/___/___
 Address _____ Apt. # _____
 City _____ State _____ ZIP _____
 Phone (H) _____ (W) _____ Email _____
 Occupation _____ Referred by _____

Please circle "Yes" when applicable, put a check mark, or fill in the blanks below:

I. Are you troubled by the following symptoms?

- | | | | | | |
|------------------------|-----|--------------------------|-----|-----------------------------|-----|
| 1. Fatigue | yes | 10. Loss of Appetite | yes | 19. Depression | yes |
| 2. Dizziness | yes | 11. Abdominal Distension | yes | 20. Anxiety | yes |
| 3. Palpitations | yes | 12. Headache | yes | 21. Nervousness | yes |
| 4. Hot Flashes | yes | 13. Stomachache | yes | 22. Angry Moods | yes |
| 5. Perspire a lot | yes | 14. Diarrhea | yes | 23. Nightmares | yes |
| 6. Shortness of Breath | yes | 15. Constipation | yes | 24. Loss of Sexual Interest | yes |
| 7. Chest Pain | yes | 16. Skin Rash | yes | 25. Forgetting Information | yes |
| 8. Back Pain | yes | 17. Dry Mouth | yes | 26. Frequent Urination | yes |
| 9. Muscle Tension | yes | 18. Insomnia | yes | 27. Cold Hands & Feet | yes |

II. Do you have or have you had the following?

- | | | | | | |
|-------------------------|------------------|------------------|------------|--------------|-----------|
| 1. Heart Disease: | ___ heart attack | ___ arrhythmia | ___ angina | medications: | _____ |
| 2. Allergies: | ___ wheat | ___ nuts | ___ fruit | ___ seafood | ___ dairy |
| | ___ pollen: | ___ fall | ___ spring | ___ all year | |
| 3. High Blood Pressure: | ___ how long | ___ special diet | | medications: | _____ |
| 4. Diabetes: | ___ how long | ___ special diet | | medications: | _____ |
| 5. High Cholesterol: | ___ how long | ___ special diet | | medications: | _____ |
| 6. Organs removed: | ___ which ones | _____ | | when | _____ |

III. For women only

- | | | | | | |
|----------------------|--------------|------------------|-----------------|-----------------|----------------|
| Menstrual Cramps: | ___ none | ___ before | ___ during | ___ after | |
| Menstrual Disorders: | ___ early | ___ late | ___ irregular | ___ short cycle | ___ long cycle |
| Other Symptoms: | ___ diarrhea | ___ constipation | ___ headache | ___ bloating | |
| Vaginal Discharge: | ___ none | ___ white | ___ yellow | ___ heavy | |
| Flow (quantity): | ___ light | ___ heavy | | | |
| Are you pregnant? | ___ no | ___ yes | ___ which month | | |

IV. Any other medical problems? _____

Signature _____ Date ___/___/___

(For Office Use Only)

Diagnosis:

- MEN _____
- PMS _____
- H _____
- ST _____
- SP _____
- LIV _____
- GB _____
- LU _____
- K _____
- UB _____
- BC _____
- UC _____
- INJ _____
- TE _____
- FS _____

Name _____

Date of Visit _____

Healing is related to the balanced relationship between the mind, body, and spirit. This communication process continually occurs on the physical and energetic level. How in-tune you are to listen to these messages will make a difference in your total well-being and happiness. We want to help you connect to this inherent language. To begin, please answer these questions. You can maximize your healing potential by being open and honest with your feelings.

What is your favorite season? Spring Summer Late Summer Fall Winter

What is your favorite color? Black White Green Yellow Red

What is your favorite taste? Bitter Sweet Spicy Sour Salty

What type of music do you enjoy most? Classical Jazz Rock Country Popular

What theme or images frequently appear in your dreams? _____

What is the craziest thing you have ever done?

What would you love to do if you had the chance?

What things bother you the most that you cannot forgive?