

Patient Name: _____ DOB: _____

Please place a check next to any condition you currently experience.

General

- Difficulty falling asleep
- Difficulty staying asleep
- Fatigue in morning
- Fatigue after meals
- Aversion to cold
- Aversion to heat
- Frequent thirst
- Excessive daytime sweating
- Nighttime sweating

Muscles and Joints

- Rheumatoid arthritis
- Osteoarthritis
- Muscle soreness
- Muscle weakness
- Muscle cramps
- Numbness / Tingling
- Paralysis

Head, Neck, & Back

- Headaches / migraines
- Neck stiffness/pain
- Shoulder stiffness/pain
- Back pain

Eyes

- Blurred vision
- Poor night vision
- Eye disease
- Glasses
- Floaters

Ears, Nose, and Throat

- Ear infection
- Ringing in ear / tinnitus
- Diminished hearing
- Chronic sinus infections
- Mouth / tongue sores
- TMJ
- Rhinitis / runny nose
- Excessive phlegm

Skin

- Itching
- Nut allergy
- Hives
- Acne
- Eczema / Psoriasis
- Dry skin/hair
- Bruise easily
- Hair loss

Respiratory

- Chronic cough
- Wheezing / asthma
- Frequent colds
- Shortness of breath
- Tight chest

Cardiovascular

- Pacemaker
- High blood pressure
- Low blood pressure
- Palpitations
- Chest pain or tightness
- Heart murmur
- Poor circulation
- Cold hands / Cold feet
- Phlebitis / Inflammation of vein
- Blood clots
- Spider veins/Varicose veins

Gastrointestinal

- Bad breath
- Poor Appetite
- Excessive hunger
- Food cravings
- Recent weight gain/loss
- Nausea / vomiting
- Reflux / acid regurgitation
- Gas / bloating
- Loose stools / diarrhea
- Constipation
- Frequency of stools: _____
- Laxative use
- Hemorrhoids
- Bloody or black stools
- Pain or cramps stomach/intestines
- Rectal pain

Genito-urinary

- Pain on urination
- Frequent urination
- Blood in urine
- Unable to hold urine / dribbling
- Wake to urinate
- Kidney stone
- Impotence

Neurological

- Seizures
- Tremors
- Dizziness / loss of balance
- Poor memory
- Poor concentration

Tobacco, Food, Drink Habits

- Currently smoke or use tobacco
How much/often? _____
- Previously smoked or used tobacco
How much/long ago? _____
- Marijuana
- Drug dependence
- Drink alcohol
How much/often? _____

Female Reproductive

__ Pregnant or possibly pregnant?

- Vaginal infections
- Pain / itching of genitalia
- Pelvic inflammatory disease
- Very light/spotty bleeding
- Menopausal symptoms:
- Hot flashes
- Night sweats
- Age at onset of menopause
- Breast lumps
- Clotting during menses
- Uterine fibroids
- Number of live births: _____
- Children's ages: _____
- History of Miscarriages
- Irregular menstrual periods
- Painful menstrual periods
- Premenstrual syndrome (PMS)
- Excessive bleeding
- Length of cycle in days
- Length of bleeding in days
- Bleeding between periods
- Date last period began: _____

Psychological

- Depression
- Anxiety
- Irritability
- Considered/Attempted Suicide
- Seeing a therapist

Other

- Hepatitis
- Infectious diseases
- Occupational Hazards
- Metal joints/implants?
- History of Cancer
- Undergoing Cancer Treatments
- Autoimmune Disorder:
Which _____
- Hypothyroid
- Hyperthyroid
- Other: _____

Please list current prescription medications, herbs, supplements, hospitalizations, & traumas below.
