

What treatments helped the most?

1) _____

2) _____

3) _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		ALLERGIES Medications, Seasonal, Environmental, Food.	OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:	DIET & EXERCISE Check (✓) all that apply.
Year	Surgery/ Hospitalization/ Accidents/ Trauma (Physical & Emotional)		<input type="checkbox"/> Stress <input type="checkbox"/> Environmental <input type="checkbox"/> Heavy Typing <input type="checkbox"/> Heavy Lifting <input type="checkbox"/> Others:	<input type="checkbox"/> Regular Exercise <input type="checkbox"/> Low-Fat <input type="checkbox"/> Low-Carb <input type="checkbox"/> Vegetarian <input type="checkbox"/> Other:
				<input type="checkbox"/> Drink Coffee: Cups/Day <input type="checkbox"/> Drink Soda oz/Day
			Occupation: _____	

SYMPTOMS – NOTE: For each symptom you currently have, rate its severity from 1-5 (5 being the worst). Leave blank if Not Applicable.

LIVER / GALLBLADDER

- _____ Irritability / Anger
- _____ Depression / Stress
- _____ Headaches / Migraines
- _____ Visual Problems
- _____ Red / Dry / Itchy Eyes
- _____ Gall Stones
- _____ Dizziness
- _____ Blurred Vision
- _____ Feeling of Lump in Throat
- _____ Clenching of Teeth at Night
- _____ Muscle Cramping / Twitching
- _____ Tension
- _____ Joints/Neck/Shoulder Pain/Tight
- _____ Poor Circulation
- _____ Soft / Brittle Nails

- _____ Poor Memory
- _____ Loss of Hair
- _____ Hearing Problems
- _____ Cavities
- _____ Fear
- _____ Hot Flash/ Night Sweating
- _____ Do you crave: Salty

- Heart / Small Intestine**
- _____ Heart Palpitations
 - _____ Chest Pain
 - _____ Insomnia / Sleep Problems
 - _____ Easily Startled

- _____ Low Resistance to Colds or Flu
- _____ Sneezing
- _____ Mild Fever Comes & goes
- _____ Smokes Cigarettes
- _____ Emphysema
- _____ Bronchitis
- _____ Black / Blood in Stools
- _____ Constipation
- _____ IBS
- _____ Colitis/ Spastic Colon
- _____ Diarrhea
- _____ Do you Crave : Pungent

SPLEEN / STOMACH

- _____ Heaviness Anywhere in the Body
- _____ Fatigue on a Scale of 1(**low**) –10 (**high**)
- _____ Hard to get up in the Morning
- _____ Muscles Feel Tired Often
- _____ Edema (swelling) hands feet
- _____ Easily Bruising & Bleeding
- _____ Bad Breath
- _____ Nausea/ Vomiting
- _____ Difficulty Digesting Fatty Foods
- _____ Nausea/ Vomiting
- _____ Gas / Belching
- _____ Hemorrhoids
- _____ Constipation
- _____ Diarrhea
- _____ Abdominal Pain
- _____ Indigestion / Heartburn
- _____ Over - Thinking

KIDNEY/ URINARY BLADDER

- _____ Urinary Problems
- _____ Bladder Infection
- _____ Dropped Bladder
- _____ Incontinence
- _____ Lack of Bladder Control
- _____ Weakness/ Pain in Lower Back
- _____ Decrease Bone Density
- _____ Feel Cold Easily
- _____ Cold Hands

LUNG / LARGE INTESTINE

- _____ Bloody Cough
- _____ Dry Cough
- _____ Cough with Sputum
- _____ Nasal Discharge / Circle Color - White Yellow Green
- _____ Post Nasal Drip / Circle Color: White Yellow Green
- _____ Sinus Infection/ Congestion
- _____ Itchy, Red, or Painful Throat
- _____ Dry Mouth/ Throat/ Nose
- _____ Skin Rashes / Hives
- _____ Snoring

<input type="checkbox"/> Cold Feet	<input type="checkbox"/> Grief / Sadness	<input type="checkbox"/> Tendency to Gain Weight
<input type="checkbox"/> Low Sex Drive / Libido	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Brain Foggy
<input type="checkbox"/> Excess Sexual Desire	<input type="checkbox"/> Allergies / Asthma	<input type="checkbox"/> Do you Crave: Sweet

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams. NOTE: If need more space, use page 5.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a “C” under the appropriate person’s column. “P” should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the space below.

Age	You	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
	AIDS / HIV						
Alcohol							
Anxiety							
Anorexia / Bulimia							
Arthritis							
Asthma / Hay Fever / Allergy							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Depression							
Diabetes							
Digestive Trouble							
Headaches							
Heart Trouble							
Hepatitis							
High Blood Pressure							
Immune Disorder							
Insomnia							
Kidney Trouble							
Liver Trouble							
Migraine							
Neck Pain							
Thyroid Disorder							
Tobacco							
Weight Problem							
Other Emotional Problems:							
Other:							

If any of the above family members are deceased, please list their age at death and cause.

MUSCULOSKELETAL

Muscle Cramps – Where?

Muscle Pain / Rheumatism – Where?

Arthritis – Where?

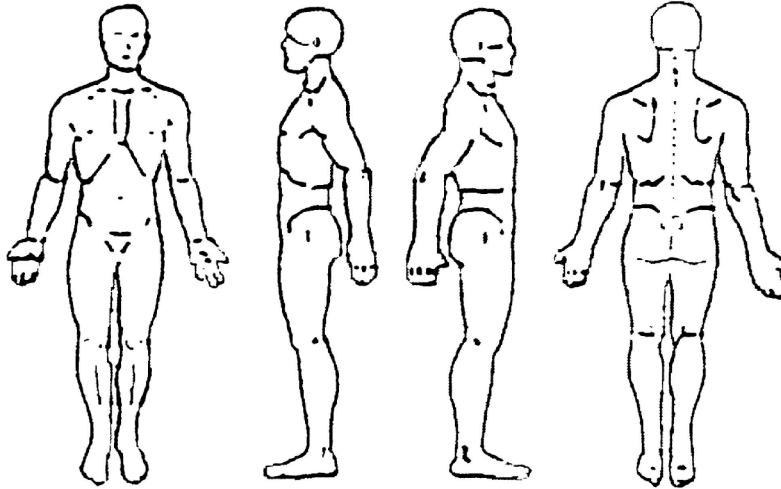
Joint Swelling – Where?

Tendonitis – Where?

Bursitis – Where?

What Makes this Better? :

Please mark problem areas on diagram:



Location of Pain	
Is the Pain	<input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Fixed <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Other: _____
On a Scale of 1 (Low) – 10 (unbearable):	
Is the Pain Better With:	<input type="checkbox"/> Rest <input type="checkbox"/> Activity <input type="checkbox"/> Ice <input type="checkbox"/> Heat <input type="checkbox"/> Other: _____ <input type="checkbox"/> Massage <input type="checkbox"/> Chiropractic

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