



Major Complaint(s) in order of significance to you. Please rate each complaint on a scale of 1-10. 1 is virtually symptom-free and 10 unbearable.

1. **Major Complaint:** \_\_\_\_\_
2. Secondary Complaint: \_\_\_\_\_
3. Other Complaint: \_\_\_\_\_
4. Other Complaint: \_\_\_\_\_
5. Other Complaint: \_\_\_\_\_

**Overall Energy (Lung, Kidney function):**

- Shortness of Breath
- Difficulty keeping eyes open in the day time
- Overall Weakness
- Easily catch colds
- Low Energy
- Feel worse after exercise

**Heart function:**

- Palpitations
- Anxiety
- Sores on the tip of the tongue
- Lack of Taste
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake up tired
- Insomnia
- Mental sluggishness
- Mental fogginess

**Spleen function:**

- Low appetite
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in the stomach
- Fatigue after eating
- Prolapsed organs (organ?: \_\_\_\_\_)
- Easily bruised
- Hemorrhoids
- Over-thinking
- Worry

**Lung function:**

- Nasal Discharge (Color: \_\_\_\_\_)
- Cough
- Nose Bleeds
- Sinus Congestion
- Dry Mouth
- Dry Throat
- Dry Nose
- Dry Skin
- Allergies (To What? \_\_\_\_\_)
- Alternating chills and fever
- Sneezing
- Headache (Location: \_\_\_\_\_)
- Overall achy feeling in body
- Stiff neck
- Stiff shoulders
- Sore throat
- Difficulty breathing
- Sadness
- Melancholy
- Smoke cigarettes (# per day: \_\_\_\_\_)

**Blood (Liver, Spleen, Heart functions):**

- Dizziness
- See floating spots
- Poor Memory
- Pale Skin

**Spleen, Stomach, Large Intestine, Small Intestine function:**

- Loose
- Constipated
- Incomplete
- Diarrhea
- Blood in stools
- Mucous in stools
- Undigested food in stools

**Dampness:**

- Heavy sensation in body
- Mental heaviness
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

**Stomach function:**

- Burning sensation after eating
- Very large appetite
- Bad breath
- Mouth (canker) sores
- Bleeding, swollen or painful gums
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccups
- Stomach pain
- Vomiting

**Liver, Gallbladder function:**

- Alternating diarrhea and constipation
- Chest pain
- Tight sensation in the chest
- Bitter taste in the mouth
- Anger easily
- Frustration
- Depression
- Irritability
- Frequent unable to adapt to stress
- Skin rashes
- Headache at top of the head
- Tingling sensation
- Numbness

- Muscle spasms
- Muscle twitching
- Muscle cramping
- Seizures
- Convulsions
- Lump in the throat
- Neck Tension
- Limited Range-of-Motion in shoulders
- Drink alcohol
- Recreation drugs? (which? \_\_\_\_\_)  
how much per week? \_\_\_\_\_
- High-pitched ringing in ears
- Gall-stones
- Sexually transmitted disease (which? \_\_\_\_\_)

**Kidney, Bladder function:**

- Frequent cavities
- Easily broken bones
- Sore knees
- Weak knees
- Cold sensation in the knees
- Low back pain
- Memory problems
- Excessive hair loss
- Low pitched ringing in ears
- Kidney stones
- Bladder infections
- Wake during the night to urinate (How many times? \_\_\_\_\_)
- Lack of bladder control
- Fear
- Easily startled

**Urination**

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful
- Difficult
- Urgent
- Frequent

**Overall Temperature (Kidney function):**

- Cold hands
- Cold feet
- Sweaty hands
- Sweaty feet
- Heat in the hands, feet or chest
- Hot flushes
- Night sweats
- Hot body temperature (sensation)
- Cold body temperature (sensation)
- Lack of perspiration
- Perspire easily
- Thirsty
- Take water to bed
- Difficulty keeping eyes open in the daytime

**Eyes (Liver function)**

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

**Libido:**

- Normal  High  Low

**Women only:**

Age of first menstruation? \_\_\_\_\_

Regular menstrual cycle?  Yes  No

Average number of days of flow: \_\_\_\_\_

Pregnant?  Yes  No

Number of children? \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_

Age of menopause: \_\_\_\_\_

Vaginal discharge:  Severe  Moderate  Slight  Normal

Bleeding between periods:  Severe  Moderate  Slight  Normal

Do you experience any of the following pre-menstrual syndromes?

- |  |  |                                     |  |
|--|--|-------------------------------------|--|
| <input type="checkbox"/> Nausea          | <input type="checkbox"/> Food Cravings     | <input type="checkbox"/> Depression | <input type="checkbox"/> Vomiting        |
| <input type="checkbox"/> Irritability    | <input type="checkbox"/> Migraines         | <input type="checkbox"/> Anxiety    | <input type="checkbox"/> Water Retention |
| <input type="checkbox"/> Breast Swelling | <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Headaches  |  |

How do these conditions impair your daily activities? \_\_\_\_\_

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Please fill in the following menstrual chart:  
(Put in a number and what color it is)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Mood							
Breast tenderness, soreness							

**Men only:**

	Severe	Moderate	Slight	Normal
Swollen testes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testicular pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of coldness or numbness in external genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____				

Please clearly mark areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

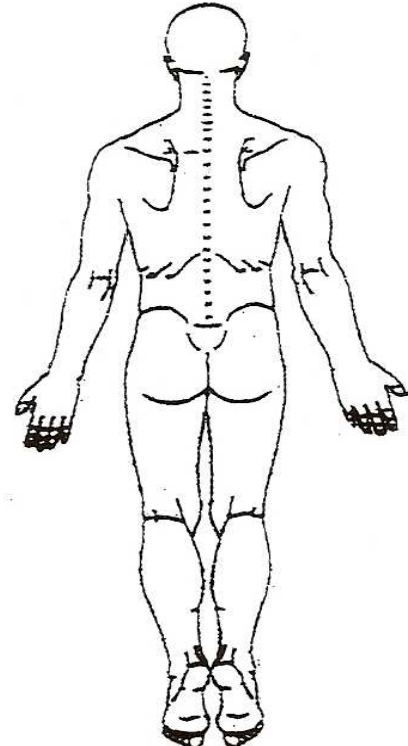
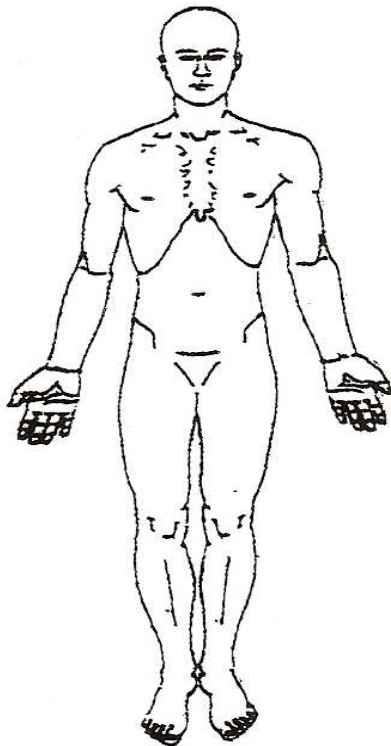
Sharp  Burning  Aching  Cramping  Dull  Moving  Fixed  Other: \_\_\_\_\_

Do the following lessen the pain?

Pressure  Cold  Heat  Exercise  Other: \_\_\_\_\_

Do the following lessen the pain?

Pressure  Cold  Heat  Exercise  Other: \_\_\_\_\_



### Patient Medical History

How was your childhood health? \_\_\_\_\_

Hospital Visits/Stays: \_\_\_\_\_

Recent tests: (please indicate test results and date below)

Physical  Cholesterol  Prostate  Blood  HIV/STD  Pap Smear  
 Mammography  Other: \_\_\_\_\_

Test Results and Date: \_\_\_\_\_

Check any you have had in the past:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> CVA (stroke)         | <input type="checkbox"/> Mumps                  | <input type="checkbox"/> Polio                 |
| <input type="checkbox"/> Chicken Pox             | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Allergies             |
| <input type="checkbox"/> Vein Condition          | <input type="checkbox"/> Bleeding Tendency    | <input type="checkbox"/> HIV                    | <input type="checkbox"/> Mononucleosis         |
| <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Meningitis           | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Nervous disorder      |
| <input type="checkbox"/> Thyroid disorder        | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Measles                | <input type="checkbox"/> Gonorrhoea            |
| <input type="checkbox"/> Syphilis                | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Paralysis             |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Hepatitis _____      | <input type="checkbox"/> Migraines              | <input type="checkbox"/> other liver illnesses |
| <input type="checkbox"/> other stomach illnesses | <input type="checkbox"/> other lung illnesses | <input type="checkbox"/> other kidney illnesses | <input type="checkbox"/> other heart illnesses |
| <input type="checkbox"/> other spleen illnesses  | <input type="checkbox"/> other: _____         |   |  |

Immunizations: \_\_\_\_\_

Surgeries (type and date): 1) \_\_\_\_\_ 2) \_\_\_\_\_  
3) \_\_\_\_\_ 4) \_\_\_\_\_

### Family History

Where are you in the birth order?  first  last  middle  only

Check the following that have occurred in your blood relatives:

- |  |                                      |  |  |
|--|--------------------------------------|--|--|
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Cancer      | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Obesity     | <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Bleeding tendency   |
| <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Allergies   | <input type="checkbox"/> Stroke        | <input type="checkbox"/> Mental Illness      |
| <input type="checkbox"/> Nervous Illness | <input type="checkbox"/> Other _____ |  |  |

Please print the telephone number(s) where you want to receive calls about your appointments or other health care information: \_\_\_\_\_

(Check one)

\_\_\_\_\_ O.K. to leave messages with detailed information.

\_\_\_\_\_ Leave message with callback number only

Please print your e-mail address if you would like us to send a reminder of your appointment via the internet. \_\_\_\_\_

**IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY THE CLINIC IF THIS INFORMATION SHOULD CHANGE.**