Name_____ Date_____
phone _____ Date of birth____/_____/_____
Email_____

General Health/Lifestyle

How often do you contract… Cold Viruses? 0-1x/year 2-4x/year 5+ x/year
Symptoms? _____

Flu Viruses? 0-1x/year 2-4x/year 5+ x/year
Symptoms? _____

How often do you take Rx Antibiotics? 0-1x/year 2-4x/year 5+ x/year

How often do you take Tylenol, NSAIDS (Aspirin, Advil, Aleve, etc.) or other pain relieving medication?
0-1x/year 2-4x/year 5+ x/year Reason(s): _____

How often do you floss your teeth? 0-1x/year 2-4x/year 5+ x/year Daily Rarely Never

How often do you use sunscreen? 0-1x/year 2-4x/year 5+ x/year Daily Summer Only Vacation Never

How many hours do you sleep each night? <4 4-6 7-8 8+
What time do you get into bed each night? _____ What time do you wake up?____

Do you have trouble falling asleep Yes No Do you have trouble staying asleep? Yes No

Do you feel rested in the morning? Yes No Sometimes Never

Please circle any painful or tense areas as well as regions that you tend to hold your stress:

Head/Face	Low Back	Shoulders	Neck	Abdomen
Legs/Feet	Arms/Hands	Mid-Back	Other	

If Other Please Describe:_____

Are you currently under a physician's care? Y/ N **For what condition**?_____
List medications you take (including pain relievers, other non-prescription drugs, vitamins, supplements and herbal remedies):_____

Do you eat 3 meals per day? Yes No If No, how many and which one(s)? _____
_____
How many snacks per day? _____ **What and when is your typical snack**? _____

What flavor do you crave most? __Sweet __Spicy __Sour __Salty __Other _____

Do you engage in meal planning? Yes No
If Yes, how often? __Daily __Weekly __Monthly __Rarely __Never

Do you exercise? Yes No Seasonally
If Yes, how often? 1x/week 2-3./week 4-6x/week Daily

Smoker? Yes No Social Quit (How long? _____
Duration? ____yrs. # of cigarettes/day: ____ # of packs/week: ___
Do you drink alcohol?___ How many drinks per week?_____

Please check the following that currently pertain to you

Overall Temperature (Kidney Energy Function):
____Cold hands
____Cold fingers
____Cold feet
____Cold Toes
____Sweaty hands
____Sweaty feet
____Hot body temperature (sensation)
____Cold body temperature (sensation)
____Afternoon flushes
____Night sweats
____Hot flashes any time of the day
____Thirsty
____Perspire easily
____Lack of perspiration
____Take water to bed

Overall Energy (Lung & Kidney Energy Function):

____Shortness of breath
____Difficulty keeping eyes open in the daytime
____General weakness
____Easily catch colds
____Low energy
____Feel worse after exercise

Heart Energy Function:

____Palpitations
____Anxiety
____Sores on the tip of the tongue
____Restlessness
____Mental confusion
____Chest pain traveling to shoulder
____Frequent dreams
____Wake un-refreshed
____Drink coffee (# of cups per week____

____

Lung Energy Function:
____Nasal discharge (Color_____)
____Cough
____Nose bleeds
____Sinus congestion
____Dry mouth
____Dry throat
____Dry nose
____Dry Skin
____Allergies (To what:_____
____Alternating fever and chills
____Sneezing
____Headache (Location:_____)
____Overall achy feeling in the body
____Stiff neck
____Stiff shoulders
____Sore throat
____Difficulty breathing
____Smoke cigarettes (# of cigarettes per day____)
____Sadness
____Melancholy

Dampness trapped in the body:
___General sensation of heaviness in the body
___Mental sluggishness
___Loss of mental clarity
___Swollen hands
___Swollen feet
___Swollen joints
___Chest congestion
___Nausea
___Snoring

Overall Blood (Liver, Spleen, & Heart Energy Function):
Dizziness
____See floating black spots
____ High/low blood pressure
____ Varicose/ Bruise easily

Kidney, Urinary Bladder Energy 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 the ears
___Kidney stones
___Bladder infections
___Wake during the night twice or more to urinate
___Lack of bladder control
___Fear
___Easily startled

Urination:
___Normal color
___Dark yellow
___Clear
___Reddish
___Cloudy
___Scanty
___Profuse
___Strong odor
___Burning
___Painful
___Discharge
___Difficult
___Painful
___Urgent
___Frequent

Liver, Gall Bladder Energy function:

___Alternating diarrhea and constipation
___Chest pain
___Tight sensation in the chest
___Bitter taste in the mouth
___Anger easily
___Depression
___Irritability
___Frequently unable to adapt to stress (What causes the stress:_____)
___Skin rashes
___Acne
___Headache at the top of the head
___Tingling sensation
___Numbness
___Muscle spasms
___Muscle twitching
___Muscle cramping
___Seizures
___Convulsions
___Lump in the throat
___Drink alcohol
___Recreational drugs (Which:_____)
___High-pitched ringing in the ears
___Gall stones (history or current)
___Sexually transmitted diseases (Which:_____)
Libido Normal___ High___ Low___

Stomach Energy Function
___Burning sensation after eating
___Large appetite
___Bad breath
___Mouth (canker) sores
___Bleeding, swollen, or painful gums
___Heartburn
___Acid regurgitation
___Ulcer (diagnosed)
___Belching/Hiccoughs
___Stomach pain
___Vomiting/Nausea

Women Only:

Regular menstrual cycle ___Y ___N
Pregnant ___Y ___N
Number of children: ___
Number of pregnancies: ___
Abortion/miscarriage/other
Age of first menstruation: ___
Age of menopause (if applicable): ___
Average number of days of flow: ___
Average number of days of entire cycle: ___

Please check if applicable:

___Vaginal discharge
___Bleeding between periods
___Clots
___Color of flow
_____

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

___Nausea ___Vomiting ___Water retention___

Breast swelling ___ Cravings___ Cramps___

Headaches ___Migraines ___Breast tenderness ___

Depression ___Irritability ___Anxiety

Allergies?_____ Pace Maker/ Port placed? _____
Please circle if you have had or currently have any of the following:

Angina	**Fibromyalgia**	**Irritable Bowel Syndrome**	**Stroke**
Asthma	**Heart disease**	**Insomnia**	**Surgery**
Blood Clot	**Hepatitis**	**Migraines/Headaches**	**Varicose Veins**
Cancer	**Herpes simplex**	**Phlebitis/Thrombosis**	**Whiplash**
Carpal Tunnel Syndrome	**Hospitalization**	**Pregnancy**	**Other:_____**
Communicable diseases	**Hypertension**	**Repetitive Strain Injuries**	**_____**
Disk Problems	**Immune System Conditions**	**Sciatica**	**_____**

Please indicate if you *currently* have any of the following conditions:

	Symptom	Yes	No	Location: Please Describe
	Any areas of infection? Any injuries?			
	Any areas of swelling, edema or tendency to swell?			
	Any areas of numbness or altered sensation?			
	Any areas of pain or tenderness?			

Please indicate if you have experienced any of the following:

	Condition	Yes	No	Please Describe
	Arthritis			
	Cancer or Tumors			
	Cardiovascular Diseases Diabetes Kidney/urinary diseases			*Please circle all that apply:* anemia, angina, arteriosclerosis, congestive heart failure, heart attack, heart murmur, hemophilia, hypertension, varicose or spider veins, other (please describe):