*future* MEDICINE *now*

LARRY HORTON :: SUE SWANBACK

*doctors of oriental medicine*

## *PERSONAL INFORMATION*

Please thoroughly review this entire document before beginning.

Full Legal Name_____

You like to be called_____ Social Security #_____

Date of Birth_____ Age_____ Place of Birth_____

Sex_____ Weight_____ Height_____ Blood Type_____

Mailing Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell Phone_____ email_____

Profession_____ How many hours per week do you work?_____

In Emergency, notify_____ Relationship_____

Home Phone_____ Work Phone_____

Do you share your home with a partner? ☐ YES ☐ NO Relationship?_____ How many others?_____

Referred by_____

Please list known drug allergies_____

_____

Please list known food allergies_____

_____

Please list known airborne allergies_____

_____

Please list all other known allergies_____

_____

Please list surgeries, their date and purpose, and the surgeon.

| Surgery | Date | Purpose | Surgeon |
|---|---|---|---|
| | | | |
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Please list significant accidents or trauma and date they occurred.

| Date | Accident |
|---|---|
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Please list scars from accidents._____

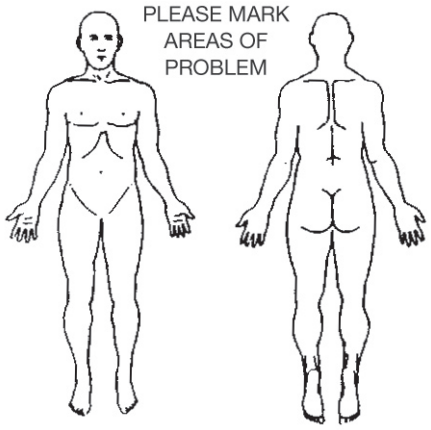
_____

_____

## *YOUR CHIEF CONCERNS*

On separate sheets of paper, please write a **narrative of your condition**. Your experience is more important to us than a name or diagnosis. Please include the following:

1. Description of your experience,
2. Date of onset,
3. Concurrent events,
4. If this has ever happened before,
5. How it affects your life and your work,
6. The diagnoses you have received,
7. Treatments you have tried,
8. Medications you have used,
9. Tests you have had completed,
10. Outcomes of treatments,
11. Your current symptoms.




Please state what makes this condition worse and what makes it better._____

_____

_____

How many health care professionals **have you seen** for your chief complaint?_____

How many physicians are you **currently** seeing?_____

Please list their names and specialties.

_____

_____

_____

_____

_____

Who made your **current diagnosis**?_____

Is this condition... ☐ Getting worse? ☐ Constant? ☐ Intermittent?

Please indicate your level of pain: MINIMAL 1 2 3 4 5 6 **7 8 9 10 EXTREME**

## *MEDICATIONS*

Please list ***medications*** (including hormones) you are ***currently using*** for any condition. Please include name and dosage of medication, prescribing physician, doctor's specialty, purpose of the medication, and approximate time span taken. If there are more, please write on a separate sheet of paper.

| MEDICATION | DOSAGE | PRESCRIBED BY | SPECIALTY | PURPOSE | FROM-TO |
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Please list ***medications*** (including hormones) you have ***previously used*** for any condition. Please include name and dosage of medication, prescribing physician, doctor's specialty, purpose of the medication, and approximate time span taken. If there are more, please write on a separate sheet of paper.

| MEDICATION | DOSAGE | PRESCRIBED BY | SPECIALTY | PURPOSE | FROM-TO |
|---|---|---|---|---|---|
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Please list each ***non-prescription drug, laxative, herbal, homeopathic, and nutritional supplement*** you are ***currently*** taking. Please ***indicate whether physician or self-prescribed***, doctor's specialty, purpose of the medication, and date began. If there are more, please write on a separate sheet of paper.

| MEDICATION | DOSAGE | PRESCRIBED BY | SPECIALTY | PURPOSE | FROM-TO |
|---|---|---|---|---|---|
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Have you ever taken corticosteroids (cortisone, prednisone, etc.)? ☐ YES ☐ NO
How long?_____

Have you taken antibiotics on more than two occasions in your lifetime? ☐ YES ☐ NO
How many?_____

Have you taken tetracyclines (Sumycin, Panmycin, Vibramycin, etc.)? ☐ YES ☐ NO How many?_____

Were you often sick as a child? ☐ YES ☐ NO Childhood illnesses_____
_____

How many silver amalgam fillings do you have?_____ Root canals?_____ Crowns?_____ Bridges?_____

How many silver amalgam fillings have you had removed?_____ When?_____ By whom?_____
Did you receive chelation during removal or afterward?_____

Unusual birth history: Prolonged labor, Forceps delivery, C-Section, etc.?_____
_____

Were you breast fed? ☐ YES ☐ NO ☐ DON'T KNOW

Have you ever had a blood transfusion? ☐ YES ☐ NO When?_____
Have you ever had chemotherapy? ☐ YES ☐ NO When?_____
Have you ever had radiation therapy? ☐ YES ☐ NO When?_____
What vaccinations have you had? How often?

| | | |
|---|---|---|
| ☐ Tetanus (lockjaw) | ☐ Rubella (German measles) | ☐ Rotavirus |
| ☐ Smallpox | ☐ Measles | ☐ Mumps |
| ☐ Diphtheria | ☐ Varicella | ☐ Varicella |
| ☐ Poliomyelitis | ☐ Flu | ☐ Meningococcal |
| ☐ Pertussis (whooping cough) | ☐ Hepatitis A or B (circle one) | ☐ Other_____ |

What vaccinations have you had in the past year?_____
Where have you traveled outside this country? When?

_____ _____
_____ _____
_____ _____
_____ _____

Do you have pets? ☐ YES ☐ NO Please list:_____

## *DO YOU HAVE OR HAVE YOU EVER HAD...*

Please circle the appropriate number on all questions.
0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS, ARC or HIV+ | 0 | 1 | 2 | 3 | Fibromyalgia | 0 | 1 | 2 | 3 | Mumps | 0 | 1 | 2 | 3 |
| Allergies | 0 | 1 | 2 | 3 | Gallstones | 0 | 1 | 2 | 3 | Rheumatic Fever | 0 | 1 | 2 | 3 |
| Anemia | 0 | 1 | 2 | 3 | Heart Attack | 0 | 1 | 2 | 3 | Sexually Transmitted Dis. | 0 | 1 | 2 | 3 |
| Arthritis | 0 | 1 | 2 | 3 | Hemophilia | 0 | 1 | 2 | 3 | Type: | | | | |
| Asthma | 0 | 1 | 2 | 3 | Herpes | 0 | 1 | 2 | 3 | Stroke | 0 | 1 | 2 | 3 |
| Cancer | 0 | 1 | 2 | 3 | Hepatitis | 0 | 1 | 2 | 3 | Sudden Weight Loss | 0 | 1 | 2 | 3 |
| Type: | | | | | High Blood Pressure | 0 | 1 | 2 | 3 | Thyroid Problems | 0 | 1 | 2 | 3 |
| Chicken Pox | 0 | 1 | 2 | 3 | Jaundice | 0 | 1 | 2 | 3 | Tuberculosis | 0 | 1 | 2 | 3 |
| Chronic Fatigue Synd. | 0 | 1 | 2 | 3 | Kidney Stones | 0 | 1 | 2 | 3 | Ulcers | 0 | 1 | 2 | 3 |
| Coronary Artery Disease | 0 | 1 | 2 | 3 | Kidney Infection | 0 | 1 | 2 | 3 | | | | | |
| Dyslexia | 0 | 1 | 2 | 3 | Mononucleosis | 0 | 1 | 2 | 3 | | | | | |

## *FAMILY MEDICAL HISTORY*

**F**ather, **M**other, **S**ibling, **G**randparent

| | | | | | |
|---|---|---|---|---|---|
| F M S G | Alcoholism | F M S G | Diabetes | F M S G | Melanoma |
| F M S G | Arthritis | F M S G | Drug Addiction | F M S G | Psychological |
| F M S G | Asthma | F M S G | Epilepsy | F M S G | Smokers |
| F M S G | Cancer | F M S G | Heart Disease | F M S G | Stroke |
| Types_____ | | F M S G | High Blood Pressure | F M S G | Thyroid Problems |
| _____ | | F M S G | Kidney Disease | F M S G | Tuberculosis |
| _____ | | F M S G | Liver Disease | Others?_____ | |
| F M S G | Coronary Artery Dis. | F M S G | Lung Disease | _____ | |

## *MALES ONLY*

Please circle the appropriate number on all questions.
0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Dribbling or difficulty urinating | 0 | 1 | 2 | 3 | Feeling of incomplete bowel movements | 0 | 1 | 2 | 3 |
| Frequent urination | 0 | 1 | 2 | 3 | Restless legs at night | 0 | 1 | 2 | 3 |
| Pain on inside of legs or heels | 0 | 1 | 2 | 3 | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Decreased libido | 0 | 1 | 2 | 3 | Muscle soreness | 0 | 1 | 2 | 3 |
| Decreased spontaneous morning erections | 0 | 1 | 2 | 3 | Decrease in physical stamina | 0 | 1 | 2 | 3 |
| Decrease in fullness of erections | 0 | 1 | 2 | 3 | Unexplained weight gain | 0 | 1 | 2 | 3 |
| Difficulty in maintaining morning erections | 0 | 1 | 2 | 3 | Increase in fat around chest and hips | 0 | 1 | 2 | 3 |
| Spells of mental fatigue | 0 | 1 | 2 | 3 | Sweating attacks | 0 | 1 | 2 | 3 |
| Inability to concentrate | 0 | 1 | 2 | 3 | More emotional than in the past | 0 | 1 | 2 | 3 |
| Episodes of depression | 0 | 1 | 2 | 3 | Premature ejaculation | 0 | 1 | 2 | 3 |

***FEMALES ONLY***

Number of pregnancies_____
Number of births_____
Premature births_____
Miscarriages_____
Abortions_____
Difficult deliveries_____
Caesarean sections_____
Ages of children_____
Age at first menses_____
Date of most recent menses_____
Duration of flow_____
Days in monthly cycle_____
☐ Have not yet begun to menstruate

☐ Currently use birth control
Type_____
How long?_____
☐ Previously used birth control
Type_____
How long?_____
☐ Trying to become pregnant
☐ Fertility issues
☐ Cannot maintain pregnancy
☐ Pregnant
☐ Nausea or morning sickness
☐ Nursing

☐ Vaginal discharge: no odor
☐ Vaginal discharge: strong smelling
☐ Vaginal discharge: brownish
☐ Vaginal discharge: white, curd-like
☐ Vaginal discharge: frothy & profuse
☐ Vaginal discharge: itchy
☐ Vaginal discharge: burning
☐ Abnormal PAP
☐ Uterine fibroids or cysts
☐ Polycystic ovarian syndrome
☐ Breast cysts or lumps
☐ Pelvic inflammatory disease
☐ Endometriosis

Please circle the appropriate number on all questions.
0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Painful periods require OTC medication | 0 | 1 | 2 | 3 | Premenstrual headache | 0 | 1 | 2 | 3 |
| Painful periods require Rx medication | 0 | 1 | 2 | 3 | Premenstrual constipation | 0 | 1 | 2 | 3 |
| Light colored or pale blood | 0 | 1 | 2 | 3 | Are you perimenopausal? | Yes | | No | |
| Bright red blood | 0 | 1 | 2 | 3 | Alternating menstrual cycle lengths? | Yes | | No | |
| Dark blood | 0 | 1 | 2 | 3 | Extended cycle, greater than 32 days? | Yes | | No | |
| Dark purple clots | 0 | 1 | 2 | 3 | Shortened cycle, less than every 24 days? | Yes | | No | |
| Dark brown clots | 0 | 1 | 2 | 3 | Spotting between periods? | Yes | | No | |
| Red clots | 0 | 1 | 2 | 3 | Missed periods? | Yes | | No | |
| Cramping **before** period starts | 0 | 1 | 2 | 3 | Scanty blood flow | 0 | 1 | 2 | 3 |
| Cramping **after** period starts | 0 | 1 | 2 | 3 | Heavy blood flow | 0 | 1 | 2 | 3 |
| Low backache with period | 0 | 1 | 2 | 3 | Pelvic pain during menses | 0 | 1 | 2 | 3 |
| Premenstrual irritability | 0 | 1 | 2 | 3 | Depression during menses | 0 | 1 | 2 | 3 |
| Premenstrual emotional sensitivity | 0 | 1 | 2 | 3 | Acne outbreaks | 0 | 1 | 2 | 3 |
| Premenstrual breast tenderness | 0 | 1 | 2 | 3 | Facial hair growth | 0 | 1 | 2 | 3 |
| Premenstrual bloating | 0 | 1 | 2 | 3 | Hair loss or thinning | 0 | 1 | 2 | 3 |

Any other pregnancy or gynecological problems?_____

_____

Date of last PAP test?_____ Gynecologist_____

## *MENOPAUSAL FEMALES ONLY*

Please circle the appropriate number on all questions.
0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Age at start of menopause: | | | | | Disinterest in sex? | 0 | 1 | 2 | 3 |
| Age menses stopped: | | | | | Mood swings? | 0 | 1 | 2 | 3 |
| Hysterectomy? | Yes | | No | | Depression? | 0 | 1 | 2 | 3 |
| Reason: | | | | | Painful intercourse? | 0 | 1 | 2 | 3 |
| Oophorectomy? | Yes | | No | | Shrinking breasts? | 0 | 1 | 2 | 3 |
| Reason: | | | | | Facial hair growth? | 0 | 1 | 2 | 3 |
| Do you ever have uterine bleeding? | 0 | 1 | 2 | 3 | Acne? | 0 | 1 | 2 | 3 |
| Hot Flashes? | 0 | 1 | 2 | 3 | Vaginal pain, dryness, or itching? | 0 | 1 | 2 | 3 |
| Mental Fogginess? | 0 | 1 | 2 | 3 | | | | | |

## *FOOD AND YOUR HEALTH*

Where do you shop for food?_____
Do you cook your own meals? ☐ YES ☐ NO
Do you use a microwave? ☐ YES ☐ NO
Do you use aluminum or aluminum alloys for cooking, food prep, serving, or drinking? ☐ YES ☐ NO
How many times per week do you eat out?_____
How many times per week do you eat fast food?_____
List the three worst foods you eat in a week._____
_____
List the three healthiest foods you eat in a week._____
_____
Do you eat breakfast? ☐ YES ☐ NO
What is your favorite breakfast?_____
What is your most common breakfast?_____
What did you eat for breakfast today?_____
What did you eat for dinner last night?_____
What time did you eat last night?_____ Is this usual? ☐ YES ☐ NO
Are you vegetarian or vegan? ☐ YES ☐ NO How long?_____
Do you eat... ☐ Red meat? ☐ Poultry? ☐ Fish? ☐ Eggs ☐ Milk products?
How many times per week do you eat fish?_____
How many times per week do you eat raw nuts and seeds?_____
Do you believe dietary choices influence your health? ☐ YES ☐ NO
Do you drink ice-cold liquids? ☐ YES ☐ NO
Are you willing to change your diet, even if it means giving up your favorite foods? ☐ YES ☐ NO ☐ NOT SURE
What is the source of your drinking water? ☐ Municipal ☐ Private Well ☐ Bottled ☐ Commercially Filtered ☐ Home Filtered
Do you drink beverages from aluminum cans? ☐ YES ☐ NO Do you use anti-perspirants with aluminum? ☐ YES ☐ NO
Have you ever been drug or alcohol dependent?_____
When?_____
Please list dietary restrictions:_____
_____
Please list between meal snacks:_____
_____

Please circle the appropriate number on all questions.
0 = 'never' 1 = 'once', 'years ago' 2 = 'recently quit' 3 ='currently'

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Tobacco use? | 0 | 1 | 2 | 3 | Type: | Frequency: | | |
| Type: | | | | | Alcohol use? | 0 | 1 | 2 | 3 |
| Amount per week: | | | | | Amount per week: | | | | |
| Number of years: | | | | | Beer Wine Liquor | | | | |
| Coffee use? | 0 | 1 | 2 | 3 | Soft Drinks? | 0 | 1 | 2 | 3 |
| Cups per day: | | | | | Number per day: | | | | |
| Recreational drug use? | 0 | 1 | 2 | 3 | Diet Regular | | | | |

## *REFLECTIONS OF FOOD CHOICES*

Please circle the appropriate number on all questions.
0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

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|---|---|---|---|---|---|---|---|---|
| Do you crave sweets during the day? | 0 | 1 | 2 | 3 | Feel shaky, jittery, tremors? | 0 | 1 | 2 | 3 |
| Are you irritable if meals are missed? | 0 | 1 | 2 | 3 | Agitated, easily upset, nervous? | 0 | 1 | 2 | 3 |
| Use coffee to get started & keep going? | 0 | 1 | 2 | 3 | Poor memory, forgetful? | 0 | 1 | 2 | 3 |
| Get light-headed if meals are missed? | 0 | 1 | 2 | 3 | Blurred vision? | 0 | 1 | 2 | 3 |
| Eating relieves fatigue? | 0 | 1 | 2 | 3 | | | | | |

II

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Fatigue after meals? | 0 | 1 | 2 | 3 | Frequent urination? | 0 | 1 | 2 | 3 |
| Eating sweets does not relieve sugar craving | 0 | 1 | 2 | 3 | Increased thirst and appetite? | 0 | 1 | 2 | 3 |
| Must have sweets after meals? | 0 | 1 | 2 | 3 | Difficulty losing weight? | 0 | 1 | 2 | 3 |
| Waist girth equal to or larger than hip girth? | 0 | 1 | 2 | 3 | | | | | |

## *GASTROINTESTINAL*

Please circle the appropriate number on all questions.
0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

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|---|---|---|---|---|---|---|---|---|
| Bowel movements feel incomplete? | 0 | 1 | 2 | 3 | Alternating constipation & diarrhea? | 0 | 1 | 2 | 3 |
| Lower abdominal pain? | 0 | 1 | 2 | 3 | Diarrhea? | 0 | 1 | 2 | 3 |
| Lower abdominal pain relieved by passing gas or stool? | 0 | 1 | 2 | 3 | Loose stools? | 0 | 1 | 2 | 3 |
| | | | | | Foul smelling stools? | 0 | 1 | 2 | 3 |
| Constipation? | 0 | 1 | 2 | 3 | Coated, fuzzy tongue? | 0 | 1 | 2 | 3 |
| Hard, dry, small stools? | 0 | 1 | 2 | 3 | Large volume of foul smelling gas | 0 | 1 | 2 | 3 |
| Frequent laxative use? | 0 | 1 | 2 | 3 | More than three bowel movements per day? | 0 | 1 | 2 | 3 |

How often do you have a bowel movement?_____

Please circle the drawing that most closely resembles the shape of your stools.

II

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|---|---|---|---|---|---|---|---|---|
| Excessive belching, burping, or bloating? | 0 | 1 | 2 | 3 | Sense of fullness during or after meals? | 0 | 1 | 2 | 3 |
| Gas immediately following meal? | 0 | 1 | 2 | 3 | Undigested food in stools? | 0 | 1 | 2 | 3 |
| Offensive breath? | 0 | 1 | 2 | 3 | Difficulty digesting fruits and vegetables? | 0 | 1 | 2 | 3 |
| Difficult bowel movements? | 0 | 1 | 2 | 3 | | | | | |

III

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|---|---|---|---|---|---|---|---|---|---|
| Stomach pain, burning, or aching 1-4 hours after eating? | 0 | 1 | 2 | 3 | Digestive problems subside with rest and relaxation? | 0 | 1 | 2 | 3 |
| Frequent use of antacids? | 0 | 1 | 2 | 3 | Heartburn from spicy foods, chocolate, citrus, peppers, alcohol, caffeine? | 0 | 1 | 2 | 3 |
| Feel hungry an hour or two after eating? | 0 | 1 | 2 | 3 | Blood in stool? | 0 | 1 | 2 | 3 |
| Heartburn lying down or bending over? | 0 | 1 | 2 | 3 | Excessive appetite? | 0 | 1 | 2 | 3 |
| Temporary relief with antacids, food, milk, carbonated beverages? | 0 | 1 | 2 | 3 | | | | | |

IV

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|---|---|---|---|---|---|---|---|---|---|
| Roughage & fiber cause constipation? | 0 | 1 | 2 | 3 | Foul smelling stools with undigested food, mucous, greasy, poorly formed? | 0 | 1 | 2 | 3 |
| Indigestion & fullness lasting 2-4 hours after eating? | 0 | 1 | 2 | 3 | Frequent urination? | 0 | 1 | 2 | 3 |
| Pain, tenderness, soreness on left side under rib cage? | 0 | 1 | 2 | 3 | Increased thirst and appetite? | 0 | 1 | 2 | 3 |
| Excessive gas? | 0 | 1 | 2 | 3 | Difficulty losing weight? | 0 | 1 | 2 | 3 |
| Nausea and/or vomiting? | 0 | 1 | 2 | 3 | Poor appetite? | 0 | 1 | 2 | 3 |
| | | | | | Fatigue following bowel movement? | 0 | 1 | 2 | 3 |

Have you been diagnosed with...

- ☐ Colitis?
- ☐ Yeast overgrowth?
- ☐ Ulcers?
- ☐ Diverticulitis?
- ☐ Pathological gut bacteria?
- ☐ Hiatal hernia?
- ☐ Parasites (protozoan or worms)?
- ☐ Hemorrhoids?
- ☐ GERD?

V

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|---|---|---|---|---|---|---|---|---|---|
| Greasy or high fat foods cause distress? | 0 | 1 | 2 | 3 | Yellowish cast to eyes? | 0 | 1 | 2 | 3 |
| Lower bowel gas or bloating several hours after eating? | 0 | 1 | 2 | 3 | Stools alternate from clay colored to brown? | 0 | 1 | 2 | 3 |
| Bitter, metallic taste in mouth, especially in the morning? | 0 | 1 | 2 | 3 | Reddened skin, especially palms? | 0 | 1 | 2 | 3 |
| Unexplained itchy skin? | 0 | 1 | 2 | 3 | Dry or flaky skin or hair? | 0 | 1 | 2 | 3 |
| | | | | | History of gall bladder attacks or stones? | 0 | 1 | 2 | 3 |
| | | | | | Have you had your gall bladder removed? | Yes | | No | |

## *ENERGY*

Please rate your energy level on a scale of 1-10 and time of day (e.g. High 8 morning; Low 0 after lunch):

High_____ Low_____

What type of exercise do you get?_____

How often?_____

Do you use a heart rate monitor? ☐ YES ☐ NO Your target heart rate during exercise?_____

Please indicate your level of stress: MINIMAL 1 2 3 4 5 6 **7 8 9 10 EXTREME**

I

Please circle the appropriate number on all questions.

0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Diminished sex drive? | 0 | 1 | 2 | 3 | Increased sex drive? | 0 | 1 | 2 | 3 |
| Menstrual disorders or lack of menses? | 0 | 1 | 2 | 3 | Tolerance to sugars reduced? | 0 | 1 | 2 | 3 |
| Increased ability to eat sugars without symptoms? | 0 | 1 | 2 | 3 | "Splitting" type headaches? | 0 | 1 | 2 | 3 |

## *ENERGY*

II

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|---|---|---|---|---|---|---|---|---|---|
| Tired, sluggish? | 0 | 1 | 2 | 3 | Morning headaches which wear off as day goes on? | 0 | 1 | 2 | 3 |
| Feel cold? Hands, feet, or all over? | 0 | 1 | 2 | 3 | Outer third of eyebrows thin? | 0 | 1 | 2 | 3 |
| Require excessive amounts of sleep to function properly? | 0 | 1 | 2 | 3 | Thinning of hair on head, face, or genitals? | 0 | 1 | 2 | 3 |
| Increase in weight regardless of diet? | 0 | 1 | 2 | 3 | Hair falling out? | 0 | 1 | 2 | 3 |
| Gain weight easily? | 0 | 1 | 2 | 3 | Dryness of skin or scalp? | 0 | 1 | 2 | 3 |
| Infrequent bowel movements? | 0 | 1 | 2 | 3 | Mental sluggishness? | 0 | 1 | 2 | 3 |
| Depression, lack of motivation? | 0 | 1 | 2 | 3 | | | | | |

## *MUSCULOSKELETAL PAIN*

Please circle the appropriate number on all questions.
0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Neck pain or stiffness? | 0 | 1 | 2 | 3 | Hip joint pain or stiffness? | 0 | 1 | 2 | 3 |
| Shoulder blade pain? | 0 | 1 | 2 | 3 | Pain into calf or lower leg? | 0 | 1 | 2 | 3 |
| Shoulder joint pain or stiffness? | 0 | 1 | 2 | 3 | Weak legs? | 0 | 1 | 2 | 3 |
| Upper arm pain or stiffness? | 0 | 1 | 2 | 3 | Knee pain or stiffness? | 0 | 1 | 2 | 3 |
| Elbow pain or stiffness? | 0 | 1 | 2 | 3 | Weak knees? | 0 | 1 | 2 | 3 |
| Wrist pain or stiffness? | 0 | 1 | 2 | 3 | Ankle pain or stiffness? | 0 | 1 | 2 | 3 |
| Hand/finger pain or stiffness? | 0 | 1 | 2 | 3 | Weak ankles? | 0 | 1 | 2 | 3 |
| Numbness or tingling in hands? | 0 | 1 | 2 | 3 | Foot or toe pain or stiffness? | 0 | 1 | 2 | 3 |
| Upper back pain or stiffness? | 0 | 1 | 2 | 3 | Numbness or tingling in feet? | 0 | 1 | 2 | 3 |
| Mid back pain or stiffness? | 0 | 1 | 2 | 3 | Muscles spasms? | 0 | 1 | 2 | 3 |
| Low back pain or stiffness? | 0 | 1 | 2 | 3 | Muscle weakness? | 0 | 1 | 2 | 3 |
| Sacroiliac pain or stiffness? | 0 | 1 | 2 | 3 | Paralysis? | 0 | 1 | 2 | 3 |

Is the problem **helped** by ☐ Pressure? ☐ Heat? ☐ Cold? ☐ Other_____

Is the problem **aggravated** by ☐ Pressure? ☐ Heat? ☐ Cold? ☐ Damp weather? ☐ Windy weather?

☐ Other_____

## *SLEEP*

How many hours do you usually sleep every 24 hours?_____ Go to bed at:_____ Arise:_____

I

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|---|---|---|---|---|---|---|---|---|---|
| Heart palpitations? | 0 | 1 | 2 | 3 | Insomnia? | 0 | 1 | 2 | 3 |
| Inward trembling? | 0 | 1 | 2 | 3 | Night sweats? | 0 | 1 | 2 | 3 |
| Increased pulse, even at rest? | 0 | 1 | 2 | 3 | Difficulty gaining weight? | 0 | 1 | 2 | 3 |
| Nervous and emotional? | 0 | 1 | 2 | 3 | | | | | |

II

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Cannot fall asleep? | 0 | 1 | 2 | 3 | Wake up tired after 6 or more hours of sleep? | 0 | 1 | 2 | 3 |
| Perspire easily? | 0 | 1 | 2 | 3 | Excessive perspiration or easy perspiration? | 0 | 1 | 2 | 3 |
| Under high amounts of stress? | 0 | 1 | 2 | 3 | | | | | |
| Weight gain when under stress? | 0 | 1 | 2 | 3 | | | | | |

## *SLEEP*

Please circle the appropriate number on all questions.
0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

III

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Cannot stay asleep? | 0 | 1 | 2 | 3 | Dizziness when standing up quickly? | 0 | 1 | 2 | 3 |
| Crave salt? | 0 | 1 | 2 | 3 | Afternoon headaches? | 0 | 1 | 2 | 3 |
| Slow starter in the morning? | 0 | 1 | 2 | 3 | Headaches with exertion or stress? | 0 | 1 | 2 | 3 |
| Afternoon fatigue? | 0 | 1 | 2 | 3 | Weak nails? | 0 | 1 | 2 | 3 |

IV

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Shallow sleep? | 0 | 1 | 2 | 3 | Difficulty waking in morning? | 0 | 1 | 2 | 3 |
| Dream disturbed sleep? | 0 | 1 | 2 | 3 | Wake unrefreshed in morning? | 0 | 1 | 2 | 3 |
| Wake at night thinking? | 0 | 1 | 2 | 3 | Sleepy in afternoon? | 0 | 1 | 2 | 3 |
| Wake at night, mind empty, eyes open? | 0 | 1 | 2 | 3 | Need to take naps? | 0 | 1 | 2 | 3 |
| Nightmares? | 0 | 1 | 2 | 3 | Sleep too much? | 0 | 1 | 2 | 3 |
| Snoring? | 0 | 1 | 2 | 3 | Sleep too little? | 0 | 1 | 2 | 3 |

Do you sleep on a water bed? ☐ YES ☐ NO
Do you sleep with an electric blanket? ☐ YES ☐ NO
Do you sleep with your cell phone next to the bed? ☐ YES ☐ NO
What hours of the day do you work?_____ Swing shift? ☐ YES ☐ NO Night shift? ☐ YES ☐ NO

## *EYES*

Please circle the appropriate number on all questions.
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| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Nearsightedness (myopia)? | Yes | No | | | Pressure behind eyes? | 0 | 1 | 2 | 3 |
| Farsightedness (hyperopia)? | Yes | No | | | Eye pain? | 0 | 1 | 2 | 3 |
| Astigmatism? | Yes | No | | | Dry eyes? | 0 | 1 | 2 | 3 |
| Glaucoma? | Yes | No | | | Watery eyes? | 0 | 1 | 2 | 3 |
| Cataracts? | Yes | No | | | Itchy eyes? | 0 | 1 | 2 | 3 |
| Night blindness? | Yes | No | | | Red eyes? | 0 | 1 | 2 | 3 |
| Sensitivity to light? | 0 | 1 | 2 | 3 | Conjunctivitis? | 0 | 1 | 2 | 3 |
| Blurred vision? | 0 | 1 | 2 | 3 | Use eyeglasses or contacts? | 0 | 1 | 2 | 3 |
| Floating spots? | 0 | 1 | 2 | 3 | Blindness? | Yes | | No | |

## *ENVIRONMENTAL*

Have you recently moved into a new house, bought new furniture, installed new carpeting, or had remodeling work done on your house? ☐ YES ☐ NO Please list:_____

_____

Have any of these things occurred at your place of work? ☐ YES ☐ NO

Have you recently bought a new car? ☐ YES ☐ NO

Do you use pesticides in or around your home? ☐ YES ☐ NO Your place of work? ☐ YES ☐ NO

How many hours per day do you watch television?_____ How late?_____
How many hours per day do you use the computer?_____ How late?_____

## *ENVIRONMENTAL*

Please list all the personal care products you use.

| TYPE OF PRODUCT | BRAND | PRODUCT NAME |
|---|---|---|
| Shampoo | | |
| Conditioner | | |
| Hair Color | | |
| Hair Gel | | |
| Hair Spray | | |
| Deodorant/Antiperspirant | | |
| Body Lotion | | |
| Hand Lotion | | |
| Face Lotion | | |
| Makeup (include foundation, eye shadow, eye liner, mascara, lip color, blush, etc) | | |
| Nail Polish | | |
| Face Cleanser | | |
| Soap | | |
| Hand Soap | | |
| Perfume | | |
| Contact Lens Solution | | |
| Other: Use a separate sheet of paper. | | |

On a separate sheet of paper, please do the same for household cleaning products, laundry products, etc.

## *SKIN & HAIR*

Please circle the appropriate number on all questions.

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| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Rashes? | 0 1 2 3 | Pimples or acne? | 0 1 2 3 | Moist feet? | 0 1 2 3 |
| Hives? | 0 1 2 3 | Ulcerations or sores? | 0 1 2 3 | Fungus on skin? | 0 1 2 3 |
| Itching? | 0 1 2 3 | Recent/changing moles? | 0 1 2 3 | Fungus under nails? | 0 1 2 3 |
| Eczema? | 0 1 2 3 | Warts? | 0 1 2 3 | Weak or brittle nails? | 0 1 2 3 |
| Psoriasis? | 0 1 2 3 | Skin tags? | 0 1 2 3 | Loss of hair? | 0 1 2 3 |
| Herpes zoster/shingles? | 0 1 2 3 | Dry skin? | 0 1 2 3 | Dandruff? | 0 1 2 3 |
| Boils? | 0 1 2 3 | Moist palms? | 0 1 2 3 | Dry hair? | 0 1 2 3 |

Any numb areas? ☐ YES ☐ NO Where?_____

## *RESPIRATORY*

| | | | | | |
|---|---|---|---|---|---|
| Chronic cough? | 0 1 2 3 | Green phlegm? | 0 1 2 3 | Asthma, difficult inhalation? | 0 1 2 3 |
| Dry cough? | 0 1 2 3 | Blood in phlegm? | 0 1 2 3 | Asthma, difficult exhalation? | 0 1 2 3 |
| Tight, rattling cough? | 0 1 2 3 | Bronchitis? | 0 1 2 3 | Asthma, worse on exertion? | 0 1 2 3 |
| Loose cough? | 0 1 2 3 | Pneumonia? | 0 1 2 3 | Asthma, worse in cold weather? | 0 1 2 3 |
| Thick, sticky phlegm? | 0 1 2 3 | Pain with deep breath? | 0 1 2 3 | Asthma, worse with emotions? | 0 1 2 3 |
| Thin, watery phlegm? | 0 1 2 3 | Shortness of breath? | 0 1 2 3 | | |
| Clear, or white phlegm? | 0 1 2 3 | Emphysema? | 0 1 2 3 | | |
| Yellow phlegm? | 0 1 2 3 | Wheezing? | 0 1 2 3 | | |

Please list any preferences or dislikes for a particular season, climate, temperature, weather, time of day, taste, or foods.

Preferences

Dislikes

## *GENERAL*

Please circle the appropriate number on all questions.

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| | | | |
|---|---|---|---|
| Head or chest colds? 0 1 2 3 | Rarely perspire? 0 1 2 3 | Recent weight gain? 0 1 2 3 |
| Flu? 0 1 2 3 | Always fatigued? 0 1 2 3 | Often thirsty? 0 1 2 3 |
| Recurrent fever? 0 1 2 3 | Fatigue easily? 0 1 2 3 | Rarely thirsty? 0 1 2 3 |
| Chills? 0 1 2 3 | Sudden energy drop? 0 1 2 3 | |
| Night sweats? 0 1 2 3 | Recent weight loss? 0 1 2 3 | |

## *HEAD, EARS, NOSE, MOUTH & THROAT*

Please circle the appropriate number on all questions.

0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

| | | |
|---|---|---|
| Frequent colds? 0 1 2 3 | Headache? 0 1 2 3 | Allergies? 0 1 2 3 |
| Sinus congestion or pain? 0 1 2 3 | Location: | Decreased sense of smell? 0 1 2 3 |
| Facial pain? 0 1 2 3 | Frequency: | Dry mouth? 0 1 2 3 |
| Jaw tension or clicking? 0 1 2 3 | Duration: | Excessive saliva, drooling? 0 1 2 3 |
| Grinding teeth? 0 1 2 3 | Quality of pain: | Sores on tongue? 0 1 2 3 |
| Frequent dental cavities? 0 1 2 3 | Congestion in ears? 0 1 2 3 | Sores in mouth? 0 1 2 3 |
| Gum disease? 0 1 2 3 | Earache? 0 1 2 3 | Sores around lips? 0 1 2 3 |
| Bleeding gums? 0 1 2 3 | Deafness? 0 1 2 3 | Difficulty swallowing? 0 1 2 3 |
| Dentures? 0 1 2 3 | Difficulty hearing? 0 1 2 3 | Lump or pit in throat? 0 1 2 3 |
| Dizziness, loss of balance? 0 1 2 3 | Nasal congestion? 0 1 2 3 | Sore throat? 0 1 2 3 |
| Concussion? 0 1 2 3 | Runny nose? 0 1 2 3 | Strep throat? 0 1 2 3 |
| Seizures? 0 1 2 3 | Nosebleeds? 0 1 2 3 | Tonsillitis? 0 1 2 3 |
| Migraine headache? 0 1 2 3 | Sneezing? 0 1 2 3 | Swollen lymph nodes? 0 1 2 3 |

## *CARDIOVASCULAR*

Please circle the appropriate number on all questions.

0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

| | | |
|---|---|---|
| High blood pressure? 0 1 2 3 | High blood cholesterol? 0 1 2 3 | Swelling of hands? 0 1 2 3 |
| Low blood pressure? 0 1 2 3 | Stroke? 0 1 2 3 | Swelling of feet? 0 1 2 3 |
| Blackouts or fainting? 0 1 2 3 | Blood clots? 0 1 2 3 | Cold hands? 0 1 2 3 |
| Irregular heartbeat? 0 1 2 3 | Phlebitis? 0 1 2 3 | Cold feet? 0 1 2 3 |
| Heart valve issue/murmer? 0 1 2 3 | Varicose veins? 0 1 2 3 | Hot hands or palms? 0 1 2 3 |
| Rapid heartbeat/palpitations? 0 1 2 3 | Easy bruising? 0 1 2 3 | Hot feet or soles? 0 1 2 3 |
| | Anemia? 0 1 2 3 | Generally too hot? 0 1 2 3 |
| Angina or chest pain? 0 1 2 3 | Water retention? 0 1 2 3 | Generally too cold? 0 1 2 3 |

## *UR0-GENITAL*

Please circle the appropriate number on all questions.

0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Scanty or small amount of urine? | 0 | 1 | 2 | 3 | Pain or burning with urination? | 0 | 1 | 2 | 3 |
| Dark urine? | 0 | 1 | 2 | 3 | Pain in bladder area? | 0 | 1 | 2 | 3 |
| Strong smelling urine? | 0 | 1 | 2 | 3 | Blood in urine? | 0 | 1 | 2 | 3 |
| Cloudy urine? | 0 | 1 | 2 | 3 | Bladder infection? | 0 | 1 | 2 | 3 |
| Profuse or large amount of urine? | 0 | 1 | 2 | 3 | Kidney infection? | 0 | 1 | 2 | 3 |
| Clear urine? | 0 | 1 | 2 | 3 | Kidney stones? | 0 | 1 | 2 | 3 |
| Unable to hold urine? | 0 | 1 | 2 | 3 | Genital sores? | 0 | 1 | 2 | 3 |
| Urgency to urinate? | 0 | 1 | 2 | 3 | Pain during intercourse? | 0 | 1 | 2 | 3 |
| Frequent urination? | 0 | 1 | 2 | 3 | Low sexual energy? | 0 | 1 | 2 | 3 |
| Difficulty urinating? | 0 | 1 | 2 | 3 | Excessive sexual energy? | 0 | 1 | 2 | 3 |
| Decreased flow of urine? | 0 | 1 | 2 | 3 | Inability to experience orgasm? | 0 | 1 | 2 | 3 |
| Flow does not stop quickly? | 0 | 1 | 2 | 3 | Prostate problems? | 0 | 1 | 2 | 3 |
| Leaking urine? | 0 | 1 | 2 | 3 | Low sperm count? | 0 | 1 | 2 | 3 |
| Bed wetting? | 0 | 1 | 2 | 3 | Ejaculation during sleep? | 0 | 1 | 2 | 3 |

How often do you urinate in 24 hours?_____ How often do you wake to urinate at night?_____

Any other urinary or genital problems?_____

## *DOMINANT HAND*

Are you ☐ Right Handed? ☐ Left Handed? ☐ Ambidextrous?

Has this always been true? ☐ YES ☐ NO

## *EMOTIONAL*

Please circle the appropriate number on all questions.

0 = 'never' or 'least' 1 = 'once', 'years ago', or 'rarely' 2 = 'sometimes' or 'recently' 3 = 'always', or 'currently'

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Depression? | 0 | 1 | 2 | 3 | Obsessiveness or compulsiveness? | 0 | 1 | 2 | 3 |
| Suicidal feelings? | 0 | 1 | 2 | 3 | Sadness or grief? | 0 | 1 | 2 | 3 |
| Frequent anger or irritation? | 0 | 1 | 2 | 3 | Frequent crying? | 0 | 1 | 2 | 3 |
| Tendency to repress emotions? | 0 | 1 | 2 | 3 | Anxiety or fear? | 0 | 1 | 2 | 3 |
| Mood swings? | 0 | 1 | 2 | 3 | Indecisiveness? | 0 | 1 | 2 | 3 |
| Manic episodes? | 0 | 1 | 2 | 3 | Difficulty handling stress? | 0 | 1 | 2 | 3 |

Have you ever been emotionally abused? ☐ YES ☐ NO

Have you ever been physically abused? ☐ YES ☐ NO

Have you ever been sexually abused? ☐ YES ☐ NO

Have you received treatment for any of the above abuses? ☐ YES ☐ NO

Have you received treatment for any other emotional issues? ☐ YES ☐ NO

Are you experiencing the effects of recent unusual stress or trauma (e.g. divorce, death of a loved one, bankruptcy, loss of a relationship or job, illness, injury, etc.)? ☐ YES ☐ NO

Is there a constant source of stress in your life, at work, with your family, or other? ☐ YES ☐ NO

Are there any other circumstances or challenges which may be affecting your health? ☐ YES ☐ NO

_____

_____

***OUTLOOK***

What is your objective in life? Seriously._____

_____

_____

What gives you the most happiness in your life?_____

_____

Who are the three most important people in your life?_____

Who is the most influential person in your life?_____

Do you perceive the needs of your friends and family as being more important than your own personal welfare?
☐ YES ☐ NO

Who do you believe is responsible for your current state of health?_____

Are you aware that if you discontinue treatment at the stage of symptom relief, your problem/s will come back?
☐ YES ☐ NO

How much time are you willing to invest to reach the stage of stabilization?_____

Do you have the support of your family in reaching stabilization? ☐ YES ☐ NO

Have you discussed your health needs with your spouse? ☐ YES ☐ NO

Is your family willing to see that financial resources are available for your treatment? ☐ YES ☐ NO

Do you have the financial resources to adequately resolve your condition through the stages of relief and stabilization?
☐ YES ☐ NO

Do you believe you can substantially improve your state of health? ☐ YES ☐ NO

***YOUR OWN WORDS***

Please express any additional issues, concerns, goals, or comments you'd like to address:_____

_____

_____

_____

_____

_____

_____

_____

_____

*Thank you for your diligence and sincerity in answering these questions.*