



Health History

Name		Today's Date	
Age	Date of Birth	Height	Weight
Please indicate if you have any of the following:			
<input type="checkbox"/> Cardiac pacemaker	<input type="checkbox"/> Seizure disorder		
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Fainting Disorder		
<input type="checkbox"/> Believe you are or may be pregnant	<input type="checkbox"/> HIV		
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Surgical implant; what kind? _____		
Chief Complaint			
List any current therapies or treatments		List all current prescription medications	
_____		_____	
_____		_____	
_____		_____	
Hospitalizations and Surgeries (specify reason and date)			

Social History			
Physical Work <input type="checkbox"/> Heavy <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> None Hours per day _____	Mental Work <input type="checkbox"/> Heavy <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> None Hours per day _____	Exercise <input type="checkbox"/> Heavy <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> None Hours / Week _____ Type _____	Meals <input type="checkbox"/> 3 Meals a Day <input type="checkbox"/> _____ a Day
Sleep _____ Hours / Night Wake Up Rested? <input type="checkbox"/> Yes <input type="checkbox"/> No	Nutritional Information <input type="checkbox"/> Low Sodium Diet <input type="checkbox"/> Diabetic Diet <input type="checkbox"/> Low Fat Diet <input type="checkbox"/> Vegetarian Diet <input type="checkbox"/> Low Cholesterol Diet <input type="checkbox"/> Other _____	Aspirin <input type="checkbox"/> None No. / Day _____ No. of Yrs. _____ Other _____	Caffeine <input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola <input type="checkbox"/> Other _____ Cups / Day _____
Alcohol <input type="checkbox"/> Beer / Week _____ <input type="checkbox"/> Liquor / Week _____ <input type="checkbox"/> Wine / Week _____ <input type="checkbox"/> None No. of Years _____	Smoking <input type="checkbox"/> None <input type="checkbox"/> Previous <input type="checkbox"/> Current No. of Yrs. _____ Quit Yr. _____	Miscellaneous Drugs <input type="checkbox"/> Vitamins <input type="checkbox"/> Herbs <input type="checkbox"/> Laxatives <input type="checkbox"/> Antacids <input type="checkbox"/> Pain Pills <input type="checkbox"/> Diet Pills <input type="checkbox"/> Sleeping Pills <input type="checkbox"/> Saccharin <input type="checkbox"/> NutraSweet <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Amphetamines <input type="checkbox"/> Others _____	
Have you experienced any major emotional/ physical trauma?		Allergies	
_____		_____	
Family History – please check applicable boxes below and indicate family member (F = father, M = mother, B = brother, S = sister, C = child)			
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Heart Disease _____	
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Mental Illness _____	
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Hay fever / Hives _____	<input type="checkbox"/> Kidney Disease _____	

Traditional Chinese Medicine Review of Symptoms

土 Earth Element Imbalances

- | | |
|--|--|
| <input type="checkbox"/> Often fatigued | <input type="checkbox"/> Cold hands and feet |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Feeling of heaviness or sluggishness |
| <input type="checkbox"/> Crave sweets | <input type="checkbox"/> Easily bruise |
| <input type="checkbox"/> Constant hunger | <input type="checkbox"/> Cystic or pustular acne |
| <input type="checkbox"/> Energy lower after a meal | <input type="checkbox"/> Aching joints, especially with movement |
| <input type="checkbox"/> Bloating after a meal | <input type="checkbox"/> Slow Wound Healing |
| <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Itching of ears |
| <input type="checkbox"/> Sour regurgitation / acid reflux | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Decreased Smell |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Nose Bleeding |
| <input type="checkbox"/> Flatulence | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Lacking of strength in arms and legs |
| <input type="checkbox"/> Constipation / dry stools | <input type="checkbox"/> Prone to worry |
| <input type="checkbox"/> Urgent, bright, or foul-smelling stools | <input type="checkbox"/> Dizziness, light-headed, or visual changes when stand up fast |
| <input type="checkbox"/> Loose stools, abdominal pain | |

火 Fire Element Imbalances

- | | |
|--|---|
| <input type="checkbox"/> Palpitations, especially when anxious | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fidgety |
| <input type="checkbox"/> Shortness of breath on exertion | <input type="checkbox"/> Prone to agitation or extreme restlessness |
| <input type="checkbox"/> Sweat excessively, especially on your chest | <input type="checkbox"/> Palpitations / Fluttering |
| <input type="checkbox"/> Wake up early in the morning and have trouble getting back to sleep | <input type="checkbox"/> Mouth Ulcers / Blisters |
| <input type="checkbox"/> Low in spirit or lacking in vitality | <input type="checkbox"/> Dream disturbed sleep / nightmares |
| <input type="checkbox"/> Propensity to be startled | <input type="checkbox"/> Blood in Urine |

金 Metal Element Imbalances

- | | |
|---|--|
| <input type="checkbox"/> Frequent Common Colds | <input type="checkbox"/> Spontaneous sweating |
| <input type="checkbox"/> Frequent Sore Throat | <input type="checkbox"/> Chronic Infection |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Eczema / Hives |
| <input type="checkbox"/> Recurrent Throat Infections | <input type="checkbox"/> Itching of skin |
| <input type="checkbox"/> Often sick or have allergies | <input type="checkbox"/> Skin Rashes |
| <input type="checkbox"/> Coughing Up Blood | <input type="checkbox"/> Nasal Congestion |
| <input type="checkbox"/> Decrease sense of smell | <input type="checkbox"/> Sinus Congestion |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Nasal Discharge |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Postnasal Drip | <input type="checkbox"/> Dryness of mouth and throat |

水 Water Element Imbalances

- | | |
|--|---|
| <input type="checkbox"/> Ankle pain
<input type="checkbox"/> Knee Pain
<input type="checkbox"/> Sore or weak lower back
<input type="checkbox"/> Mid Back Pain
<input type="checkbox"/> Cold feet, especially at night
<input type="checkbox"/> Typically colder than those around you
<input type="checkbox"/> Feel warmer than those around
<input type="checkbox"/> Wake up at night or early in the morning to urinate
<input type="checkbox"/> Pupils usually dilated and large
<input type="checkbox"/> Dental cavities, loose teeth
<input type="checkbox"/> Hair loss – all over the head
<input type="checkbox"/> Thirsty for cold drinks most of the time
<input type="checkbox"/> Mouth and throat usually dry
<input type="checkbox"/> Frequent Urinary Tract Infection
<input type="checkbox"/> Swollen Extremities | <input type="checkbox"/> Wake up sweating or have hot flashes
<input type="checkbox"/> Frequent urination, and urine is clear and/or profuse
<input type="checkbox"/> Frequent Urination at Night
<input type="checkbox"/> Difficult Urination <input type="checkbox"/> Painful Urination
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Ringing in the ears
<input type="checkbox"/> Low libido
<input type="checkbox"/> High libido
<input type="checkbox"/> Loose, urgent stools in the morning
<input type="checkbox"/> Describe yourself as “afraid/ fearful”
<input type="checkbox"/> Skeletal deformity
<input type="checkbox"/> Stunted growth
<input type="checkbox"/> Poor memory
<input type="checkbox"/> Deviated Septum |
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木 Wood Element Imbalances

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|---|--|
| <input type="checkbox"/> Arm Pain
<input type="checkbox"/> Neck / Shoulder Pain
<input type="checkbox"/> Upper Back Pain
<input type="checkbox"/> Periodic numbness of your hands and feet, especially at night
<input type="checkbox"/> Cherry red spots (red hemangiomas) on skin
<input type="checkbox"/> Prone to anger and/or rage
<input type="checkbox"/> Difficulty falling asleep at night
<input type="checkbox"/> Experience heartburn or wake up with a bitter taste in mouth
<input type="checkbox"/> Prone to chapped lips | <input type="checkbox"/> Hair loss – on top of head
<input type="checkbox"/> Brittle or dry hair
<input type="checkbox"/> Swelling eyes
<input type="checkbox"/> Tired after meals
<input type="checkbox"/> Pain / Strain of eyes
<input type="checkbox"/> Itching / Dry/ Red / Tearing / Burning eyes
<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Muscle Spasm / Cramps
<input type="checkbox"/> Dry, flaky skin
<input type="checkbox"/> Diminished nighttime vision
<input type="checkbox"/> Brittle fingernails or toenails |
|---|--|

Diagnosed Diseases

- | | |
|---|---|
| <input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> Crohn’s disease
<input type="checkbox"/> Diabetes Insipidus (Type I)
<input type="checkbox"/> Diabetes Mellitus (Type II)
<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Dizziness/vertigo
<input type="checkbox"/> Gastric Ulcers
<input type="checkbox"/> Earache
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Headaches/Migraine
<input type="checkbox"/> Head Injuries
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Hepatitis B or C
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Hemorrhoids or polyps
<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Graves’ Disease
<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Hashimoto’s Disease
<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver / Gallbladder Disease
<input type="checkbox"/> Neck Stiffness / Soreness / Lumps / Masses
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Stroke
<input type="checkbox"/> Seizures / Epilepsy |
|---|---|

Diagnosed Diseases (Cont.)

- Rheumatic Fever
- TMJ / Jaw Problems
- Loss of Balance
- Tuberculosis
- Rapid Heartbeat
- Urinary Tract Infection
- Uterine prolapsed
- Varicose or spider veins
- Vascular abnormality or blood clotting disorder

WOMEN'S Reproductive System

Libido (Sex Drive)

- Normal
- Low
- High

Breasts

- Lumps
- Tenderness
- Engorged / Painful Before Menses
- Nipple Discharge

Menstruation / Birthing History

- Bleeding Between Cycles
- Irregular Cycles
- Painful Menstruation
- Heavy Menstruation
- Vaginal Discharge
- Premenstrual
- Clotting
- Difficulty Conceiving
- Menopausal Symptoms
- Mood Changes
- Nausea
- Diarrhea / Constipation Before or During Menses

Menstrual Flow

- Normal
- Heavy
- Light

Color of Flow

- Bright Red
- Dark Red
- Purple
- Light Brown
- Brown

Age of 1st menses: _____ # of days of menses: _____ # of miscarriages: _____
 Birth control type: _____ # of pregnancies: _____ # of live births: _____
 Length of cycle: _____

MEN'S Reproductive System

Libido (Sex Drive)

- Normal
- Low
- High

- Feeling of Coldness or Numbness in External Genitalia
- Erectile Dysfunction / Impotence
- Testicular Pain or Swelling
- Penile Discharge
- Enlarged Prostate
- Low Sperm Count

Additional Health Concerns