Patient Name_____DOB_____Sex____Age_____

What are your main health concerns and /or reasons for your visit?

Past and Current Treatments for this complaint (therapy, practitioner, herbs, meds):

Severe Illnesses:

Injuries (including motor vehicle accidents):

Surgeries:

Chronic or continuing conditions:

Current Medications and Herbs/Vitamins:

Allergies:

Diet and Habits: (exercise, caffeine, tobacco, alcohol, other)

Please Check all of the following that apply:

Condition:	Past	Current	
Headaches	____	____	
Dizziness	____	____	
Ear ringing	____	____	
Eye floaters	____	____	
Stuffy nose	____	____	
Post nasal drip	____	____	
Ears blocked	____	____	
Hay fever	____	____	
Sinus headache	____	____	
Heart palpitations	____	____	
High blood pressure____		____	
Nightsweats	____	____	
Excessive thirst	____	____	
Vivid dreams	____	____	
Insomnia	____	____	
Nighttime urination	____	____	
Nausea	____	____	
Flatulence	____	____	
Heartburn	____	____	
Stomach bloating	____	____	
Loose stools	____	____	
Constipation	____	____	
Low back pain	____	____	
Knee pain	____	____	
Arthritis	____	____	Where?

Women:
Length of cycle (28 typical)____ Days of flow____
Cramps? ____ ____
PMS symptoms/describe:

Surgeries:

Number of pregnancies_____ Number of births_____ Number miscarriages_____
Number of abortions_____ Complications in any_____