Consultation Form

First Name (Print) Last Name (Print) Age Sex

Address City State Zip Code

Phone (Home) Phone (Work) Phone (Cell)

E-mail address Date

Referral Nationality Occupation

Below, describe all of your complaints on the left side of the page, then list how long you have had them and how you are treating them *directly opposite* on the right side. Be sure to mention any drugs, vitamin supplements, or other medicinal substances you are taking.

Complaints:	How long have you had it?	Treatment:

Brief Health History: (list major diseases, surgeries, etc.)

How many times per year do you get a cold or the flu?________________

Family Medical History:

What other medication and/or supplements are you taking? How long have you taken them?

Emotions: ____**Normal** ____**Problem**

____Depression ____Sadness Panic attack ____Sensitive

____Worries ____Overly excited ____Angry ____Anxiety

Describe:____________________

Energy: ____**Normal** ____**Problem** ____Low ____Up and down

____Exhausted ____Hyperactive ____Nervous energy ____Abundant

Describe:____________________

Sleep Pattern: ____**Normal** ____**Insomnia**

Falling Asleep: ____Sometimes difficult ____Always difficult ____Sometimes very difficult

____Always very difficult ____Sleepy in daytime ____Take naps

Waking up: ____Times per night ____Wake up too early

____Wake up at night and cannot go back to sleep again

Sleep Quality: ____Deep ____Light ____Poor ____Many dreams

____Bad dreams ____Grinding teeth ____Talking in sleep ____Other

Describe:____________________

Diet: Any special diet?

____**Food cravings**: ____Sugar ____Salt ____**Food allergies**

Describe:____________________

Temperature: ____**Normal** ____**Abnormal**

____Feel cold easily ____Cold hands ____Cold feet ____Feel hot easily

____Alternating hot & cold ____Hot flash ____Sensitive to weather changes

Describe:____________________

Sweating: ____**Normal** ____**Abnormal** ____Too easily ____Too much

____Difficult ____Too little ____Night sweats ____Other

Describe:____________________

Sensitivity and Allergy: ____No ____Yes

Temperature: ____Cold ____Hot ____Dampness ____Light

____Noise ____Airborne particles ____Drugs ____Other

Describe:____

Appetite and Digestion: ____Normal ____Abnormal

____Rapid hungering ____Poor appetite ____Nausea ____Anorexia

____Hungry, but no desire to eat ____Bloating ____Gas ____Other

Describe: ____

Bowel Movement: ____Normal ____Abnormal ____Time of day

____Constipation ____Diarrhea ____Loose ____Watery ____Incomplete

____Hard and dry ____Strong smell ____With mucus ____With blood ____Other

Describe:____

Body Weight: ____Normal ____Overweight ____Underweight

If overweight: ____How many pounds would you like to lose?

____How many years ago did you first start to gain weight?

____Are you following a weight control program at this time?

Describe:____

Drinking: ____Normal ____Abnormal

____Thirsty ____Dry mouth ____Drink a lot

____Dry mouth but no desire to drink

____Not thirsty, but drink a lot of water anyway

Describe:____

Urination: ____**Normal** ____**Abnormal**

____Frequent ____Urgent ____Burning ____Painful ____Cloudy

____Dark color ____Foul smell ____Bloody ____Difficult ____Retention

____Number of time per day ____Number of times you get up to urinate at night ____Other

Describe: ____________________

Eye, Ear, and Nose: ____**Normal** ____**Abnormal**

Describe:____________________

Sex Function: ____**Normal** ____**Abnormal**

Describe:____________________

Menstrual Cycle: Age of onset: _____years old Date of last period: ____/____/

____**Regular** ____**Irregular** ____How many days between cycles?

____How many days did it last?

Color: ____Pale red ____Dark red ____Bright red ____Purplish

Were there clots? ____Yes ____No

Menstrual Pain: ____Yes ____No

____Before flow ____During flow ____After flow

____Abdomen ____Back ____Breast

Emotion around period: ____Normal ____Abnormal

____Before flow ____During flow ____After flow ____Depression

____Irritability ____Anger ____Sadness ____Crying ____Other

Describe:____________________

Addictions: ____Tobacco ____Alcohol ____Others

Describe:____________________

Any other disorders or abnormalities:

Describe:____________________