Integrative Med Solutions®
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Patient Name: _____ Today's examination date: _____

Primary Care or Referring Physician (Name, Degree, Address, Zip, Phone/Fax and Email Address)
Please additionally list the name of whoever else may have referred you for our services.

_____

_____

A NOTE TO OUR PATIENTS: Naturopathic and preventative health care are only possible when the physician has a complete picture of the patient physically, mentally and emotionally. Therefore, please take this time to carefully and thoroughly complete this health history questionnaire.

I. PROBLEM LIST (PL)

A. In your opinion, what are the most important health concerns?

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Others: _____

B. What of the above problems are of most immediate concern to you? #?

_____

II. HISTORY OF THE PRESENT ILLNESS

A. Describe further your health concerns (problem list)? What makes them better or worse? (Palliation), Quality of pain?, Radiation of pain?, Severity of pain?, Time/Date of onset & duration? (PQRST)

PL#1 _____

PL#2 _____

PL#3 _____

PL#4 _____

B. ETIOLOGY

How did these conditions develop? Are there traumatic events (surgeries, drug reactions, light trauma) that you can identify having caused or clearly aggravated your health problems.

B. PRIOR TREATMENTS AND RESPONSES

Please list all of the former treatments you have used, both conventional and alternative and the degree of effectiveness of each treatment. Please be specific about the benefits you received (if any) from each treatment. This greatly aids us in developing an optimal treatment plan for you.

C. PRIOR DOCTOR-PATIENT RELATIONSHIP

Please take a moment to reflect on your past relationships with physicians and note how the relationship with future physicians could improve to optimize your health care. What do you need from a physician that you have not received? How can you become effective in your role with your physician?

III. PAST MEDICAL HISTORY

A. YOUR HEALTH HISTORY

NOW	PAST	NEVER		NOW	PAST	NEVER	
☐	☐	☐	Anemia	☐	☐	☐	Diabetes
☐	☐	☐	Arthritis	☐	☐	☐	Hypoglycemia
☐	☐	☐	Asthma	☐	☐	☐	Allergies
☐	☐	☐	Alcoholism	☐	☐	☐	Candida (Yeast)
☐	☐	☐	Bleeding	☐	☐	☐	Emphysema
☐	☐	☐	Cancer	☐	☐	☐	Eczema
☐	☐	☐	Colitis	☐	☐	☐	Drug/alcohol use (Specify)
☐	☐	☐	Heart Murmur	☐	☐	☐	_____
☐	☐	☐	High Blood Pressure	☐	☐	☐	Headache
☐	☐	☐	Injury (serious)	☐	☐	☐	Pneumonia
☐	☐	☐	Kidney Disease	☐	☐	☐	Rheumatism
☐	☐	☐	Liver Dz/Jaundice	☐	☐	☐	Thyroid
☐	☐	☐	Overweight	☐	☐	☐	☐ Hyper ☐ Hypo
☐	☐	☐	Ulcers	☐	☐	☐	Tuberculosis
_____			Other (specify)	☐	☐	☐	Venereal Disease

B. CHILDHOOD ILLNESSES

☐ Rubella (German 3 day measles) ☐ Measles (2 week) ☐ Mumps ☐ Chicken pox
☐ Whooping Cough ☐ Polio ☐ Rheumatic Fever ☐ Scarlet Fever
☐ Roseola ☐ Asthma ☐ Others _____
☐ Adverse reactions to childhood vaccinations _____

C. HOSPITALIZATIONS (list as best as you can)

Type of illness or operation/procedure | Date | Summary of findings (if known)

_____ _____ _____
_____ _____ _____

D. IMAGING (Chest-Spinal X-Rays,CT Scans, Mammograms, Ultrasounds, MRI, angiogram, arterial-venous studies, etc.)

Date | Summary of findings (if known)

_____ _____ _____
_____ _____ _____

E. PROCEDURES (PAP, EKG, Stress test, holter monitor, spirometry, sigmoid/colonoscopy, TB test, IVP, cystoscopy, bronchoscopy, if older than 50, list date of last glaucoma check, etc.

_____ _____ _____
_____ _____ _____

F. LAB (Blood, urine analysis, PSA, thyroid, etc.)

_____ _____ _____
_____ _____ _____

G. CHRONOLOGY Now that your medical past is clear, please use the space below to very briefly list the chronology of major life stresses that have adversely effected your health beginning from conception (en utero) to the present. Include life stressors, drug or surgical complications, major illnesses and any significant mental, emotional, and physical trauma. Simply list the date and event Example: 1982: divorce -> irregular menstrual cycle, 1989 : mono - Chronic fatigue.

_____
_____
_____
_____

IV. FAMILY HISTORY Please list ages and if deceased, what they died from and at what age. Please list any chronic health problems of your living parents and siblings.

A. ANCESTRAL MEDICAL HISTORY

Mother's Side

Grandfather _____
Grandmother _____
Mother _____
Sister/s _____
Brother/s _____

Father's Side

Grandfather _____
Grandmother _____
Father _____

B. Has any BLOOD RELATIVE had any of the following:

YES	NO	DK (don't know)		YES	NO	DK (don't know)	
☐	☐	☐	Anemia	☐	☐	☐	Hay Fever
☐	☐	☐	Arthritis	☐	☐	☐	Heart Attack/High Blood
☐	☐	☐	Asthma	☐	☐	☐	Pressure
☐	☐	☐	Bleeding (Easily)	☐	☐	☐	Seizure/Epilepsy
☐	☐	☐	Cancer (Type?) _____	☐	☐	☐	Sickle Cell Anemia
☐	☐	☐	Diabetes	☐	☐	☐	Stroke
☐	☐	☐	Eczema	☐	☐	☐	Thyroid (hyper/hypo)
☐	☐	☐	Glaucoma	☐	☐	☐	Tuberculosis (TB
☐	☐	☐	Gout	☐	☐	☐	Venereal Disease)

Other _____

V. ALLERGIC HISTORY

A. Please list any drugs, food, airborne or other substances you are allergic to.

_____

B. What happens when you have an "allergy attack?"

_____

_____

C. List any chronic problems you have that may have resulted from a prior medication? What was the medicine and what problems did you develop?

_____

_____

D. What prior types of allergy testing have you had?

☐ Intradermal	☐ Blood IgG food	☐ Blood IgG inhalant/food	☐ Cylotoxic
☐ Electroacupuncture	☐ Kinesiology	☐ Food intolerance testing	☐ None

VI. SOCIAL HISTORY

Does income meet monthly expenses? ☐ Yes ☐ No

Are you currently married? _____ divorced? _____ number of children? _____

Have you traveled outside the US in the past year? ☐ Yes ☐ No Where? _____

Military Status: When did you serve? _____ Where?_____ Discharge Status _____

VII. MEDICATIONS

A. Drugs and other medication allergies: _____

B. List any chronic problems you have that may have resulted from a prior medication. List the Rx. and the problem _____

_____

_____

C. Please bring all prescription, over the counter drugs and supplements with you to your first visits. In table on the next page, please list the drugs and natural medicine products you take, the dose per pill, # of pills taken and the time of day taken.

PRESCRIPTION & OVER THE COUNTER DRUGS Please list drug name & dose of pill, ex: Lanoxin 0.25 mg. In the box to the right of the medication, list the date you started/or stopped taking the medicine followed by the number of pills taken at the designated time of day.	Start or Stop date	# refills	on rising	breakfast	breakfast/lunch	lunch	lunch/dinner	dinner	bedtime
NATURAL MEDICATIONS: Vitamins, minerals, herbs, homeopathics.									

VIII. HEALTH HABITS

A) ALCOHOL

How often do you drink: wine _____ beer _____ other alcohol _____

B) TOBACCO

Do you currently use tobacco? ☐ Yes ☐ No Total years _____ packs/year? _____

Have you used tobacco in the past? ☐ Yes ☐ No Total years _____ packs/year? _____

C) OTHER DRUGS

If yes, have you developed any chronic problems from their use? _____

_____

D) CHEMICAL EXPOSURES

explain_____

_____

E) EXERCISE

Do you exercise? ☐ Yes ☐ No Which of the following do you do on a regular basis:

☐ Jog ☐ Swim ☐ Walk ☐ Bicycle ☐ Gardening ☐ Yoga ☐ Breathing Exercises

☐ Meditation ☐ Weightlifting ☐ Other: _____

How often do you exercise? _____

F) RELAXATION

Do you make time for rest, relaxation, or meditation during the day and/or before bed?

☐ Yes ☐ No How often?_____ How do you relax?_____

G) HOBBIES

What are your interests or hobbies? _____

H) DIET

How many meals do you generally eat each day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Where do you usually buy your food? _____

Who cooks this food you eat?_____

List the primary foods included in your diet?_____

_____

List the primary foods excluded in your diet?_____

_____

List any of the following (and relative amounts) eaten regularly by you. Coffee, foods, and other foods you suspect may be harmful to your health_____

_____

List any food you crave, regardless of their nutritional value (include sweets, chocolate, salty, sour, bread, rich/fatty foods, etc.) _____

_____

List any food to which you have a bad reaction: _____

_____

Are you satisfied with your diet as it is now? ☐ Yes ☐ No If no, why not? _____

_____

I) WATER CONSUMPTION

Are you thirsty? ☐ Yes ☐ No Amount of liquid you drink each day: _____

What temperature do you prefer to drink? ☐ Hot ☐ Cold ☐ Room Temperature

J) PERSONAL CARE Which of the following do you use on a regular basis

☐ Dry brushing of skin ☐ Enemas ☐ Colonic Irrigation ☐ Hot/Cold Baths ☐ Saunas
☐ Shower ☐ Steam ☐ Mineral Bath ☐ Oils ☐ Clay Baths
☐ Toothbrush/_____day ☐ Flossing ☐ Hair Spray ☐ Deodorant ☐ Cosmetics
☐ Elec. Hair Dryer/Blanket

What type of clothing do you wear? ☐ Cotton ☐ Wool ☐ Synthetic ☐ Dyed

Are you intolerant of tight fitting clothes or neck ties? ☐ Yes ☐ No

K) SLEEP

Do you have trouble falling asleep? ☐ Yes ☐ No If so, what keeps you awake _____

_____

Do you sleep through the night? ☐ Yes ☐ No

Do you wake up refreshed? ☐ Yes ☐ No

Do you have recurring dreams? ☐ Yes No If yes, what is the theme? _____

What position do you sleep in? _____

Is there a position that you cannot sleep in? ☐ Yes No If yes, which one? _____

L) JOB SATISFACTION

How do you feel about your work? Do you enjoy it; are you satisfied and fulfilled by it; does it provide you with the necessities of life; is it a job that you feel you must do in order to make a living? _____

_____

IX. HOME ENVIRONMENT AND OTHER ENVIRONMENTAL EXPOSURES

A) Which of the following do you routinely use at home?

☐ Forced Air ☐ Oil Heat ☐ AC ☐ Microwave ☐ Heated Waterbed
☐ Radiant Heat ☐ Electric Heat ☐ Electric Blanket ☐ Feather Pillow ☐ Computer Screen
☐ Gas Heat ☐ Wood Stove ☐ T.V. ☐ Other (specify) _____

B) WATER ☐ Distilled ☐ Filtered ☐ Spring ☐ Well ☐ Deionized ☐ Tap

C) Are your home and/or work environments well ventilated? ☐ Yes ☐ No ☐ Damp ☐ Moist

D) Are there unusual/unpleasant smells in your work/living environment? ☐ Yes ☐ No

E) When were the ducts in your house last cleaned? _____

F) Which of the following are most bothersome to you or are known allergies?

☐ Sunshine ☐ Summer ☐ Mold ☐ Dogs ☐ Tobacco smoke
☐ Lack of sunshine ☐ Grass/weed ☐ Dust ☐ Cats ☐ Car fumes
☐ Fall ☐ Cold ☐ Dryness ☐ Seashore ☐ Poor air ventilation
☐ Winter ☐ Heat ☐ Dampness ☐ Mountains ☐ Approach of storms
☐ Spring ☐ Tree pollens ☐ Perfume ☐ New Moon ☐ Fluorescent lighting
☐ Foods (specify) _____ ☐ Change of weather (specify) _____
☐ Chemicals (specify) _____ ☐ Other (specify) _____

G) Do you get outdoors daily, even in the winter? ☐ Yes ☐ No

X. REVIEW OF SYMPTOMS

NOTE: Please mark (1) =MILD, (2) =MODERATE, (3) = SEVERE next to the following symptoms which apply to you NOW or in the PAST.

Integument (Skin)

NOW PAST

_____ _____ Skin rough, dry, scaly, bumpy, itchy (Please circle if applicable)
_____ _____ Rashes, warts, moles, cysts (circle those applicable)
_____ _____ Have any of these changed in color or size recently? _____
_____ _____ Light or dark patches of skin (circle those applicable)
_____ _____ Pimples List location(s) _____
_____ _____ Color changes, ridges, pits, white spots on nails (please circle)
_____ _____ Loss of hair List location(s) _____
_____ _____ Hives List what causes them. _____
_____ _____ Scars List location(s) _____

Hematopoietic, Lymph, Immune

NOW	PAST		NOW	PAST	
_____	_____	Painful lymph nodes	_____	_____	Wounds heal slowly
_____	_____	Difficulty stopping bleeding	_____	_____	Anemia
_____	_____	Bleeding from unusual places	_____	_____	Swollen glands
_____	_____	Bruising easily	_____	_____	Fluid retention

Endocrine

NOW	PAST		NOW	PAST	
_____	_____	Unexplained weight loss/gain	_____	_____	Cold hands or feet
_____	_____	Prefers hot weather	_____	_____	Chronic fatigue
_____	_____	Prefers cold weather	_____	_____	Weakness
_____	_____	Can't stand cold	_____	_____	Increased thirst
_____	_____	Can't stand heat	_____	_____	Increased hunger

Head

NOW	PAST		NOW	PAST	
_____	_____	Dizziness	_____	_____	Double vision
_____	_____	Severe headaches	_____	_____	Fainting Spells
_____	_____	Seizures, convulsions			

Eyes

NOW PAST

_____ _____ Poor eyesight (near or far-sighted)
_____ _____ Light hurts eyes

Ears

NOW	PAST		NOW	PAST	
_____	_____	Discharge from ears	_____	_____	Pain in ears
_____	_____	Hearing problems	_____	_____	Ringing in ears
_____	_____	Sensitivity to noise	_____	_____	Date of last hearing test

Nose

NOW	PAST		NOW	PAST	
_____	_____	Nose bleeds	_____	_____	Loss of smell
_____	_____	Sinus congestion	_____	_____	Nasal scabs/crusts

Mouth

NOW	PAST		NOW	PAST	
_____	_____	Sore mouth or tongue	_____	_____	Loss of teeth
_____	_____	Speech difficulties	_____	_____	Cold sores, blisters
_____	_____	Bleeding gums	_____	_____	Amount of Mercury Amalgam

Throat

NOW	PAST		NOW	PAST	
_____	_____	Persistent hoarseness	_____	_____	Loss of voice
_____	_____	Difficulty swallowing	_____	_____	Pain
_____	_____	Recurrent strep throat	_____	_____	Chronic sore throat

Neck

NOW	PAST		NOW	PAST	
_____	_____	Stiffness	_____	_____	Injuries
_____	_____	Swelling	_____	_____	Pain (describe area/type) _____

Pulmonary (Respiratory)

NOW	PAST		NOW	PAST	
_____	_____	Unexplained fever	_____	_____	Dry Sweats
_____	_____	Chest pain while breathing	_____	_____	Night sweats
_____	_____	Wheezing	_____	_____	Shortness of breath
_____	_____	Difficulty breathing at night	_____	_____	Daily cough

Have you ever been exposed to T.B. (Tuberculous)? ☐ Yes ☐ No

How many pillows do you sleep on? _____

Cardiovascular

NOW	PAST		NOW	PAST	
_____	_____	Chest pain when walking	_____	_____	Leg vein problems
_____	_____	Chest pain when sit/lying	_____	_____	Leg pain when walking
_____	_____	Ankle or abdominal swelling	_____	_____	Numbness/tingling in extremities
_____	_____	Heart palpations-fibrillation flutter, skipping beat, beating fast, beating slow (circle if yes)	_____	_____	Heart murmur (list type)_____

Have you ever had rheumatic fever or syphilis? ☐ Yes ☐ No If yes, when? _____

How far can you walk? _____ How many stairs can you climb before having to stop? _____

What symptoms make you stop? _____

Gastrointestinal

NOW	PAST		NOW	PAST	
_____	_____	Constipation	_____	_____	Indigestion immediately after a meal
_____	_____	Diarrhea	_____	_____	Indigestion 2-3 hours after meals with fullness, bloating, or pain
_____	_____	Alternating constipation, diarrhea			
_____	_____	Change in bowel movements	_____	_____	Stomach pain 5-6 hours after eating, usually at night,relieved by eating or drinking
_____	_____	Vomiting blood			
_____	_____	Strain at stooling	_____	_____	Above symptoms worse with worry, stress & tension
_____	_____	Heavy, full after eating			
_____	_____	Hemorrhoids	_____	_____	Frequency of bowel movements per day
_____	_____	Black stools	_____	_____	Nervous, shaky with headaches relieved by sweets.
_____	_____	Blood in stools			
			_____	_____	Sudden strong cravings for sweets or alcohol

Gastrointestinal (continued)

NOW	PAST		NOW	PAST	
_____	_____	Stools - yellow, grey, green, foul odored, black, undigested matter (circle applicable)	_____	_____	Irritable if late for a meal, miss meal or prior to breakfast
_____	_____	Date of last hemoccult test (hidden blood in stool)	_____	_____	Loss of appetite
			_____	_____	Insatiable appetite
_____	_____	Frequent/severe nausea	_____	_____	Weight change – increase or decrease (circle which)
_____	_____	Heartburn			
_____	_____	Trouble swallowing	_____	_____	Diet but fail to lose weight
_____	_____	Excessive belching	_____	_____	Eat but fail to gain weight
_____	_____	Excessive lower bowel gas	_____	_____	Overweight
_____	_____	Difficulty belching, stomach cramps, colic	_____	_____	Underweight
_____	_____	Abdominal bloat/distension	_____	_____	Compulsive eating
_____	_____	Distress from fat or greasy foods	_____	_____	Addictive eating
_____	_____	Bad breath	_____	_____	Anorexia
_____	_____	Body odor (including feet)	_____	_____	Bulimia
_____	_____	Bad taste in mouth	_____	_____	Stomach/abdominal pain
_____	_____	Intestinal parasites suspected	_____	_____	Yellow jaundice

Urinary

NOW	PAST		NOW	PAST	
_____	_____	Frequent urination	_____	_____	Painful urination
_____	_____	Night urination	_____	_____	Difficult starting urine
_____	_____	Difficulty holding urine	_____	_____	Blood in urine

Male Reproductive

NOW	PAST		NOW	PAST	
_____	_____	Prostate problems	_____	_____	Painful erection
_____	_____	Swelling, lumps, pain in testicles	_____	_____	Difficulty achieving maintaining erection
_____	_____	Discharge from penis	_____	_____	Date of last prostate exam
_____	_____	Infertility	_____	_____	Difficulty or premature ejaculation

Are you currently sexually active? ☐ Yes ☐ No What type of contraception do you use? _____

Female Reproductive

NOW	PAST		NOW	PAST	
_____	_____	Lump in breast(s)	_____	_____	Painful sex
_____	_____	Nipple discharge	_____	_____	Lack of sexual desire
_____	_____	Breast pain	_____	_____	Difficulty feeling sexual arousal
_____	_____	Pelvic pain	_____	_____	Never/seldom have orgasms
_____	_____	Discharge from vagina	_____	_____	Menstruation excessive
_____	_____	Vaginal itching/burning	_____	_____	Menstruation absent
_____	_____	Genital eruptions	_____	_____	Bleed/spot between periods
_____		Type?			

Have you ever used birth control pills? ☐ Yes ☐ No If yes, how long? _____

Side effects? _____

Are you currently sexually active? ☐ Yes ☐ No What type of contraception do you use? _____

Age of menstruation? _____ Did you have a normal puberty? ☐ Yes ☐ No

Periods occur _____ days. Regular? ☐ Yes ☐ No

Periods usually last _____ days (average). Date of last period _____

Female Reproductive (continued)

Please mark B if before, D if during, or A if after menstruation.

PM-T ("Anxiety")

_____ Nervous tension
_____ Irritability
_____ Mood changes
_____ Anxiety
_____ Insomnia

PM-D ("Depression")

_____ Depression
_____ Forgetful
_____ Crying
_____ Confusion

PM-C ("Craving")

_____ Headaches
_____ Craving for sweets
_____ Increased Appetite
_____ Heart pounding
_____ Dizziness or fainting
_____ Fatigue

PM-H ("Hyperhydration")

_____ Weight gain
_____ Abdominal bloating
_____ Extremity swelling
_____ Breast tenderness

Have you had in the past, or do you currently have problems with infertility?_____

___# of pregnancies ___# of births ___# of miscarriages ___# of abortions

Have you has any complications due to pregnancy? ☐ Yes ☐ No If yes, please explain_____

Pituitary

NOW	PAST		NOW	PAST		NOW	PAST	
_____	_____	Failing memory	_____	_____	Menstrual disorders	_____	_____	Decrease sex desire
_____	_____	Low blood pressure	_____	_____	High/Low sugar tolerance	_____	_____	Chunky hips or waist
_____	_____	Increase sex desire	_____	_____	Intestinal bloating	_____	_____	Ulcers, colitis
_____	_____	Splitting headaches	_____	_____	Abnormal thirst			

Thyroid

NOW	PAST		NOW	PAST		NOW	PAST	
_____	_____	Overweight	_____	_____	Chilly/sensitive to cold	_____	_____	Irritable/restless
_____	_____	Difficulty losing weight	_____	_____	Mental slowness	_____	_____	Increased appetite
_____	_____	Constipation	_____	_____	Decrease appetite	_____	_____	Underweight
_____	_____	Tired upon rising	_____	_____	Nervousness	_____	_____	Flush/get hot easily
_____	_____	Easily fatigued	_____	_____	Heart palpitations	_____	_____	Insomnia
_____	_____	Dry or scaly skin						

Adrenals

NOW	PAST		NOW	PAST		NOW	PAST	
_____	_____	Easily stressed	_____	_____	Bronzing on the skin	_____	_____	Poor circulation
_____	_____	Easily/chronically fatigued	_____	_____	Craves salt	_____	_____	Increased blood pressure
_____	_____	Dizziness	_____	_____	Nails weak, ridged	_____	_____	Weak after getting a cold
_____	_____	Headaches	_____	_____	Tendency to get hives	_____	_____	Facial hair (women)
_____	_____	Hot flashes	_____	_____	Rheumatism/arthritis			

Sympathetic Nervous System

NOW	PAST		NOW	PAST		NOW	PAST	
_____	_____	Upset from acid foods	_____	_____	Gag easily			
_____	_____	Dry eyes, nose, mouth	_____	_____	Very quick mentally	_____	_____	Decreased urine output
_____	_____	Nervousness	_____	_____	Cold extremities	_____	_____	Heart pounds when lying
_____	_____	Wound heal slowly	_____	_____	Light sensitive	_____	_____	Reduced appetite
								Frequent cold sweats

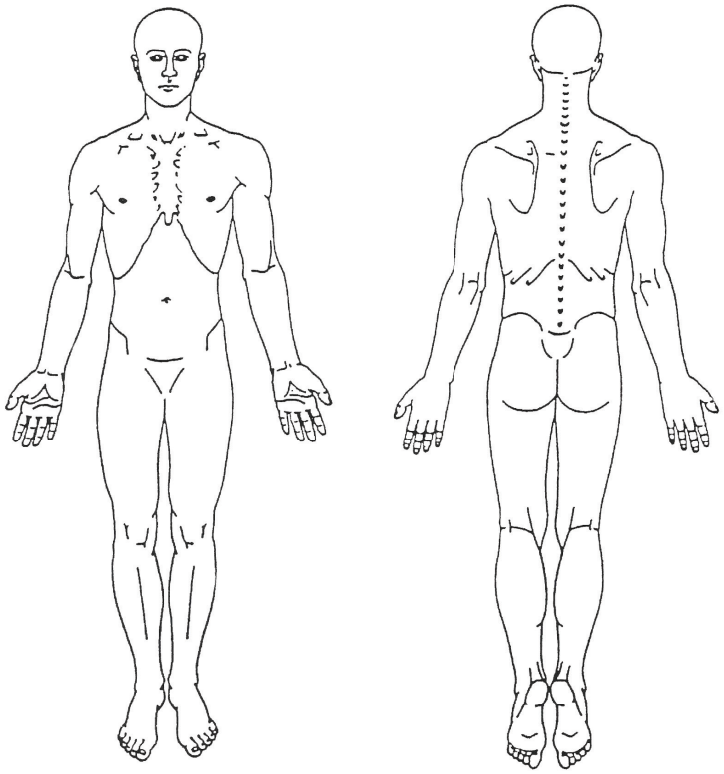
Parasympathetic Nervous System

NOW	PAST		NOW	PAST	
_____	_____	Joint stiffness on rising	_____	_____	Frequent vomiting
_____	_____	Muscle/leg/toe cramps	_____	_____	Alternating constipation/diarrhea
_____	_____	Butterfly stomach cramps	_____	_____	Pulse slow/irregular
_____	_____	Digestion rapid	_____	_____	Breathing irregular
_____	_____	Indigestion after eating	_____	_____	Poor circulation
_____	_____	Perspiration scant/absent	_____	_____	Eyelids swollen/puffy
_____	_____	Perspire easily/profusely			

Central and Peripheral Nervous System

NOW	PAST		NOW	PAST	
_____	_____	Loss of balance/fainting	_____	_____	Paralysis
_____	_____	Dizziness regularly	_____	_____	Numbness/tingling (circle)
_____	_____	Convulsions (seizures)	_____	_____	Temporary loss of sensation
_____	_____	Tremor (shaking, trembling)	_____	_____	Lack of strength Where? _____
_____	_____	Blurred/double vision	_____	_____	Continual headaches
_____	_____	Is one arm or leg shorter than the other? ☐ Yes ☐ No			

Please mark your problem and painful areas as exactly as possible with an X on the diagram below.



Spine and Extremities

NOW	PAST		NOW	PAST	
_____	_____	Joint pains/swelling stiffness (mark location)	_____	_____	Muscle cramps
_____	_____	Backaches (mark location)	_____	_____	Unusual redness of palms of hand
_____	_____	Burning on soles of feet or palms of hands (circle)	_____	_____	Coughing, sneezing, or straining at stools intensifies back pain

General Status

Listed below are factors which may or may not influence your state of being.
Please mark the appropriate box signifying their influence.

BETTER	WORSE		BETTER	WORSE	
☐	☐	Winter	☐	☐	Spring
☐	☐	Summer	☐	☐	Autumn
☐	☐	Cold	☐	☐	Heat
☐	☐	Dampness	☐	☐	Storms
☐	☐	Sun	☐	☐	Wind
☐	☐	Open air	☐	☐	Confined (stuffy) air
☐	☐	Change of weather	☐	☐	Moonlight
☐	☐	Ocean seashore	☐	☐	Mountains
☐	☐	Physical exertion	☐	☐	Upon rising
☐	☐	Morning	☐	☐	Afternoon
☐	☐	Evening	☐	☐	Night
☐	☐	Bath	☐	☐	Warm application
☐	☐	Cold application	☐	☐	Traveling
☐	☐	Before menstruation	☐	☐	During menstruation
☐	☐	After menstruation	☐	☐	Other _____

What are your best and worst times of day? _____

What time of day is your energy level highest and lowest? _____

_____

Mental Status

NOW	PAST		NOW	PAST	
_____	_____	Anxiety	_____	_____	Memory difficulty, forgetting
_____	_____	Restlessness	_____	_____	Mental confusion
_____	_____	Excessive worry	_____	_____	Decreased concentration, comprehension
_____	_____	Depression	_____	_____	Make many mistakes
_____	_____	Despair/Discontent	_____	_____	Shy, timid
_____	_____	Suicidal thoughts	_____	_____	Critical of self
_____	_____	Suicide attempts	_____	_____	Critical of others
_____	_____	Loneliness/feel alone	_____	_____	Lack self-confidence
_____	_____	Mood swings	_____	_____	Suspicious/jealous
_____	_____	Prefer to be with company	_____	_____	Organized, neat/clean
_____	_____	Prefer to be alone, don't see out company	_____	_____	Affectionate
_____	_____	Afraid when left alone	_____	_____	Assertive, powerful
_____	_____	Would rather be left alone when not feeling well	_____	_____	Confident, secure
			_____	_____	Intimate with others

*****THANK YOU FOR YOUR COOPERATION, PATIENCE AND THOROUGHNESS*****