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:_____
