lama.			
Name:			

#### **Dear New Patient:**

- a) Please read and fill in all of the information that pertains to you.
- b) On pages 2 through 11, under each category, **check all** symptoms that you experience either acutely or chronically.
- c) Add and total all of the boxes you check.
- d) Date today's date.

Test	Date	Test Results	
Physical Cholesterol Prostate Mamography Pap Smear Blood (which test?) HIV/STD Other			

Please indicate if you have (or have been tested for) any of the following								
Diabetes		Allergies		Rheumatic Fever		Vein Condition		
Heart Disease		CVA (stroke)		Thyroid Disorder		Tuberculosis		
Asthma		Pneumonia		Emphysema		Chicken Pox		
High Blood Pressure		Gonnorhea		Bleeding Tendency		Polio		
Syphilis		Measles		Nervous Disorder		Migraines		
Meningitis		HIV		Monoucleosis		Other Liver Illnesses		
Epilepsey		High Fever		Multiple Sclerosis		Other Heart Illnesses		
Paralysis		Cancer		Jaundice		Other Kidney Illnesses		
Glaucoma		Mumps		Hepatitis		Other Lung Illnesses		

Immunizations?						

Surgeries?	

1. Pain						below, please and indicate any	mark clearly any v scars.
What ma Soft Pre Hard Pre Cold Hot Exercise Rest Other	essure	S H C H	makes the pain oft Pressure ard Pressure old ot xercise est ther	worse?			
2. Desci	ribe Your Pain	FOR LONG TER LONGER pertain your boxes and e	to you, or if you_	HAVE NOT exp	ay of your re-exan perienced the sym		
Sharp Fixed Burning Moving Cramping Aching Dull Other: Total Box	xes Checked	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
Date		Date:	Date:	Date:	Date:	Date:	Date:

5.	Liver, Spleen, Heart Function	FOR LONG TERM PATIENTS ONLY: On the day of your re-exam only check the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and enter current date.								
		your boxes and enter current date.  Re-Exam 1 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 5 Re-Exam 6								
	±0.0	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6			
	Dizziness See floating black spots									
	Total Boxes Checked	Total	Total	Total	Total	Total	Total			
Date		Date:	Date:	Date:	Date:	Date:	Date:			
6.	Heart	FOR LONG TERM PATIENTS ONLY: On the day of your re-exam only check the boxes that <a href="LONGER">LONGER</a> pertain to you, or if you <a href="HAVE NOT">HAVE NOT</a> experienced the symptoms for two weeks. <a href="Add upper boxes">Add upper boxes</a> and enter current date.								
		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6			
	Anxiety Sores on tip of tongue Restlessness Mental confusion Chest pain traveling to shoulder Frequent dreams Wake unrefreshed Coffee? How much per week?									
	Total Boxes Checked	Total	Total	Total	Total	Total	Total			
Date		Date:	Date:	Date:	Date:	Date:	Date:			
7.	Spleen Function	LONGER perta		ou <u>HAVE NOT</u> e	day of your re-exa xperienced the sy					
		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6			
	Low Appetite Abrupt Weight Gain Abrupt Weight Loss Abdominal Bloating Abdominal Gas (Continued)									

3.	Kidney Function (Overall Temperature)	NO LONGE	TERM PATIENT R pertain to you, boxes and enter	or if you HAVE I		The state of the s	
		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
Date	Cold Fingers Cold Toes Cold Feet Sweaty Hands Sweaty Feet Hot Body Temperature Sensation Cold Body Temperature Sensaton Afternoon Flushes Night Sweats Heat in the hands, feet & chest Hot flashes any time of the day Thirsty Perspire easily Lack of perspiration Do you take water to bed Total Boxes Checked	Total Date:	Total Date:	Total Date:	Total Date:	Total Date:	Total Date:
			7511458077000				
4.	Lung, Kidney Function (Overall Energy)	NO LONGER Add up your	TERM PATIENT Repertain to you, boxes and enter	or if you HAVE Note to current date.	IOT experienced	I the symptoms t	for two weeks.
		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
	Shortness of breath Difficulty keeping eyes open (daytime) General Weakness Easily catch colds Low Energy Feel worse after exercise Chronic (daily) fatigue & malaise Total Boxes Checked	Total	Total	Total	Total	Total	Total
Date	TOTAL BOXES OFFICERED	Date:	Date:	Date:	Date:	Date:	Date:

7.	Spleen Function	Cont'd	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	D. F
	Gurgling noise in stomach Fatigue after eating Prolapsed Organs? Which? Bruise easily? Over-Thinking Worry		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
	Total Boxes Checked		Total	Total	Total	Total	Total	Total
Date			Date:	Date:	Date:	Date:	Date:	Date:
8.	Lung Function		LONGER perta		ONLY: On the da u <u>HAVE NOT</u> exp te. Re-Exam 3	perienced the syr		
	Nasal discharge (color)							Tto Exam o
	Cough						======	
	Nose Bleeds							
	Sinus Congestion							
	Dry Mouth		<u> </u>					
	Dry Nose							
	Dry Skin Allergies (what?	v.						
	Alternating Chills/Fever							
	Sneezing							
	Heartache (location	)						
	Overall achy feeling in body							
	Stiff Neck							
	Stiff Shoulders							
	Sore Throat							
	Difficulty breathing							
	Smoke cigarettes (# per day	)						
	Saddness							
	Melancholy							
	Total Boxes Checked		Total	Total	Total	Total	Total	Total
Date			Date:	Date:	Date:	Date:	Date:	Date:

9.	Spleen, Stomach, Small / Large intestine Function	LONGER pert	FOR LONG TERM PATIENTS ONLY: On the day of your re-exam only check the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and enter current date.							
		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6			
	Loose Stools Constipated Incomplete Stools Diarrhea Blood in Stools Mucous in Stools Undigested food in the stools									
	Total Boxes Checked	Total	Total	Total	Total	Total	Total			
Date		Date:	Date:	Date:	Date:	Date:	Date:			
10.	Stomach Function	FOR LONG TI	ERM PATIENTS	ONLY: On the d	ay of your re-exa	m only check the	ooxes that NO			
10.	Stomach Function	LONGER pert your boxes an	ain to you, or if yo d enter current <u>da</u>	ou <u>HAVE NOT</u> ex ate.	xperienced the sy	mptoms for two w	eeks. Add up			
10.	Burning sensation after eating Large appetite Bad Breath Canker Sores (mouth) Bleeding, swollen or painful gums Heartburn Acid Regurgitation Ulcer (diagnosed?) Belching Hiccoughs Stomach Pain Vomiting	LONGER pert your boxes an Re-Exam 1	ain to you, or if you denter current da Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6			
10.	Burning sensation after eating Large appetite Bad Breath Canker Sores (mouth) Bleeding, swollen or painful gums Heartburn Acid Regurgitation Ulcer (diagnosed?) Belching Hiccoughs Stomach Pain	LONGER pert your boxes an	ain to you, or if yo d enter current <u>da</u>	ou <u>HAVE NOT</u> ex ate.	xperienced the sy	mptoms for two w	eeks. Add up			
10.	Burning sensation after eating Large appetite Bad Breath Canker Sores (mouth) Bleeding, swollen or painful gums Heartburn Acid Regurgitation Ulcer (diagnosed?)	LONGER pert your boxes an	ain to you, or if yo d enter current <u>da</u>	ou <u>HAVE NOT</u> ex ate.	xperienced the sy	mptoms for two w	eeks. Add			

11.	Dampness Trapped in the	The state of the s	FOR LONG TERM PATIENTS ONLY: On the day of your re-exam only check the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up						
	Body		tain to you, or if you do not enter current do		perienced the sy	mptoms for two	weeks. Add up		
		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6		
	Bodily sensation of heaviness Mental heaviness Mental sluggishness Mental fogginess Swollen hands Swollen feet Swollen joints Chest congestion Nausea Snoring			· ·		The Exam of			
	Total Boxes Checked	Total	Total	Total	Total	Total	Total		
Date <b>12.</b>	Liver Function ( Eyes )	LONGER per	Date:  ERM PATIENTS tain to you, or if you and enter current date.	ONLY: On the da		m only check the	boxes that NO		
		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6		
	Itchy Bloodshot Hot Dry Watery Gritty Blurry Vision Decreased Night Vision Near-sighted Far-sighted Total Boxes Checked	Total	Total	Total	Total	Total	Total		
Date		Date:	Date:	Date:	Date:	Date:	Date:		
							at Almost All the Control of the Control		

13.	Liver, Gall Bladder		RM PATIENTS ON n to you, or if you_l				
	Function	boxes and enter		TIAVE NOT exper	ienced the sympt	orns for two week	.s. <u>Auu</u> up your
		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
	Alternating Diarrhea & Constipation						
	Chest Pain		H. L.				
	Tight sensaton in the Chest						
	Bitter taste n the mouth						16
	Anger easily						
	Depression						
	Frustraton						
	Irritability						
	Skin Rashes						
	Headache at the top of the head						
	Tingling Sensation						
	Numbness						
	Muscle twitching						
	Muscle cramping						
	Muscle spasms						
	Seizures						
	Convulsions						
	Lump in the throat		1				
	Neck tension						
	Shoulder tension						
	Limited Range-of-Motion (Neck)						
	Limited Range-of-Motion (Shoulder)						
	How much Alcohol / day?						
	Recreatonal drugs? (which?)						
	High-pitched ringing in ears						
	Gall Stones (history or current)					•	
	STD's (which?)						
	Unable to adept to Stress						
	Total Boxes Checked	Total	Total	Total	Total	Total	Total
Date		Date:	Date:	Date:	Date:	Date:	Date:

14.	Kidney, Urinary Bladder	FOR LONG TERM PATIENTS ONLY: On the day of your re-exam only check the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your							
	Function	boxes and enter current date.							
		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6		
	Frequent cavities, teeth problems Easily broken bones Sore knees Weak knees Cold sensaton in the knees Low back pain Memory problems Excessive hair loss Low-pitched ringing in the ears Kidney Stones Bladder infectons Lack of bladder control Wake during the night 2 (or more) times to urinate Fear Easily startled Total Boxes Checked	Total	Total	Total	Total	Total	Total		
Date		Date:	Date:	Date:	Date:	Date:	Date:		
15.	FOR LONG TERM PATIENTS ONLY: On the day of your re-exam only check the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and enter current date.								
		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6		
	Normal High Low Total Boxes Checked	Total	Total	Total	Total	Total	Total		
Date		Date:	Date:	Date:	Date:	Date:	Date:		

#### **NEW PATIENT HEALTH HISTORY QUESTIONNAIRE**

	Irination (Bladder		FOR LONG TERM PATIENTS ONLY: On the day of your re-exam only check the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up						
-	unction)		The second secon	nd enter current da		ochonood the byn	inprovino for two we	cks. <u>Add</u> up	
(C	olor - (please check)		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6	
Pa Re Cli Sc Pr St Bu Pa Dii Ur Fre	ale Dark yellow Clear eddish oudy canty of use rong Odor urning ainful scharge fficult gent equent otal Boxes Checked		Total	Total	Total	Total	Total	Total	
Date	<del></del>		Date:	Date:	Date:	Date:	Date:	Date:	
			WC	OMEN ONLY					
Ye	es No	Are you prgna Do you have	a regular menstru ant? bleeding between a vaginal discharg	periods?		Average nu Number of o		re cycle	
Please fill in	the Menstrual chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	
rust, da Amount o normal, Pain/Cran dull, sha Vomiting	ose one):  , pale, bright red, brown  ark purple, other  of flow (chose one): , heavy, light  mps (chose one):  arp, other (check if yes):  check if yes):								
-	the Menstrual chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	
rust, da Amount o normal, Pain/Cran dull, sha Vomiting	ose one):  pale, bright red, brown  rk purple, other  of flow (chose one):  heavy, light  nps (chose one):  arp, other  (check if yes):								

Women Only:	FOR LONG TERM PATIENTS ONLY: On the day of your re-exam only check the boxes that NC LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and enter current date.					
Nausea Vomiting Food cravings Water retention Breast swelling Breast tenderness Headaches Migraines	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
Migraines Dull pain (where? Sharp pain (whre? Deprsesion Irritability Anxiety Infertility Other (explain:						
Date	Date:	Date:	Date:	Date:	Date:	Date:

M. O.I.								
Men Only:	FOR LONG TERM PATIENTS ONLY: On the day of your re-exam only check the boxes that							
		NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks.						
	Add up your b	poxes and enter c	urrent date.					
	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6		
Swollen testes					1			
Testicular pain								
Impotence								
Premature ejaculaton								
Feeling of colenss or numbness in								
external genitalia								
Difficulty with erection								
Thick or dense semen								
High sex drive								
Low sex drive								
Discolored or yellow semen								
Nocturnal emissions								
Fatigue after sex								
Pain in penis								
Pain in testes								
Infertility								
Other (explain:)								
Total Boxes Checked	Total	Total	Total	Total	Total	Total		
Date	Date:	Date:	Date:	Date:	Date:	Date:		