

New Patient Health History Questionnaire

Name: _____

Dear New Patient:

- Please **read** and **fill in** all of the information that pertains to you.
- On pages 2 through 11, under each category, **check all** symptoms that you experience either acutely or chronically.
- Add and **total** all of the boxes you check.
- 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		Gonorrhea		Bleeding Tendency		Polio
Syphilis		Measles		Nervous Disorder		Migraines
Meningitis		HIV		Mononucleosis		Other Liver Illnesses
Epilepsy		High Fever		Multiple Sclerosis		Other Heart Illnesses
Paralysis		Cancer		Jaundice		Other Kidney Illnesses
Glaucoma		Mumps		Hepatitis		Other Lung Illnesses

Immunizations?

Surgeries?

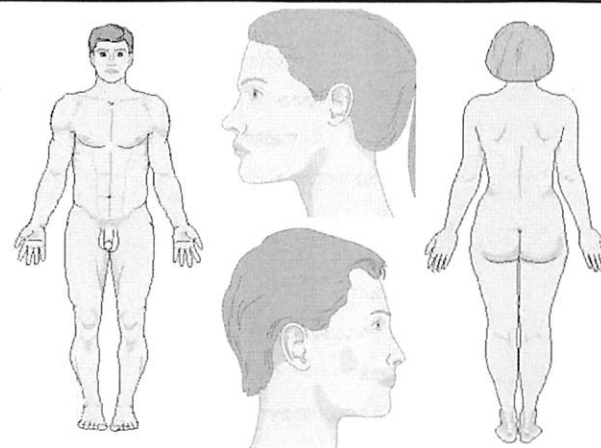
1. Pain

What make the pain better?

Soft Pressure
Hard Pressure
Cold
Hot
Exercise
Rest
Other

What makes the pain worse?

Soft Pressure
Hard Pressure
Cold
Hot
Exercise
Rest
Other



2. Describe Your Pain

Sharp
Fixed
Burning
Moving
Cramping
Aching
Dull
Other: _____

Total Boxes Checked

Date _____

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

Total

Total

Total

Total

Total

Total

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

New Patient Health History Questionnaire

5. Liver, Spleen, Heart Function

	Dizziness
	See floating black spots

Total Boxes Checked

Date _____

6. Heart

	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

Date _____

7. Spleen Function

	Low Appetite
	Abrupt Weight Gain
	Abrupt Weight Loss
	Abdominal Bloating
	Abdominal Gas

(Continued . . .)

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Re-Exam 1		Re-Exam 2		Re-Exam 3		Re-Exam 4		Re-Exam 5		Re-Exam 6	
	Total		Total		Total		Total		Total		Total
Date:		Date:		Date:		Date:		Date:		Date:	

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[illegible]

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[illegible]

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3. Kidney Function (Overall Temperature)

	Cold hands
	Cold Fingers
	Cold Toes
	Cold Feet
	Sweaty Hands
	Sweaty Feet
	Hot Body Temperature Sensation
	Cold Body Temperature Sensation
	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

Date _____

Date _____

Date _____

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[illegible]

4. Lung, Kidney Function (Overall Energy)

	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

Date

Date

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[illegible]

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7. Spleen Function .. Cont'd

	Gurgling noise in stomach
	Fatigue after eating
	Prolapsed Organs? Which? _____
	Bruise easily?
	Over-Thinking
	Worry

Total Boxes Checked

Date _____

8. Lung Function

	Nasal discharge (color) _____
	Cough
	Nose Bleeds
	Sinus Congestion
	Dry Mouth
	Dry Nose
	Dry Skin
	Allergies (what? _____)
	Alternating Chills/Fever
	Sneezing
	Heartache (location _____)
	Overall achy feeling in body
	Stiff Neck
	Stiff Shoulders
	Sore Throat
	Difficulty breathing
	Smoke cigarettes (# per day _____)
	Sadness
	Melancholy

Total Boxes Checked

Date _____

Re-Exam 1		Re-Exam 2		Re-Exam 3		Re-Exam 4		Re-Exam 5		Re-Exam 6	
Total		Total		Total		Total		Total		Total	
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[illegible]

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9. Spleen, Stomach, Small / Large intestine Function

- ☐ Loose Stools
- ☐ Constipated
- ☐ Incomplete Stools
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Mucous in Stools
- ☐ Undigested food in the stools

☐ Total Boxes Checked

Date: _____

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10. Stomach Function

- ☐ 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

☐ Total Boxes Checked

Date: _____

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New Patient Health History Questionnaire

11. Dampness Trapped in the Body

	Bodily sensation of heaviness
	Mental heaviness
	Mental sluggishness
	Mental fogginess
	Swollen hands
	Swollen feet
	Swollen joints
	Chest congestion
	Nausea
	Snoring

Total Boxes Checked

Date _____

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	
Total		Total		Total		Total		Total		Total	
Date:		Date:		Date:		Date:		Date:		Date:	

12. Liver Function (Eyes)

	Itchy
	Bloodshot
	Hot
	Dry
	Watery
	Gritty
	Blurry Vision
	Decreased Night Vision
	Near-sighted
	Far-sighted

Total Boxes Checked

Date _____

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**.

[illegible]

New Patient Health History Questionnaire

13. Liver, Gall Bladder Function

	Alternating Diarrhea & Constipation
	Chest Pain
	Tight sensation in the Chest
	Bitter taste in the mouth
	Anger easily
	Depression
	Frustration
	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
	Neck tension
	Shoulder tension
	Limited Range-of-Motion (Neck)
	Limited Range-of-Motion (Shoulder)
	How much Alcohol / day? _____
	Recreational drugs? (which? _____)
	High-pitched ringing in ears
	Gall Stones (history or current)
	STD's (which? _____)
	Unable to adapt to Stress

Total Boxes Checked

Date _____

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**.

[illegible]

New Patient Health History Questionnaire

14. Kidney, Urinary Bladder Function

<input type="checkbox"/>	Frequent cavities, teeth problems
<input type="checkbox"/>	Easily broken bones
<input type="checkbox"/>	Sore knees
<input type="checkbox"/>	Weak knees
<input type="checkbox"/>	Cold sensation in the knees
<input type="checkbox"/>	Low back pain
<input type="checkbox"/>	Memory problems
<input type="checkbox"/>	Excessive hair loss
<input type="checkbox"/>	Low-pitched ringing in the ears
<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Bladder infections
<input type="checkbox"/>	Lack of bladder control
<input type="checkbox"/>	Wake during the night 2 (or more) times to urinate
<input type="checkbox"/>	Fear
<input type="checkbox"/>	Easily startled

Total Boxes Checked

Date _____

15. Libido

<input type="checkbox"/>	Normal
<input type="checkbox"/>	High
<input type="checkbox"/>	Low

Total Boxes Checked

Date _____

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**.

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<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
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<input type="checkbox"/>		<input type="checkbox"/>									

16. Urination (Bladder Function)

Frequent

Date _____

Date: _____ Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

Age of menopause (if applicable)

Day 7

Nausea (check if yes):

Day 7

Nausea (check if yes):

New Patient Health History Questionnaire

Women Only:

	Nausea
	Vomiting
	Food cravings
	Water retention
	Breast swelling
	Breast tenderness
	Headaches
	Migraines
	Dull pain (where? _____)
	Sharp pain (where? _____)
	Depression
	Irritability
	Anxiety
	Infertility
	Other (explain: _____)

Total Boxes Checked

Date _____

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**.

[illegible]

Men Only:

	Swollen testes
	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

Date _____

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.**

[illegible]