### I. Have you ever had or do you now have:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>CARDIOVASCULAR</th>
<th>OFTEN</th>
<th>Seldom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Chronic or Frequent Colds</td>
<td>1 Shortness of Breath with Normal Activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 Sinusitis</td>
<td>2 Ankle Swelling</td>
<td></td>
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<tr>
<td></td>
<td>3 Heart Condition</td>
<td>3 High Blood Pressure</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>4 Stomach, Liver, or Intestinal Trouble</td>
<td>4 Rapid Heart Beat</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 Gall Bladder Trouble or Gall Stones</td>
<td>5 Irregular Heart Beat</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 Jaundice</td>
<td>6 Dizziness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 Tumor, Growth Cyst, Cancer</td>
<td>7 Fainting Spells</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8 Venereal Disease</td>
<td>8 Chest Pain or Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 Ear, Eye, Nose, Throat Trouble</td>
<td>9 Leg Cramps</td>
<td></td>
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<tr>
<td></td>
<td>10 Drug/Alcohol Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### II. Female Issues: A. Have you ever:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>RESPIRATORY</th>
<th>OFTEN</th>
<th>Seldom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 Cough</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 Been pregnant</td>
<td>2 Cough up Blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 Had Chronic yeast problems</td>
<td>3 Frequent Sore Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 Been treated for female disorders</td>
<td>4 Hoarseness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 Had painful menstruation</td>
<td>5 Frequent Sneezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 Had irregular menstruation</td>
<td>6 Hay Fever</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Complete the following:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>GASTRO-INTESTINAL</th>
<th>OFTEN</th>
<th>Seldom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7 Nose Bleeds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 Age at onset of menstruation</td>
<td>8 Asthmatic Wheezing</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>2 Interval between periods</td>
<td>9 Pneumonia</td>
<td></td>
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<tr>
<td></td>
<td>3 Duration of periods</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>4 Date of last period</td>
<td>1 Indigestion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MEDICATIONS CURRENTLY TAKING

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>Quantity: Normal</th>
<th>Excessive</th>
<th>Scanty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Abdominal Pain or Cramps</td>
<td>3 Constipation</td>
<td>4 Diarrhea</td>
<td>5 Increased Thirst</td>
<td></td>
</tr>
<tr>
<td>6 Decreased Appetite</td>
<td>7 Nausea and Vomiting</td>
<td>8 Undigested Food in Stool</td>
<td>9 Bloating After Eating</td>
<td></td>
</tr>
<tr>
<td>10 Excessive gas</td>
<td>11 Acid Reflux</td>
<td>12 Blood in Bowel Movement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SKIN</td>
<td>YES</td>
<td>NO</td>
<td>SELDOM</td>
<td>OFTEN</td>
</tr>
<tr>
<td>------</td>
<td>-----</td>
<td>----</td>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>1 Ulcerations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Itching</td>
<td></td>
<td></td>
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<tr>
<td>3 Rash</td>
<td></td>
<td></td>
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<tr>
<td>4 Psoriasis</td>
<td></td>
<td></td>
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<tr>
<td>5 Long Term Dry Skin</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6 Frequent Boils</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>GENITO-URINARY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Frequent Urination</td>
<td></td>
</tr>
<tr>
<td>2 Painful, Burning Urination</td>
<td></td>
</tr>
<tr>
<td>3 Pain in the Testicle</td>
<td></td>
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<tr>
<td>4 Bloody or other discharge</td>
<td></td>
</tr>
<tr>
<td>5 Loss of Sexual Potency or Desire</td>
<td></td>
</tr>
<tr>
<td>6 Cold Feeling in the Genital Area</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MUSCLE/SKELETAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Arthritis</td>
<td></td>
</tr>
<tr>
<td>2 Rheumatoid Arthritis</td>
<td></td>
</tr>
<tr>
<td>3 Muscle Pain or Cramps</td>
<td></td>
</tr>
<tr>
<td>4 Painful Joints</td>
<td></td>
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<tr>
<td>5 Lameness</td>
<td></td>
</tr>
<tr>
<td>6 Backaches</td>
<td></td>
</tr>
<tr>
<td>7 Back Pain</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MISCELLANEOUS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Fever</td>
<td></td>
</tr>
<tr>
<td>2 Chills</td>
<td></td>
</tr>
<tr>
<td>3 Night Sweats</td>
<td></td>
</tr>
<tr>
<td>4 Headaches</td>
<td></td>
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<tr>
<td>5 Insomnia</td>
<td></td>
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<tr>
<td>6 Nervousness</td>
<td></td>
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<tr>
<td>7 Easy Fatigability</td>
<td></td>
</tr>
<tr>
<td>8 Frequent Irritability</td>
<td></td>
</tr>
<tr>
<td>9 Morning Tiredness</td>
<td></td>
</tr>
<tr>
<td>10 Tremors or uncontrollable shaking</td>
<td></td>
</tr>
<tr>
<td>11 Nightmares</td>
<td></td>
</tr>
<tr>
<td>Do you have or have you had recently?</td>
<td>YES</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>1 Weight Loss: How Much? ___________</td>
<td></td>
</tr>
<tr>
<td>2 Weight Gain: How Much? ___________</td>
<td></td>
</tr>
<tr>
<td>3 Memory Loss</td>
<td></td>
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<tr>
<td>4 Difficulty Walking in the dark</td>
<td></td>
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<tr>
<td>5 Balance Problems</td>
<td></td>
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<tr>
<td>6 Numbness &amp; Tingling in the extremities</td>
<td></td>
</tr>
<tr>
<td>7 Hearing Loss</td>
<td></td>
</tr>
<tr>
<td>8 Ringing in the ears</td>
<td></td>
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<tr>
<td>9 Vision Change</td>
<td></td>
</tr>
<tr>
<td>10 Double Vision</td>
<td></td>
</tr>
<tr>
<td>11 Earaches (Chronic during Childhood)</td>
<td></td>
</tr>
<tr>
<td>12 Running ears</td>
<td></td>
</tr>
<tr>
<td>13 Tendency to bleed or bruise easily</td>
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</tr>
<tr>
<td>14 Heat Intolerance</td>
<td></td>
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<tr>
<td>15 Cold Intolerance</td>
<td></td>
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<tr>
<td>16 Lymph node enlargement</td>
<td></td>
</tr>
</tbody>
</table>

**ARE YOU ALLERGIC TO ANY TYPE OF FOOD? IF SO, WHICH?**

**Please list all operations & your age when each was performed**

**HOW OFTEN DO YOU EXERCISE?**

**NAME THE MOST RECENTLY SELF-HELP BOOK THAT YOU'VE READ**

**PLEASE LIST ALL THE VITAMINS AND OTHER SUPPLEMENTS THAT YOU CURRENTLY TAKE**

**WHICH OF THE FOLLOWING MODALITIES HAVE YOU BEEN TREATED WITH IN THE PAST?**

- ACUPUNCTURE  |  MASSAGE
- CHIROPRACTIC |  HYPNOSIS
- HERBAL MEDICINE |  HOMEOPATHY
- CHINESE HERBS  |  OTHER