

Brief Health History: (list major diseases, surgeries, etc.)

How many times per year do you get a cold or the flu? _____

Diet: (summarize how you eat; list any special diet such as high protein, raw food, etc.)

Family Medical History:

Emotions:

Normal ____ Problem ____

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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 ____ Bad ____

many dreams ____ bad dreams ____ grinding teeth ____
 talking in sleep ____ other ____

Describe: _____

Menstrual Cycle:

Age of onset: ____ years old Date of last period: / /

Regular ____ Irregular ____

How many days per cycle? ____ 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: _____

Bowel Movement: Normal ____ Abnormal ____ Time of day: _____ Page 5

constipation ____ diarrhea ____ loose ____ watery ____

incomplete ____ hard and dry ____ strong smell ____

with mucous ____ 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 times per day ____ Number of times per night ____ other ____

Describe: _____