NAME: ______________________________ DATE: __________

Indicate with ✓ one check any conditions that you sometimes experience, use ✓✓ two checks for those which occur often and ✓✓✓ three checks for symptoms of major concern.

Check	Present History
❑ ❑ ❑	chills
❑ ❑ ❑	fever
❑ ❑ ❑	sweating
❑ ❑ ❑	pain
❑ ❑ ❑	bedwetting
❑ ❑ ❑	Nightly Urination # of times:
✓	Daily Urination # of times:
✓	Bowel Movement # of times daily:
❑ ❑ ❑	long & thin stools
❑ ❑ ❑	dry stools
❑ ❑ ❑	round, small stools, like pebbles
❑ ❑ ❑	pale stools
❑ ❑ ❑	dark stools
❑ ❑ ❑	exhaustion after bowel movement

Check	Water Element
❑ ❑ ❑	hearing loss
❑ ❑ ❑	ringing in ears
❑ ❑ ❑	dizziness
❑ ❑ ❑	lower back ache
❑ ❑ ❑	neck pain
❑ ❑ ❑	sinus congestion
❑ ❑ ❑	edema
❑ ❑ ❑	darkness under eyes
❑ ❑ ❑	emotional instability
❑ ❑ ❑	aversion to cold
❑ ❑ ❑	hair thinning or loss
❑ ❑ ❑	pre-mature aging
❑ ❑ ❑	frequent urination
❑ ❑ ❑	kidney stones
❑ ❑ ❑	perspire very easily
❑ ❑ ❑	night sweats
❑ ❑ ❑	afternoon fever
❑ ❑ ❑	weakness of legs/knees sore knees
❑ ❑ ❑	cold extremities
❑ ❑ ❑	asthmatic cough inhalation difficult
❑ ❑ ❑	rapid weight change
❑ ❑ ❑	loose teeth
❑ ❑ ❑	reduced sexual energy
❑ ❑ ❑	increased sexual energy
❑ ❑ ❑	thyroid problems
❑ ❑ ❑	diabetes
❑ ❑ ❑	poor memory/concentration
❑ ❑ ❑	fatigue
❑ ❑ ❑	craving for salty taste
❑ ❑ ❑	thirst for hot drinks
❑ ❑ ❑	dreams of boats/water/ravines/fear/drowning

Check	Wood Element
❑ ❑ ❑	headaches
❑ ❑ ❑	migraines
❑ ❑ ❑	ringing in ears
❑ ❑ ❑	poor eyesight
❑ ❑ ❑	dry/red eyes
❑ ❑ ❑	watering eyes
❑ ❑ ❑	eye infections
❑ ❑ ❑	blurry vision
❑ ❑ ❑	craving for sour taste
❑ ❑ ❑	eczema
❑ ❑ ❑	shingles
❑ ❑ ❑	herpes
❑ ❑ ❑	warts
❑ ❑ ❑	nervousness
❑ ❑ ❑	convulsions/spasms
❑ ❑ ❑	irritability
❑ ❑ ❑	constipation
❑ ❑ ❑	alternating constipation/diarrhea
❑ ❑ ❑	hepatitis
❑ ❑ ❑	ulcer
❑ ❑ ❑	vomiting
❑ ❑ ❑	gallstones
❑ ❑ ❑	indecisive
❑ ❑ ❑	fullness below ribs
❑ ❑ ❑	shoulder/neck tension
❑ ❑ ❑	insomnia 11pm-3 am
❑ ❑ ❑	frustration
❑ ❑ ❑	depression
❑ ❑ ❑	anger easily
❑ ❑ ❑	bitter taste in mouth
❑ ❑ ❑	hemorrhoids
❑ ❑ ❑	wrist & hand pain/soreness
❑ ❑ ❑	dreams of trees/afraid to get up/fights/cutting your own body

TONGUE:

REFERRAL:

Fire Element	Earth Element	Metal Element
❑ ❑ ❑ dry scalp	❑ ❑ ❑ indigestion	❑ ❑ ❑ bronchitis
❑ ❑ ❑ skin eruptions/rashes	❑ ❑ ❑ flatulence	❑ ❑ ❑ asthma exhalation difficult
❑ ❑ ❑ cysts/tumours	❑ ❑ ❑ food allergy	❑ ❑ ❑ shallow breathing
❑ ❑ ❑ ear infections	❑ ❑ ❑ stomach ache/ulcer	❑ ❑ ❑ cough
❑ ❑ ❑ sore throat/tonsillitis	❑ ❑ ❑ loose stool	❑ ❑ ❑ sinus congestion
❑ ❑ ❑ lymphatic swelling	❑ ❑ ❑ anemia	❑ ❑ ❑ nasal infections
❑ ❑ ❑ craving for bitter taste	❑ ❑ ❑ bad breath	❑ ❑ ❑ dry skin
❑ ❑ ❑ hot hands/feet	❑ ❑ ❑ sores on mouth	❑ ❑ ❑ spontaneous sweating
❑ ❑ ❑ aversion to heat	❑ ❑ ❑ heart burn	❑ ❑ ❑ catch colds easily
❑ ❑ ❑ dry mouth	❑ ❑ ❑ appetite increased	❑ ❑ ❑ craving spicey taste
❑ ❑ ❑ gum problems	❑ ❑ ❑ appetite decreased	❑ ❑ ❑ dreams of white/cruel killing/fear/crying/flying/metal/fields/rural landscapes
❑ ❑ ❑ nose bleed	❑ ❑ ❑ nausea	
❑ ❑ ❑ facial redness	❑ ❑ ❑ abdominal bloating	
❑ ❑ ❑ itching/burning skin	❑ ❑ ❑ low body weight	
❑ ❑ ❑ heart palpitations	❑ ❑ ❑ bleeding prolonged	
❑ ❑ ❑ thirst for cold drinks	❑ ❑ ❑ fatigue	
❑ ❑ ❑ vivid dreaming	❑ ❑ ❑ vomiting	
❑ ❑ ❑ dark urine	❑ ❑ ❑ bruising easily	
❑ ❑ ❑ night sweats	❑ ❑ ❑ organ prolapse	
❑ ❑ ❑ chest pain	❑ ❑ ❑ craving for sweet taste	
❑ ❑ ❑ insomnia: falling asleep	❑ ❑ ❑ heaviness in legs	
❑ ❑ ❑ insomnia: waking up	❑ ❑ ❑ sticky saliva	
❑ ❑ ❑ sores on tongue	❑ ❑ ❑ thirst but don't like to drink	
❑ ❑ ❑ thirst but only like small sips	❑ ❑ ❑ dreams of food/buildings/walls/singing/music/heavy body/difficulty getting up/abysses/marshes/storms	
❑ ❑ ❑ very thirsty	❑ ❑ ❑ vaginal infections	
❑ ❑ ❑ dreams of fire/laughing/fear/hills/mountains/populated cities or streets		
❑ ❑ ❑ fatigue upon waking		

Describe your BIRTH:

____

____

List your CHIEF COMPLAINTS in order of priority and their date of onset:

____

____

____

____

____

Describe a typical day's DIET, including beverages:

BREAKFAST	LUNCH	DINNER

Do you now or have you ever undertaken a restricted DIET? Please give dates and describe:

____

____

MENSTRUATION:

Length of cycle: ❑ 28 days/ ❑ ___ days/ ❑ irregular (give range ________ days)

Length of bleeding: ______ days

Colour of blood: ❑ bright red/ ❑ dark red/ ❑ brown/ ❑ purple

Consistency of blood: ❑ normal/ ❑ sticky,thick/ ❑ watery/ ❑ clots

PMS: ❑ breast distention/ ❑ cramps: ❑ before or ❑ during/ ❑ headaches
❑ chocolate craving/ ❑ other ______________________
❑ bloating, edema

Date of last menstrual period: ________________

Number of pregnancies: ________________

Number of children: ________________

List all SURGERIES and their approximate dates:

____

____

____

____

List all prescription DRUGS you are taking and any history of non-prescription & prescription drug use:

____

____

Choose one or two EMOTIONS that are influential in your life which are either frequently experienced or difficult to express:

____

Describe any TRAUMATIC experiences you have had and give their approximate dates (i.e. divorce, change of residence, injury, death in family, bankruptcy, etc.):

DATE:	EVENT:
________	________________________________
________	________________________________
________	________________________________
________	________________________________
________	________________________________

Describe briefly your EMPLOYMENT HISTORY:

DATE:	EMPLOYMENT:
________	________________________________
________	________________________________
________	________________________________
________	________________________________
________	________________________________

Describe your current program of PHYSICAL FITNESS:

____

____

____

What types of ACUTE ILLNESSES do you suffer from and approximately how often have you experienced them in the last five years?

____

____

List any SERIOUS OR CHILDHOOD ILLNESSES and their approximate dates:

____

____

____

Check any FAMILY HISTORY of illness:

☐	asthma	☐	infertility
☐	autoimmune disease	☐	fibroids
☐	heart disease	☐	hepatitis
☐	high blood pressure	☐	stroke
☐	heart attack	☐	miscarriage
☐	migraines	☐	alcoholism/drug addiction
☐	allergies	☐	cancer
☐	arthritis	☐	anemia
☐	epilepsy	☐	mental illness
☐	kidney disease	☐	tuberculosis