Name:	nme: Date:					
	th <b>v</b> one check any conditions t s for symptoms of major conce	•	times experience, use <b>√√</b> two che	ecks for thos	e which occur often, and VVV	
				T 1	VOOD EL EMENT	
	RESENT HISTORY Chills		VATER ELEMENT Hearing loss		VOOD ELEMENT Headaches	
	Fever		Dizziness		Migraines	
	Sweating		Ringing in ears – low pitch		Ringing in ears – high pitch	
	Pain		Low back ache		Poor eyesight	
	Bedwetting		Neck pain		Dry/Red eyes	
	Nightly Urination # of times:		Sinus congestion		Watering eyes	
V	Daily Urination # of times:		Edema		Eye infections	
Ø	Bowel Movement # of times:		Darkness under eyes		Blurry vision	
	Long & thin stools		Emotional instability		Craving for sour taste	
	Dry stools		Aversion to cold		Eczema	
	Round, small stools, like pebbles		Hair thinning or loss		Shingles	
	Pale stools		Pre-mature aging		Herpes	
	Dark stools		Frequent urination		Warts	
	Exhaustion after bowel movement		Kidney stones		Nervousness	
			Perspire very easily		Convulsions/Spasms	
Tongue:			Night sweats		Irritability	
			Afternoon fever		Constipation	
Pulse:			Weakness of legs/knees or Sore knees		Alternating constipation/ Diarrhea	
L-			Cold extremities		Hepatitis	
R-			Asthmatic cough inhalation difficult		Ulcer	
			Rapid weight change		Vomiting	
			Loose teeth		Gallstones	
			Reduced sexual energy		Indecisive	
			Increased sexual energy		Fullness below ribs	
			Thyroid problems		Shoulder/Neck tension	
			Diabetes		Insomnia 11pm – 3am	
			Fatigue		Frustration	
			Poor memory/Concentration		Depression	
			Craving for salty taste		Anger easily	
			Thirst for hot drinks		Bitter taste in the mouth	
			Dreams of boats/water/		Hemorrhoids	
			ravines/fear/drowning		TEHIOTHORS	
					Wrist & hand pain/Soreness	
					Dreams of trees/afraid to get up/fights/cutting your own	

body

	FIRE ELEMENT	ŀ	EARTH ELEMENT	N	IETAL ELEMENT
	Dry scalp		Indigestion		Bronchitis
	Skin eruptions / Rashes		Flatulence		Asthma exhalation difficult
	Cysts / Tumors		Food allergy		Shallow breathing
	Ear infections		Stomachache/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		Heartburn		Catch colds easily
	Dry mouth		Appetite increased		Craving for spicy taste
	Gum problems		Appetite decreased		Dreams of white/cruel/ killing/fear/crying/flying/ metal/fields/rural landscapes
	Nosebleed		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 prolapses		
	Chest pain		Craving for sweet taste		
	Insomnia: falling asleep		Heaviness in legs		
	Insomnia: waking up		Sticky saliva		
	Sores on tongue		Vaginal infections		
	Fatigue upon waking		Thirst but don't like to drink		
	Very thirsty		Dreams of food/building /walls/singing/music/heavy /body/difficulty getting up /abysses/marshes/storms		
	Thirst but only like small sips				
	Dreams of fire/laughing/fear /hills/mountains/populated cities or streets				
Describe t	he circumstances around yo	our Birth (t	traumas, full term, parent's	age etc.):	

List your CHIEF COMPLAINTS in order of priority and their date of onset:					
Describe a typical day's DIET, inc	cluding beverages:				
BREAKFAST	LUNCH	DINNER			
DREARFAST	Donch	DIMER			
Do you now or have you ever und	ertaken a restricted DIET? Please give	e dates and describe:			
MENSTRUATION:					
Length of cycle: □ 28 days / □	days /   irregular (give range	_ days)			
Length of bleeding: days					
Color of blood: □ bright red / □ d	ark red/ □ brown / □ purple				
_	□ sticky, thick / □ watery / □ clots				
	ps: □ before or □ during / □ headache	es /   chocolate craving /   bloating,			
Date of last menstrual period:					
Number of pregnancies:	<del>-</del>				
Number of children:					

List all SURGERIES	S and their approximate dates:
List all prescription	DRUGS you are taking and any history of non-prescription & prescription drug use:
Choose one or two E difficult to express:	MOTIONS that are influential in your life which are either frequently experienced or
	MATIC experiences you have had and give their approximate dates (i.e., divorce, change death in the family, bankruptcy, etc.)
Date:	Event:
Briefly describe you	r EMPLOYMENT HISTORY:
Date:	Employment:
	·

Describe your current progra	m of PHYSICAL FITNESS:		
What types of ACUTE ILLN them in the last five years?	ESSES do you suffer from a	nd approximately how often have you experi	enced
List any SERIOUS OR CHII	LDHOOD ILLNESSES and the	neir approximate dates:	
Check any FAMILY HISTO	RY of illness:		
□ Asthma	□ Arthritis	☐ Migraines	
☐ Autoimmune disease	□ Epilepsy	☐ Alcoholism /drug addiction	
☐ Heart disease	☐ Kidney disease	□ Cancer	
☐ High blood pressures	□ Infertility	□ Anemia	
☐ Heart attack	□ Fibroids	☐ Mental illness	
□ Miscarriage	□ Hepatitis	☐ Tuberculosis	
□ Allergies	□ Stroke	□ Diabetes	