



Today's Date: _____ Referred by: _____

Name: _____ M F Occupation: _____

Birth date: _____ Age: _____ Weight: _____ Height: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Daytime phone: _____ Evening phone: _____

Email address: _____

Marital Status: S M D W Spouse's Name: _____

Emergency Contact: _____ Phone: _____

Chief complaints. Please tell us the main reason you are here: _____

Secondary Complaints. Please tell us about other health concerns you may have:

Previous Treatments for these complaints: _____

Are you currently under the care of a physician or health care professional? If yes, please give name and date of last visit: _____

Major Illness: Please list all major illness and approximate dates of diagnosis:



Surgeries. Please list all surgeries and approximate dates: _____

Injuries. Please list all injuries and traumas and approximate dates: _____

Current medication (drugs) and dosage (use separate sheet if needed): _____

Current nutritional supplements and dosage (use separate sheet if needed):

Please list any allergies (including food): _____

Please circle any of the following vaccinations you have received:

Influenza (if yes, most recent shot: _____) HPV Tetanus

Child Vaccinations: _____

COVID-19 - Manufacturer: _____ Number of Doses: _____

Any family history of serious illnesses (circle all that applies):

Cancer / Diabetes / Heart disease / Other: _____

Describe health of spouse/partner: _____

Number of children(if any): _____

Name of child	Age	Sex	Health or health concerns
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



Do you drink coffee? Y N How much per day?

Do you drink alcohol? Y N Type and quantity:

Do you smoke? Y N Type and quantity:

Do you exercise? Y N Type and duration:

Do you have any trouble with sleep? Y N Please explain:

Do you have pets? Y N What Kind and how many:

What can we do to make you happier? _____

WOMEN ONLY

Are you pregnant? Y N Are you trying to conceive? Y N Are you nursing? Y N

Do you have regular monthly periods? _____

Circle any of the following symptoms you experience associated with your period:

Cramping Bloating Moodiness Heavy bleeding Back pain Headaches Clots



Dietary Intake 2 Days Before Initial Consultation:

Vegan: Y N | Vegetarian: Y N | Pescaterian: Y N | Other:

Day 1

Day 2

Breakfast:

Breakfast:

Snacks:

Snacks:

Lunch:

Lunch:

Snacks:

Snacks:

Dinner:

Dinner:

Snacks:

Snacks:

Water and other liquids:

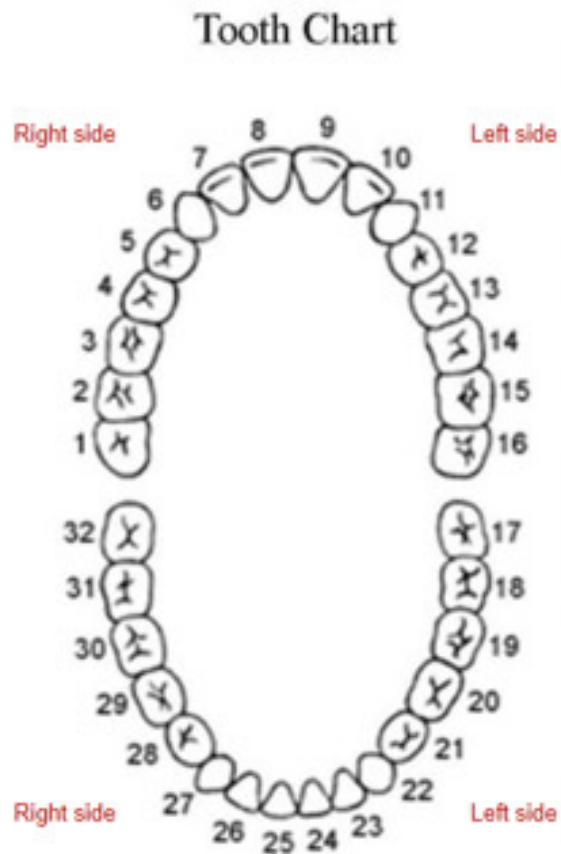
Water and other liquids:



Dental Chart

On the chart below please indicate the following:

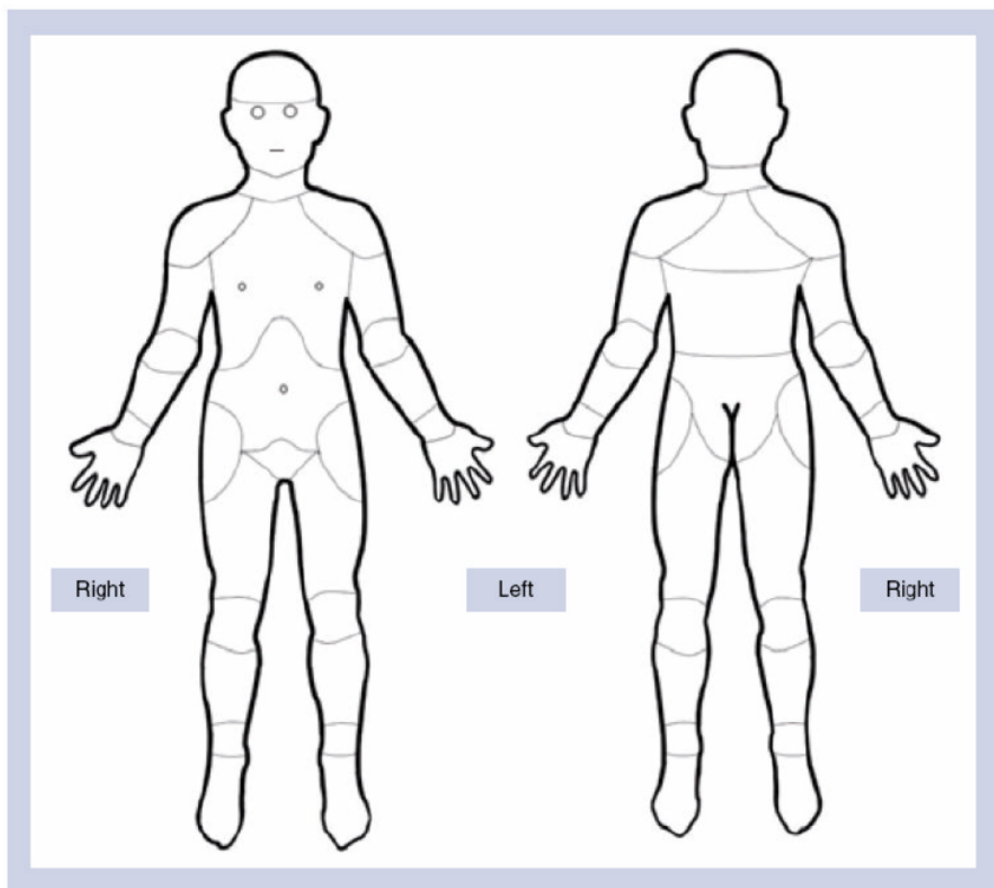
- Silver fillings
- Composite or porcelain fillings
- Gold Fillings
- Crowns
- Root canals
- Veneers
- Bridges
- Dentures
- Extracted teeth (don't forget about the wisdom teeth)



Scars, Surgeries, Piercings, Tattoos and Metal Implants

On the diagram above please indicate where you have any scars, piercings, tattoos and metal implants.

Don't forget about C-sections, episiotomies, cosmetic surgery, vasectomies, laparoscopic surgeries, metal pins, trauma scars, joint replacements and vaccination scars



Office use only:

Scars
Piercings
Tattoos

Surgery
Trauma
Implants

SYMPTOM SURVEY FORM



Patient _____ Doctor _____ Date _____
Birth Date ____ / ____ / ____ Approx Weight _____ Sex: Male ** Female **
Pulse: Recumbent _____ Standing _____ Vegetarian: Yes ** No **
Blood pressure: Recumbent ____ / ____ Standing ____ / ____ Ragland's Test is Positive **

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurred once or twice last 6 months).
○ ● ○ MODERATE symptoms (occurred once or twice last month).
○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
○ ○ ○ Leave circles **BLANK** if they don't apply to you!

- 1 2 3 GROUP 1**
- 1 ○ ○ ○ Acid foods upset
 - 2 ○ ○ ○ Get chilled often
 - 3 ○ ○ ○ "Lump" in throat
 - 4 ○ ○ ○ Dry mouth-eyes-nose
 - 5 ○ ○ ○ Pulse speeds after meal
 - 6 ○ ○ ○ Keyed up - fail to calm
 - 7 ○ ○ ○ Cut heals slowly
 - 8 ○ ○ ○ Gag easily
 - 9 ○ ○ ○ Unable to relax; startles easily
 - 10 ○ ○ ○ Extremities cold, clammy
 - 11 ○ ○ ○ Strong light irritates
 - 12 ○ ○ ○ Urine amount reduced
 - 13 ○ ○ ○ Heart pounds after retiring
 - 14 ○ ○ ○ "Nervous" stomach
 - 15 ○ ○ ○ Appetite reduced
 - 16 ○ ○ ○ Cold sweats often
 - 17 ○ ○ ○ Fever easily raised
 - 18 ○ ○ ○ Neuralgia-like pains
 - 19 ○ ○ ○ Staring, blinks little
 - 20 ○ ○ ○ Sour stomach often
- GROUP 2**
- 21 ○ ○ ○ Joint stiffness on arising
 - 22 ○ ○ ○ Muscle-leg-toe cramps at night
 - 23 ○ ○ ○ "Butterfly" stomach, cramps
 - 24 ○ ○ ○ Eyes or nose watery
 - 25 ○ ○ ○ Eyes blink often
 - 26 ○ ○ ○ Eyelids swollen, puffy
 - 27 ○ ○ ○ Indigestion soon after meals
 - 28 ○ ○ ○ Always seems hungry; feels "lightheaded" often
 - 29 ○ ○ ○ Digestion rapid
 - 30 ○ ○ ○ Vomiting frequent
 - 31 ○ ○ ○ Hoarseness frequent
 - 32 ○ ○ ○ Breathing irregular
 - 33 ○ ○ ○ Pulse slow; feels "irregular"
 - 34 ○ ○ ○ Gagging reflex slow
 - 35 ○ ○ ○ Difficulty swallowing
 - 36 ○ ○ ○ Constipation, diarrhea alternating
 - 37 ○ ○ ○ "Slow starter"
 - 38 ○ ○ ○ Get "chilled" infrequently
 - 39 ○ ○ ○ Perspire easily
 - 40 ○ ○ ○ Circulation poor, sensitive to cold
 - 41 ○ ○ ○ Subject to colds, asthma, bronchitis
- GROUP 3**
- 42 ○ ○ ○ Eat when nervous
 - 43 ○ ○ ○ Excessive appetite
 - 44 ○ ○ ○ Hungry between meals
 - 45 ○ ○ ○ Irritable before meals
 - 46 ○ ○ ○ Get "shaky" if hungry
 - 47 ○ ○ ○ Fatigue, eating relieves
 - 48 ○ ○ ○ "Lightheaded" if meals delayed
 - 49 ○ ○ ○ Heart palpitates if meals missed or delayed
 - 50 ○ ○ ○ Afternoon headaches
 - 51 ○ ○ ○ Overeating sweets upsets

- 1 2 3**
- 52 ○ ○ ○ Awaken after few hours sleep - hard to get back to sleep
 - 53 ○ ○ ○ Crave candy or coffee in afternoons
 - 54 ○ ○ ○ Moods of depression - "blues" or melancholy
 - 55 ○ ○ ○ Abnormal craving for sweets or snacks
- GROUP 4**
- 56 ○ ○ ○ Hands and feet go to sleep easily, numbness
 - 57 ○ ○ ○ Sigh frequently, "air hunger"
 - 58 ○ ○ ○ Aware of "breathing heavily"
 - 59 ○ ○ ○ High altitude discomfort
 - 60 ○ ○ ○ Opens windows in closed rooms
 - 61 ○ ○ ○ Susceptible to colds and fevers
 - 62 ○ ○ ○ Afternoon "yawner"
 - 63 ○ ○ ○ Get "drowsy" often
 - 64 ○ ○ ○ Swollen ankles, worse at night
 - 65 ○ ○ ○ Muscle cramps, worse during exercise; get "charley horses"
 - 66 ○ ○ ○ Shortness of breath on exertion
 - 67 ○ ○ ○ Dull pain in chest or radiating into left arm, worse on exertion
 - 68 ○ ○ ○ Bruise easily, "black and blue" spots
 - 69 ○ ○ ○ Tendency to anemia
 - 70 ○ ○ ○ "Nose bleeds" frequent
 - 71 ○ ○ ○ Noises in head, or "ringing in ears"
 - 72 ○ ○ ○ Tension under the breastbone, or feeling of "tightness", worse on exertion
- GROUP 5**
- 73 ○ ○ ○ Dizziness
 - 74 ○ ○ ○ Dry skin
 - 75 ○ ○ ○ Burning feet
 - 76 ○ ○ ○ Blurred vision
 - 77 ○ ○ ○ Itching skin and feet
 - 78 ○ ○ ○ Excessive falling hair
 - 79 ○ ○ ○ Frequent skin rashes
 - 80 ○ ○ ○ Bitter, metallic taste in mouth in mornings
 - 81 ○ ○ ○ Bowel movements painful or difficult
 - 82 ○ ○ ○ Worrier, feels insecure
 - 83 ○ ○ ○ Feeling queasy; headache over eyes
 - 84 ○ ○ ○ Greasy foods upset
 - 85 ○ ○ ○ Stools light colored
 - 86 ○ ○ ○ Skin peels on foot soles
 - 87 ○ ○ ○ Pain between shoulder blades
 - 88 ○ ○ ○ Use laxatives
 - 89 ○ ○ ○ Stools alternate from soft to watery
 - 90 ○ ○ ○ History of gallbladder attacks or gallstones
 - 91 ○ ○ ○ Sneezing attacks
 - 92 ○ ○ ○ Dreaming, nightmare type bad dreams
 - 93 ○ ○ ○ Bad breath (halitosis)
 - 94 ○ ○ ○ Milk products cause distress
 - 95 ○ ○ ○ Sensitive to hot weather
 - 96 ○ ○ ○ Burning or itching anus
 - 97 ○ ○ ○ Crave sweets
- GROUP 6**
- 98 ○ ○ ○ Loss of taste for meat
 - 99 ○ ○ ○ Lower bowel gas several hours after eating
 - 100 ○ ○ ○ Burning stomach sensations, eating relieves
 - 101 ○ ○ ○ Coated tongue
 - 102 ○ ○ ○ Pass large amounts of foul-smelling gas
 - 103 ○ ○ ○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
 - 104 ○ ○ ○ Mucous colitis or "irritable bowel"
 - 105 ○ ○ ○ Gas shortly after eating
 - 106 ○ ○ ○ Stomach "bloating" after eating

1 2 3 GROUP 7A

- 107 Insomnia
- 108 Nervousness
- 109 Can't gain weight
- 110 Intolerance to heat
- 111 Highly emotional
- 112 Flush easily
- 113 Night sweats
- 114 Thin, moist skin
- 115 Inward trembling
- 116 Heart palpitates
- 117 Increased appetite without weight gain
- 118 Pulse fast at rest
- 119 Eyelids and face twitch
- 120 Irritable and restless
- 121 Can't work under pressure

GROUP 7B

- 122 Increase in weight
- 123 Decrease in appetite
- 124 Fatigue easily
- 125 Ringing in ears
- 126 Sleepy during day
- 127 Sensitive to cold
- 128 Dry or scaly skin
- 129 Constipation
- 130 Mental sluggishness
- 131 Hair coarse, falls out
- 132 Headaches upon arising, wear off during day
- 133 Slow pulse, below 65
- 134 Frequency of urination
- 135 Impaired hearing
- 136 Reduced initiative

GROUP 7C

- 137 Failing memory
- 138 Low blood pressure
- 139 Increased sex drive
- 140 Headaches, "splitting or rending" type
- 141 Decreased sugar tolerance

GROUP 7D

- 142 Abnormal thirst
- 143 Bloating of abdomen
- 144 Weight gain around hips or waist
- 145 Sex drive reduced or lacking
- 146 Tendency to ulcers, colitis
- 147 Increased sugar tolerance
- 148 Women: menstrual disorders
- 149 Young girls: lack of menstrual function

GROUP 7E

- 150 Dizziness
- 151 Headaches
- 152 Hot flashes
- 153 Increased blood pressure
- 154 Hair growth on face or body (female)
- 155 Sugar in urine (not diabetes)
- 156 Masculine tendencies (female)

GROUP 7F

- 157 Weakness, dizziness
- 158 Chronic fatigue
- 159 Low blood pressure
- 160 Nails weak, ridged
- 161 Tendency to hives
- 162 Arthritic tendencies
- 163 Perspiration increase
- 164 Bowel disorders
- 165 Poor circulation
- 166 Swollen ankles
- 167 Crave salt
- 168 Brown spots or bronzing of skin
- 169 Allergies - tendency to asthma

1 2 3

- 170 Weakness after colds, influenza
- 171 Exhaustion - muscular and nervous
- 172 Respiratory disorders

GROUP 8

- 173 Apprehension
- 174 Irritability
- 175 Morbid fears
- 176 Never seems to get well
- 177 Forgetfulness
- 178 Indigestion
- 179 Poor appetite
- 180 Craving for sweets
- 181 Muscular soreness
- 182 Depression; feelings of dread
- 183 Noise sensitivity
- 184 Acoustic hallucinations
- 185 Tendency to cry without reason
- 186 Hair is coarse and/or thinning
- 187 Weakness
- 188 Fatigue
- 189 Skin sensitive to touch
- 190 Tendency toward hives
- 191 Nervousness
- 192 Headache
- 193 Insomnia
- 194 Anxiety
- 195 Anorexia
- 196 Inability to concentrate; confusion
- 197 Frequent stuffy nose; sinus infections
- 198 Allergy to some foods
- 199 Loose joints

FEMALE ONLY

- 200 Very easily fatigued
- 201 Premenstrual tension
- 202 Painful menses
- 203 Depressed feelings before menstruation
- 204 Menstruation excessive and prolonged
- 205 Painful breasts
- 206 Menstruate too frequently
- 207 Vaginal discharge
- 208 Hysterectomy / ovaries removed
- 209 Menopausal hot flashes
- 210 Menses scanty or missed
- 211 Acne, worse at menses
- 212 Depression of long standing

MALE ONLY

- 213 Prostate trouble
- 214 Urination difficult or dribbling
- 215 Night urination frequent
- 216 Depression
- 217 Pain on inside of legs or heels
- 218 Feeling of incomplete bowel evacuation
- 219 Lack of energy
- 220 Migrating aches and pains
- 221 Tire too easily
- 222 Avoids activity
- 223 Leg nervousness at night
- 224 Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____