



<b>Sweating</b>	<b>Circulation</b>
<input type="checkbox"/> Night sweats <input type="checkbox"/> Rarely sweat <input type="checkbox"/> Excess sweating <input type="checkbox"/> Spontaneous sweating	Feelings of <input type="checkbox"/> Hot                      What area? _____ <input type="checkbox"/> Cold Hands and feet get easily cold: <input type="checkbox"/> Yes <input type="checkbox"/> No

**General**

<input type="checkbox"/> Chills <input type="checkbox"/> Low energy <input type="checkbox"/> Dizziness <input type="checkbox"/> Allergies	<input type="checkbox"/> Fatigue <input type="checkbox"/> Excess thirst <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain	<input type="checkbox"/> Aversion to heat <input type="checkbox"/> Aversion to cold <input type="checkbox"/> Low back pain <input type="checkbox"/> Joint disorders
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**Skin**

<input type="checkbox"/> Dry <input type="checkbox"/> Itchy <input type="checkbox"/> Moist, clammy <input type="checkbox"/> Burning <input type="checkbox"/> Blood not clotting <input type="checkbox"/> Hives	<input type="checkbox"/> Changing moles/lumps (cysts/tumors) <input type="checkbox"/> Boils <input type="checkbox"/> Frequent rashes <input type="checkbox"/> Acne <input type="checkbox"/> Bruises easily (black & blue spots)	<input type="checkbox"/> Hair loss/thinning <input type="checkbox"/> Dry scalp <input type="checkbox"/> Skin puffy/wrinkled <input type="checkbox"/> Dark circles under eyes <input type="checkbox"/> Other: _____
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**Sleep Problems**

<input type="checkbox"/> Trouble falling asleep <input type="checkbox"/> Trouble staying asleep <input type="checkbox"/> Restful	<input type="checkbox"/> Insomnia <input type="checkbox"/> Excess dreaming <input type="checkbox"/> Other: _____	How many hours do you sleep each night? _____
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**Head & Neck**

<input type="checkbox"/> Dizziness <input type="checkbox"/> Memory loss <input type="checkbox"/> Eye pain <input type="checkbox"/> Dry eyes	<input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Floaters <input type="checkbox"/> Loss of balance <input type="checkbox"/> Darkness under eyes	<input type="checkbox"/> Headaches: _____ (list area) <input type="checkbox"/> Other: _____
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**Ears & Nose**

<input type="checkbox"/> Poor hearing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear discharge/infections	<input type="checkbox"/> Ringing/buzzing in ears <input type="checkbox"/> Frequent nose bleeds <input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Congestion/allergies <input type="checkbox"/> Frequent colds <input type="checkbox"/> Other: _____
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**Chest**

<input type="checkbox"/> Hard to breathe <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Pain/pressure in chest <input type="checkbox"/> Palpitations	<input type="checkbox"/> Mucous rattles when breathing <input type="checkbox"/> Trouble breathing at night <input type="checkbox"/> Persistent cough <input type="checkbox"/> Chest pain <input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Swollen ankles <input type="checkbox"/> Coughing phlegm Color _____ <input type="checkbox"/> Other: _____
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**Genitourinary**

<input type="checkbox"/> Frequent urination <input type="checkbox"/> Daytime <input type="checkbox"/> At night <input type="checkbox"/> Hard to urinate	<input type="checkbox"/> Strong smelling urine <input type="checkbox"/> Pain or burning on urination <input type="checkbox"/> Blood in urine	<input type="checkbox"/> Frequent infections <input type="checkbox"/> Water retention <input type="checkbox"/> Other: _____
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**Gastrointestinal** (check those that apply)

	Often	Seldom	Severe	Mild	None
Poor appetite					
Excessive appetite					
Nausea					
Vomiting					
Belching					
Indigestion					
Stomach pain					
Lower abdominal pain					
Bloody Stools					
Black Stools					
Mucus in stools					
Hemorrhoids					
Lower bowel gas					
Stools have foul odor					
Colon problems					
Diarrhea					
Constipation					

**Neurological**

<input type="checkbox"/> Tremors <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling	<input type="checkbox"/> Pain <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures	<input type="checkbox"/> Poor coordination <input type="checkbox"/> Stroke <input type="checkbox"/> Other: _____
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**Emotional & Mental**

<input type="checkbox"/> Nervousness <input type="checkbox"/> Depressed <input type="checkbox"/> Easily angered <input type="checkbox"/> Easily irritated <input type="checkbox"/> Frequent crying <input type="checkbox"/> Disoriented	<input type="checkbox"/> Moody <input type="checkbox"/> Mind not clear <input type="checkbox"/> Manic <input type="checkbox"/> Obsessive <input type="checkbox"/> Compulsive <input type="checkbox"/> Anxiety	<input type="checkbox"/> Fearful <input type="checkbox"/> Terrors <input type="checkbox"/> Difficulty expressing emotions Other: _____
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**Lifestyle Habits**

(please state how much, how many and how often)

Cigarettes (packs): \_\_\_\_\_ Coffee/Tea (cups): \_\_\_\_\_

Alcohol (type/per week): \_\_\_\_\_

Prescription drugs: \_\_\_\_\_

Over-the-counter drugs: \_\_\_\_\_

Recreational drugs: \_\_\_\_\_

Vitamins/Herbs: \_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

Food cravings: \_\_\_\_\_

Exercise (type and frequency): \_\_\_\_\_

Briefly describe your diet: \_\_\_\_\_