Consultation Form

First Name (Print)_____ Last Name (Print)_____

Age_____ Sex_____ Address_____

City_____ State_____ Zip_____

Phone (Home)_____ Phone (Work)_____

Phone (Cell)_____ E-mail address_____

Date_____ Referral_____

Nationality_____ Occupation_____

Below, describe all of your complaints on the left side of the page, then list how long you have had them and how you are treating them directly opposite on the right side. Be sure to mention any drugs, vitamins supplements, or other medical substances you are taking.

Complaints: Brief Health History: (list major diseases, surgeries, etc.)	**How long have you had it?** How many times per year do you get a cold or the flu?	**Treatment:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical History

What other medications and/or supplements are you taking? _____
How long have you taken them? _____

Emotions: ❒ Normal ❒ Problem ❒ 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 ❒ Poor ❒ Many dreams ❒ Bad dreams ❒ Grinding teeth ❒ Talking in sleep
❒ Other Describe: _____

Diet: Any special diet? _____

Food Cravings: ❒ Sugar ❒ Salt ❒ Food allergies
Describe: _____

Temperature:
❒ Normal ❒ Abnormal ❒ Feel cold easily ❒ Cold hands ❒ Cold feet
❒ Feel hot easily ❒ Alternating hot & cold ❒ Hot flash ❒ Sensitive to weather changes
Describe: _____

Sweating: ❒ Normal ❒ Abnormal ❒ Too easily ❒ Too much ❒ Difficult
❒ Too little ❒ Night sweats ❒ Other
Describe: _____

Sensitivity and Allergy: ❒ No ❒ Yes

Temperature: ❒ Cold ❒ Hot ❒ Dampness light ❒ Noise ❒ Airborne particles ❒ Drugs ❒ Other
Describe: _____

Appetite and Digestion:
❒ Normal ❒ Abnormal ❒ Rapid hungering ❒ Poor appetite ❒ Nausea ❒ Anorexia
❒ Hungry, but no desire to eat ❒ Bloating ❒ Gas ❒ Other
Describe: _____

Bowel Movement: ❒ Normal ❒ Abnormal ❒ Constipation ❒ Diarrhea ❒ Loose
❒ Watery ❒ Incomplete ❒ Hard and dry ❒ Strong smell ❒ With mucus ❒ With blood
❒ Other Time of day: _____
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
❒ Other Number of time per day: _____ Number of times you get up to urinate at night: ____
Describe: _____

Eye, Ear and Nose: ❒ Normal ❒ Abnormal Describe: _____

Sex Function: ❒ Normal ❒ Abnormal Describe: _____

Menstrual Cycle: Age of onset: _____years old Date of last period: _____
❒ Regular ❒ Irregular How many days between cycles? _____ 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 ❒ After flow ❒ Depression
❒ Irritability ❒ Anger ❒ Sadness ❒ Crying ❒ Other
Describe: _____

Addictions: ❒ Tobacco ❒ Alcohol ❒ Others Describe: _____

Any other disorders or abnormalities: Describe: _____