Please Read this First

Welcome to the Alternative Medicine Family Care Center. We are committed to providing you with a personalized health plan tailored to your needs. Please be aware that many factors must be considered in designing the appropriate health building program for you, because treating the whole person requires attention to ALL symptoms and conditions. Often, minor symptoms are clues to delicate biochemical or somatic imbalances. Therefore, please complete this questionnaire as carefully and thoroughly as possible. This is a confidential record of your medical history and will not be released to any person or agency without your authorization.

NAME____DATE______________

ADDRESS__________________________CITY/STATE ________________ZIP CODE ________

HOME PHONE________________WORK PHONE________________CELL PHONE______________

E-MAIL ADDRESS______________________________ DOB____________ AGE________

SS#________________ MARITAL STATUS______________ CHILDREN? (AGES)________________

PARENT/GUARDIAN (If Patient is a Minor)____________________________________

HOW DID YOU FIRST LEARN ABOUT THE ALTERNATIVE MEDICINE FAMILY CARE CENTER?

Please list any medication you are taking and why you are taking them: ☐ No Medications

Please list any vitamins, herbs, or supplements you are taking and why are you taking them: ☐ No Vitamins, herbs, etc.

Please list any surgeries you have had and when did you have the surgery: ☐ No Surgeries

TO BE COMPLETED BY THE DOCTOR

Blood Pressure Supine:________________ Blood Pressure Standing:________________

Pulse Supine:____________ Standing:______________ With Exertion______________

Pulse Qualities____

____

Tongue Qualities_______________________________________

Please list your 5 major health concerns in YOUR order of importance:

1.____________________

2.____________________

3.____________________

4.____________________

5.____________________

Please circle the appropriate number from 0 – 3 on all questions below.
0 = least/never to 3 = most/always.

Category I

Feeling that bowels do not empty	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Do you use laxatives frequently?	0 1 2 3

Category II

Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables	0 1 2 3
Undigested foods found in stools	0 1 2 3

Category III

Stomach pain, burning, or aching 1 - 4 hours after eating	0 1 2 3
Do you frequently use antacids?	0 1 2 3
Feeling hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief of heartburn from antacids, food, milk, or carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3

Category IV

Roughage and fiber cause constipation	0 1 2 3
Indigestion and fullness lasts 2 - 4 hours after eating	0 1 2 3
Pain, tenderness, soreness on the left side under rib cage or bloated	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category V

Greasy or high fat foods cause distress	0 1 2 3
Lower bowel gas and bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from light clay colored to normal brown	0 1 2 3
Reddened skin, especially the palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed?	Yes No

Category VI

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep yourself going or to get yourself started	0 1 2 3
Get lightheaded if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory, forgetful	0 1 2 3
Blurred vision	0 1 2 3

Category VII

Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve cravings for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal to or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst & appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category VIII

Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

Category IX

Difficulty falling asleep	0 1 2 3
Perspire easily	0 1 2 3
Under high amounts of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

Category X

Tired, sluggish	0 1 2 3
Feel cold – hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight gain even with a low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression, lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of the eyebrows are thinned out	0 1 2 3
Thinning of hair on scalp, face, or genitals or hair excessively falling out	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XI

Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse rate even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category XII

Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars without symptoms	0 1 2 3

Category XIII

Increased sex drive	0 1 2 3
Tolerance to sugars reduced	0 1 2 3
"Splitting" type headaches	0 1 2 3
Secretion from breast in males or females (not nursing)	0 1 2 3

Category XIV (Males Only)

Urination difficult or dribbling	0 1 2 3
Urination frequent	0 1 2 3
Pain on the inside of legs or heels	0 1 2 3
Feeling of incomplete bowel evacuation	0 1 2 3
Leg nervousness at night. Restless legs.	0 1 2 3

Category XV (Males Only)

Decrease in libido	0 1 2 3
Decrease in spontaneous morning erections	0 1 2 3
Decrease in fullness of erections	0 1 2 3
Difficulty in maintaining morning erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decrease in physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

Category XVI (Menstruating Females Only)

Are you menopausal?	Yes No
Alternating menstrual cycle lengths	Yes No
Extended menstrual cycle, greater than 32 days	Yes No
Shortened menses, less than every 24 days	Yes No
Pain and cramping during period	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne break outs	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3

Category XVII (Menopausal Females Only)

For how many years have you been menopausal?	_________
Do you ever have uterine bleeding since menopause?	Yes No
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Shrinking in size of breasts	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Increased vaginal pain, dryness, or itching	0 1 2 3

How many alcoholic beverages do you consume per week? __________

How many caffeinated beverages do you consume per day? _________

How many times do you eat out per week? __________

How many times a week do you eat raw nuts or seeds? _____________

How many times a week do you eat fish? ___________

How many times a week do you workout? ________________________

Do you smoke? __________ If yes, how much do you smoke in the course of one day? ____

Rate your stress level on a scale of 0 – 10 during the average week (0 is no stress, 10 is unmanageable) __________________________________

Please list the three healthiest foods that you eat during the average week? ___________________, ___________________, __________________

Please list the three worst foods that you eat during the average week? ______________________, ___________________, __________________

TO BE COMPLETED BY THE DOCTOR

Hot:	**Cold:**
Excess:	**Deficiency:**
External:	**Internal:**
Qi:	**Blood:**
Dry:	**Damp:**
Yang:	**Yin:**

Color, nails, odor, scars, discharges, eruptions, excretions, skin tags, moles, skin patches, or other observations: