NAME _____

Please take the time to fill this form out completely. The more information we have, the better we can assist you, and will make better use of your initial visit. ☺

What is the main problem you would like help with, and how long ago did it begin?:		
To what extent does this interfere with your activities?	**What makes it better?**	**What makes it worse?**
Have you been given a diagnosis for this condition and what is it?		
Condition #2: What is the next important condition you would like help with, and how long ago did it begin?:		
To what extent does this interfere with your activities?	**What makes it better?**	**What makes it worse?**
Have you been given a diagnosis for this condition and what is it?		
Condition #3: What is the next important condition you would like help with, and how long ago did it begin?:		
To what extent does this interfere with your activities?	**What makes it better?**	**What makes it worse?**
Have you been given a diagnosis for this condition and what is it?		

Condition #4: What is the next important condition you would like help with, and how long ago did it begin?:

To what extent does this interfere with your activities?	What makes it better?	What makes it worse?

Have you been given a diagnosis for this condition and what is it?

Conditions #5: List any remaining conditions you would like help with, and how long ago did they begin?:

To what extent does this interfere with your activities?	What makes it better?	What makes it worse?

Have you been given a diagnosis for this condition(s) and what is it?

Are you taking:

Please list:

__ prescribed drugs / over-the-counter drugs
__ recreational drugs
__ vitamins / minerals / supplements / herbs
__ homeopathic remedies

What are your typical work and recreational activities (ie. computer, lifting, sitting or standing long periods, running, skiing, etc.)

Please describe your typical foods and beverages: (ie: dairy? protein? fruit? veggies? coffee? water? alcohol?)

Please *circle* any conditions you have had, and *note how recently*:

General
- Addictions (list:)
  _____
- AIDS / HIV / ARC
- Allergies (list:) _____
- Aversion to: cold / heat / wind / damp
- Bleed or bruise easily
- Cancer (type:) _____
- Candida / yeast infections
- Chills
- Chronic viral, bacterial, or parasitic infection
- Fevers
- Fatigue / Chronic Fatigue Syndrome
- Hepatitis
- Hot palms / soles (esp. at night)
- Organ or gland malfunctions (list:)
  _____
- Past history of IV drug use
- Poor sleep / insomnia / dream-disturbed sleep
- Sensitive to light / sound / easily startled
- Smoking
- Substance abuse
- Sudden energy drop
  Time of day? _____
- Surgeries / Major dental work: _____

  _____
- Thyroid disease
- Traumas, major (physical or emotional):

  _____
- Use of products containing Aspartame, Nutrasweet, or Equal
- Use of long-term prescription drugs (please list):

  _____

Cardiovascular / Chest
- Anemia
- Blood clots
- Chest pain / pressure
- Cold hands, feet
- Embolisms, thromboids, aneurism
- Fainting
- Heart Disease
- High blood pressure:
  Cause? _____
- High cholesterol
- Low blood pressure
- Palpitations / irregular heart beats
- Swelling of feet, hands
- Varicose veins

- Other _____

Ears
- Discharge from ear
- Earaches
- Poor hearing
- Ringing in ears

Eyes
- Blind field
- Blurry vision
- Cataracts
- Color blindness
- Discharge from eyes
- Excessive tearing
- Eye dryness
- Eye pain
- Eye strain
- Glasses / contacts
- Night blindness
- Poor vision
- Spots in front of eyes (floaters)

Gastrointestinal
- Abdominal pain or cramps
- Anorexia / Bulimia
- Antacid use, regular (Tums, etc.)
- Bad breath
- Belching
- Black stools
- Blood in stools
- Change in appetite
- Constipation
- Cravings
- Diabetes
- Diarrhea / Loose stools / watery stools
- Gas
- Gallstones
- Heartburn
- Hemorrhoids
- Hypoglycemia
- Indigestion
- Irritable Bowel Syndrome
- Lactose intolerant
- Laxative use, regular
- Nausea
- Nutritional deficiencies
- Peculiar tastes or smells
- Poor appetite
- Rectal pain
- Strong thirst (cold or hot)
- Thirst, no desire to drink
- Vomiting
- Weight gain
- Weight loss

- Other _____

Head / Mouth / Throat
- Cold sores (herpes)
- Concussions
- Dizziness / Fainting spells
- Facial pain
- Headaches
  When: _____
  Where: _____
- Lump in throat
- Migraines
- Sores on lips or tongue
- Sore throats, chronic
- Teeth problems
- TMJ / Grinding / Jaw clicks
- Other _____

Musculoskeletal
- Arthritis
- Bursitis / Tendinitis
- Carpal Tunnel
- Dislocations
- Fibromyalgia
- Fractures
- Herniated disk
- Inflammation
- Muscle cramping
- Muscle pain / soreness
  - Back: low / middle / upper / sacrum
  - Elbow
  - Foot / ankle / leg / thigh
  - Hand / wrist / lower arm / upper arm
  - Hip
  - Knee
  - Neck
  - Shoulder
- Muscle weakness
- Osteoporosis
- Pinched nerves
- Whiplash
- Other: _____

_____

Neuropsychological
- Anger / Anxiety / Fear / Sadness / Irritability
- Balance, lack of
- Coordination, lack of
- Depression
- Loss of control / violence potential
- Memory, poor
- Numbness, areas of
- Seizures
- Sleep disorder
- Stress, easily susceptible to
- Tremors
- Vertigo
- Weakness
- Worry
- Other _____

Nose
- Nasal drainage
- Nose bleeds
- Sinus congestion

OB Gyn / Pregnancy
pregnancies: _____
births: _____
premature births: _____
miscarriages : _____
abortions: _____
Age at first menses: _____
Period between menses: _____
Durations of menses: _____
First date of last menses:
_____
Menopause: Age ___ Year _____
Date of last pap: _____ Results: _____
Type of Birth Control _____

- Bleeding after intercourse
- Breast lumps
- Changes in body / emotions prior to period
- Clots
- Flow: light / medium / heavy
- Irregular periods
- Nipple discharge
- Painful periods
- Vaginal discharge

Family History:

Alcoholism	Cancer	High blood pressure	Other _____
Allergies	Diabetes	Seizures	
Asthma	Heart disease	Stroke	

If there are any health care providers you wish me to consult with, please list below:

Respiratory
- Asthma / wheezing
- Bronchitis
- Cough
- Coughing blood
- Difficulty breathing lying down
- Pain with deep breath
- Phlegm (color:_____)
- Pneumonia
- Shortness of breath

- Other: _____

Skin and Hair
- Acne
- Change in hair or skin
- Dandruff
- Edema (swelling)
  Where? _____
- Eczema
- Hair loss
- Hives
- Itching
- Moles, recent changes
- Oozing on skin lesion
- Ulcerations
- Rashes / Non-healing rash or lesion
- Sweat easily / Night sweats / Hot flashes

- Other _____

Uro-genital
- Blood in urine
- Change in sexual drive
- Color of urine: _____
- Decrease in flow
- Dribbling
- Frequent urination
- Genital herpes
- Impotence
- Incontinence
- Kidney stones
- Night urine
  How often: _____
- Pain or burning on urination
- Urgency to urinate
- Sores on genitals
- Viral / bacteria infections (list:)

- Other: _____

Any problems with using Eucalyptus, Menthol, Camphor, or Wintergreen?
YES NO

Therapy will not be administered to anyone under the influence of alcohol or other drugs. Cupping will not be administered to anyone with disease of the circulatory or lymphatic systems (ie. most cancers), or in any other cases where conditions contraindicate, unless permission has been obtained from your physician and you are willing to sign a release form.

I have read and filled out the above information to the best of my knowledge. I am responsible for making my practitioner aware of any changes in my conditions on an on-going basis *before* any therapy is administered.

_____

Signed Dated

How did you hear about this clinic? _____