Name: _____ **Date:** _____

Indicate with √ one check any conditions that you sometimes experience, use √√ two checks for those which occur often, and √√√ three checks for symptoms of major concern.

PRESENT HISTORY	WATER ELEMENT	WOOD ELEMENT
☐ ☐ ☐ Chills	☐ ☐ ☐ Hearing loss	☐ ☐ ☐ Headaches
☐ ☐ ☐ Fever	☐ ☐ ☐ Dizziness	☐ ☐ ☐ Migraines
☐ ☐ ☐ Sweating	☐ ☐ ☐ Ringing in ears – low pitch	☐ ☐ ☐ Ringing in ears – high pitch
☐ ☐ ☐ Pain	☐ ☐ ☐ Low back ache	☐ ☐ ☐ Poor eyesight
☐ ☐ ☐ Bedwetting	☐ ☐ ☐ Neck pain	☐ ☐ ☐ Dry/Red eyes
☐ ☐ ☐ Nightly Urination # of times:	☐ ☐ ☐ Sinus congestion	☐ ☐ ☐ Watering eyes
☑ Daily Urination # of times:	☐ ☐ ☐ Edema	☐ ☐ ☐ Eye infections
☑ Bowel Movement # of times:	☐ ☐ ☐ Darkness under eyes	☐ ☐ ☐ Blurry vision
☐ ☐ ☐ Long & thin stools	☐ ☐ ☐ Emotional instability	☐ ☐ ☐ Craving for sour taste
☐ ☐ ☐ Dry stools	☐ ☐ ☐ Aversion to cold	☐ ☐ ☐ Eczema
☐ ☐ ☐ Round, small stools, like pebbles	☐ ☐ ☐ Hair thinning or loss	☐ ☐ ☐ Shingles
☐ ☐ ☐ Pale stools	☐ ☐ ☐ Pre-mature aging	☐ ☐ ☐ Herpes
☐ ☐ ☐ Dark stools	☐ ☐ ☐ Frequent urination	☐ ☐ ☐ Warts
☐ ☐ ☐ Exhaustion after bowel movement	☐ ☐ ☐ Kidney stones	☐ ☐ ☐ Nervousness
	☐ ☐ ☐ Perspire very easily	☐ ☐ ☐ Convulsions/Spasms
Tongue:	☐ ☐ ☐ Night sweats	☐ ☐ ☐ Irritability
	☐ ☐ ☐ Afternoon fever	☐ ☐ ☐ Constipation
Pulse:	☐ ☐ ☐ Weakness of legs/knees or Sore knees	☐ ☐ ☐ Alternating constipation/ Diarrhea
L-	☐ ☐ ☐ Cold extremities	☐ ☐ ☐ Hepatitis
R-	☐ ☐ ☐ Asthmatic cough inhalation difficult	☐ ☐ ☐ Ulcer
	☐ ☐ ☐ Rapid weight change	☐ ☐ ☐ Vomiting
	☐ ☐ ☐ Loose teeth	☐ ☐ ☐ Gallstones
	☐ ☐ ☐ Reduced sexual energy	☐ ☐ ☐ Indecisive
	☐ ☐ ☐ Increased sexual energy	☐ ☐ ☐ Fullness below ribs
	☐ ☐ ☐ Thyroid problems	☐ ☐ ☐ Shoulder/Neck tension
	☐ ☐ ☐ Diabetes	☐ ☐ ☐ Insomnia 11pm – 3am
	☐ ☐ ☐ Fatigue	☐ ☐ ☐ Frustration
	☐ ☐ ☐ Poor memory/Concentration	☐ ☐ ☐ Depression
	☐ ☐ ☐ Craving for salty taste	☐ ☐ ☐ Anger easily
	☐ ☐ ☐ Thirst for hot drinks	☐ ☐ ☐ Bitter taste in the mouth
	☐ ☐ ☐ Dreams of boats/water/ ravines/fear/drowning	☐ ☐ ☐ Hemorrhoids
		☐ ☐ ☐ Wrist & hand pain/Soreness
		☐ ☐ ☐ Dreams of trees/afraid to get up/fights/cutting your own body

FIRE ELEMENT	EARTH ELEMENT	METAL ELEMENT
☐ ☐ ☐ Dry scalp	☐ ☐ ☐ Indigestion	☐ ☐ ☐ Bronchitis
☐ ☐ ☐ Skin eruptions / Rashes	☐ ☐ ☐ Flatulence	☐ ☐ ☐ Asthma exhalation difficult
☐ ☐ ☐ Cysts / Tumors	☐ ☐ ☐ Food allergy	☐ ☐ ☐ Shallow breathing
☐ ☐ ☐ Ear infections	☐ ☐ ☐ Stomachache/ulcer	☐ ☐ ☐ Cough
☐ ☐ ☐ Sore throat / Tonsillitis	☐ ☐ ☐ Loose stool	☐ ☐ ☐ Sinus congestion
☐ ☐ ☐ Lymphatic swelling	☐ ☐ ☐ Anemia	☐ ☐ ☐ Nasal infections
☐ ☐ ☐ Craving for bitter taste	☐ ☐ ☐ Bad breath	☐ ☐ ☐ Dry skin
☐ ☐ ☐ Hot hands/feet	☐ ☐ ☐ Sores on mouth	☐ ☐ ☐ Spontaneous sweating
☐ ☐ ☐ Aversion to heat	☐ ☐ ☐ Heartburn	☐ ☐ ☐ Catch colds easily
☐ ☐ ☐ Dry mouth	☐ ☐ ☐ Appetite increased	☐ ☐ ☐ Craving for spicy taste
☐ ☐ ☐ Gum problems	☐ ☐ ☐ Appetite decreased	☐ ☐ ☐ Dreams of white/cruel/ killing/fear/crying/flying/ metal/fields/rural landscapes
☐ ☐ ☐ Nosebleed	☐ ☐ ☐ Nausea	
☐ ☐ ☐ Facial redness	☐ ☐ ☐ Abdominal bloating	
☐ ☐ ☐ Itching/burning skin	☐ ☐ ☐ Low body weight	
☐ ☐ ☐ Heart palpitations	☐ ☐ ☐ Bleeding prolonged	
☐ ☐ ☐ Thirst for cold drinks	☐ ☐ ☐ Fatigue	
☐ ☐ ☐ Vivid dreaming	☐ ☐ ☐ Vomiting	
☐ ☐ ☐ Dark urine	☐ ☐ ☐ Bruising easily	
☐ ☐ ☐ Night sweats	☐ ☐ ☐ Organ prolapses	
☐ ☐ ☐ Chest pain	☐ ☐ ☐ Craving for sweet taste	
☐ ☐ ☐ Insomnia: falling asleep	☐ ☐ ☐ Heaviness in legs	
☐ ☐ ☐ Insomnia: waking up	☐ ☐ ☐ Sticky saliva	
☐ ☐ ☐ Sores on tongue	☐ ☐ ☐ Vaginal infections	
☐ ☐ ☐ Fatigue upon waking	☐ ☐ ☐ Thirst but don't like to drink	
☐ ☐ ☐ Very thirsty	☐ ☐ ☐ Dreams of food/building /walls/singing/music/heavy /body/difficulty getting up /abysses/marshes/storms	
☐ ☐ ☐ Thirst but only like small sips		
☐ ☐ ☐ Dreams of fire/laughing/fear /hills/mountains/populated cities or streets		

Describe the circumstances around your Birth (traumas, full term, parent's age etc.):

_____

_____

_____

List your CHIEF COMPLAINTS in order of priority and their date of onset:

_____

_____

_____

_____

_____

Describe a typical day's DIET, including beverages:

BREAKFAST	LUNCH	DINNER

Do you now or have you ever undertaken a restricted DIET? Please give dates and describe:

_____

_____

_____

MENSTRUATION:

Length of cycle: □ 28 days / □ _____ days / □ irregular (give range _____ days)

Length of bleeding: _____ days

Color of blood: □ bright red / □ dark red/ □ brown / □ purple

Consistency of blood: □ normal / □ sticky, thick / □ watery / □ clots

PMS: □ breast distention/ □ cramps: □ before or □ during / □ headaches / □ chocolate craving / □ bloating, edema / □ other:

_____

Date of last menstrual period: _____

Number of pregnancies: _____

Number of children: _____

List all SURGERIES and their approximate dates:

_____

_____

_____

_____

List all prescription DRUGS you are taking and any history of non-prescription & prescription drug use:

_____

_____

Choose one or two EMOTIONS that are influential in your life which are either frequently experienced or difficult to express:

_____

_____

Describe any TRAUMATIC experiences you have had and give their approximate dates (i.e., divorce, change of residence, injury, death in the family, bankruptcy, etc.)

Date:	**Event:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Briefly describe your EMPLOYMENT HISTORY:

Date:	**Employment:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Describe your current program of PHYSICAL FITNESS:

_____

_____

_____

What types of ACUTE ILLNESSES do you suffer from and approximately how often have you experienced them in the last five years?

_____

_____

_____

List any SERIOUS OR CHILDHOOD ILLNESSES and their approximate dates:

_____

_____

_____

Check any FAMILY HISTORY of illness:

□ Asthma	□ Arthritis	□ Migraines
□ Autoimmune disease	□ Epilepsy	□ Alcoholism /drug addiction
□ Heart disease	□ Kidney disease	□ Cancer
□ High blood pressures	□ Infertility	□ Anemia
□ Heart attack	□ Fibroids	□ Mental illness
□ Miscarriage	□ Hepatitis	□ Tuberculosis
□ Allergies	□ Stroke	□ Diabetes