Please complete this form as best you can and circle choices where possible. Thankyou.

| | | | | |
|---|---|---|---|---|
| **NAME:** Surname | Given Name | | | Mr/Mrs/Miss |
| **ADDRESS:** | | | | |
| **PROFESSION/TRADE:** | | | | |
| **CONTACTS: Home** | **Work** | **Mobile** | | |
| **E-mail:** | | **DATE OF BIRTH:** | | **AGE:** |
| **WEIGHT:** | **HEIGHT:** | **MARITAL STATUS:** | **CHILDREN:** | **BLOOD TYPE:** |
| **CHILDHOOD DISEASES:** | | | | |
| **FAMILY HEALTH STATUS:** | | | | |
| **OPERATIONS, SCARS, HOSPITAL DIAGNOSES:** | | | | |
| **PAST MEDICATIONS:** | | | | |
| **PRESENT MEDICATIONS:** | | | | |
| **MODALITIES TRIED:** eg Acupuncture, Herbs, Massage, Naturopathy, Chiropractic, Physiotherapy, Bowen, Kinesiology, Iridology, Chinese Herbs | | | | |

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|---|---|
| **SLEEP:** | Heavy/Light/Cannot/Too Much/Dreams/Wake up tired |
| **HEADACHES:** | Constant/Intermittent - Frequency<br>Location - Front/Side L/R/Back/Top Pain - Dull/Throbbing/Tight Band |
| **THROAT:** | Cough/Sore/Phlegm/Difficulty Swallowing/Ticklish/Dry |
| **NOSE:** | Blocked/Running/Bleeds/Sinusitis/Hay Fever/Allergies |
| **EARS:** | Ringing - Loud/Soft/Constant/Intermittent Poor Hearing/Pain |
| **EYES:** | Itchy/sore/bloodshot/blurred vision/spots before the eyes |
| **CHEST:** | Heavy/Pain/Tight/Palpitations/Pacemaker |
| **SWEATING:** | Sweat easily/Night Sweats/Rarely Sweat |
| **CHILLS AND FEVERS:** | Catch Colds easily/Prone to Cold/Prone to Heat |
| **APPETITE:** | Strong/Medium/Poor |
| **THIRST:** | Often Thirsty/Thirsty especially at Night/Little Thirst |
| **BOWELS:** | Frequency Consistency - Hard/Medium/Soft<br>Tendency to Constipation/Diarrhoea |
| **DIET:** | Sweet/Salty/Sour/Spicy/Bitter/Alcohol/Cigarettes/Coffee |
| **URINE:** | Copious/Scanty/Clear/Dark/Incontinent |
| **MENSTRUAL CYCLE:** | Regular/Irregular/Painful/Clots/Heavy/Light/Pill |
| **STIFFNESS/PAIN:** | Shoulders/Neck/Back L R /Upper/Middle/Lower/Hip L R |
| **NUMBNESS:** | Arm/Hand L R /Leg/Foot L R |
| **SKIN:** | Clammy/Puffy/Dry/Oily/Itchy/Rashes |
| **ENERGY:** | Not enough/Tire easily/Erratic/Always tired |
| **EXERCISE:** | Frequency<br>Gym/Yoga/Running/Aerobics/Swimming/Martial Arts/Sport/Walking/Tai Qi |
| **MOST DISTRESSING SYMPTOMS:** | |