SYMPTOM SURVEY

Name: ______________________________ **Age:** __________ **Date:** ______________

This survey will allow your practitioner to evaluate your whole person more completely in order to provide you with individualized care. All information will be held confidential.

What are your primary health concerns for which you are seeking treatment?

1. ____________________________ **2.** ___________________________ **3.**____________________________

Do you have a primary care physician? Please name: ____

Have you received any prior treatment for the above complaints? If so, please list the nature of the treatment(s), the approximate date(s), and whether or not it was helpful:

____
____
____
____
____

Have you had any Western medical tests such as x-rays, MRI's, or blood tests for the above complaints? Please indicate the results and the approximate dates below:

____
____
____
____

Do you have any known allergies?

Food: _____________________________________
Medications: ________________________________
Pollens: ____________________________________
Pet: _______________________________________

MSG: ______________________________
Chemicals: __________________________
Other: _____________________________
____

Please place a check mark next to those symptoms which you NOW experience or have experienced in the PAST. If there are one or more words in a line which describe your specific symptoms, ***please circle those words.***

GENERAL SYMPTOMS	NOW	PAST	GENERAL SYMPTOMS	NOW	PAST
Tired, Weak, Low energy			Sweat too much/Too little		
Depression, Melancholy, Irritability			Night sweats		
Worry, Anxiety, Nervousness			Dizziness, Fainting, Convulsions		
Sleeplessness, Sleep too much			Loss of weight, Weight gain		
Headaches			Other:		

EYES	NOW	PAST	EARS	NOW	PAST
Blurred vision			Earaches		
Dryness, Burning, Itchy			Ear ringing		
Bloodshot, Redness, Puffy			Ear discharges, Excess wax		
Floaters			Loss of hearing		
Other:			Other:		

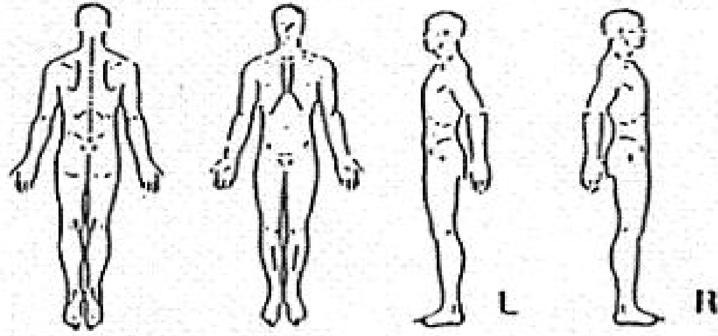
NOSE AND THROAT	NOW	PAST	RESPIRATORY	NOW	PAST
Hay fever, Sinusitis, Runny nose			Difficulty breathing		
Dry mouth or nose			General shortness of breath		
Nosebleeds			Shortness of breath on exertion		
Dry lips			Spitting or coughing up mucus		
Sore throat			Spitting or coughing up blood		
Clear throat frequently			Chest tightness		
Sore, Red, or Cracked tongue			Chest pain		
Cold sores, Herpes			Other:		
Inability to smell or taste					
Bleeding gums					
Other:					

SKIN AND HAIR	NOW	PAST	SKIN AND HAIR	NOW	PAST
Acne, Pimples			Numbness/Tingling		
Skin rashes			Burning sensation in feet		
Hives, Itchy skin			Athletes foot		
Skin ulcers or sores			Hair loss, Hair thinning		
Dryness, Roughness, Scaling skin			Dry hair, Coarse hair		
Brown spots			Bruise easily		
Moles, Warts			Other:		

GASTROINTESTINAL	NOW	PAST	GASTROINTESTINAL	NOW	PAST
Loss of appetite			Diarrhea or loose stools		
Difficulty swallowing			Constipation		
Nausea, Vomiting			Alternating diarrhea/constipation		
Bad breath			Light colored or greasy stools		
Metallic or Bitter taste in mouth			Dark stools		
Food cravings			Blood in stools		
Heartburn			Undigested food in stool		
Indigestion			Foul odor of stool or gas		
Heaviness after eating			Hemorrhoids		
Gas, bloating, belching			Avoid certain foods		
Tender or painful abdomen			Gallbladder stones		
Symptoms relieved by eating			Pain under ribs		
Symptoms worse after eating			Other:		

CARDIOVASCULAR	NOW	PAST	URINARY	NOW	PAST
Irregular or fast heart beat			Difficult urination		
Chest tightness, Chest pain			Frequent urination at night		
Dizzy or weak when standing up			Bed-wetting		
Swollen feet, Ankles, or Legs			Incomplete urination or dribbling		
Cold Hands or Feet			Painful urination		
Leg pains when walking			Bladder infection		
Varicose veins/Spider veins			Kidney infection		
Tendency toward anemia			Kidney stones		
High/Low blood pressure			Low back pain		
Other:			Other:		

MUSCULOSKELETAL: Please circle areas of pain.



MUSCULOSKELETAL	NOW	PAST
Muscle stiffness		
Swollen, painful, stiff joints		
Bone pain		
Tremors, Twitches		
Loss of strength		
Hernia		
Muscle wasting		
Broken bones		
Other:		

FEMALE	NOW	PAST	MALE	NOW	PAST
Irregular menstruation			Prostate problems		
Pain prior to or with menses			Difficult or Unusual urination		
Depressed, Irritable with menses			Discomfort in genital area		
Painful or Swollen breasts			Pain in genital area		
Discharge from breasts			Diminished sexual desire		
Lumps in breasts			Excessive sexual desire		
Hot flashes			Difficulty maintaining an erection		
Diminished or Excessive sexual desire			Penile discharge		
Inability to conceive			Other:		
Miscarriages, Abortions					
Vaginal discharge					
Discomfort, Dryness, Itching in genital area					
Other:					

FEMALE	
Date of last period:	
Number of days:	Length of cycle:
Date of last pap smear:	
Was it normal?	
Birth control?	Method:
Have you ever used birth control?	
Methods used:	

Have you been exposed in significant or long term doses to chemicals, radiation, toxins, or other? If so, please explain:

___

___

Please indicate any incidents (and approximate dates) for which you may have had surgery or have been hospitalized for a serious accident or illness.

___

___

___

___

Do you have any chronic illnesses? If so, please list:

___

___

Do you have any contagious diseases? If so, please list:

___

___

Have you traveled outside the USA within the last two years? Where?

___

___

Height: __________ Current weight: ___________ Past maximum weight: ___________ When: __________
Most recent blood pressure reading: __________

HABITS (Please estimate frequency or quantity)

Cigarettes or Tobacco _______ packs a day

Coffee or Black Tea _______ cups a day

Alcohol _____drinks per week, or _____ per month

Soda _____________ per day

Marijuana or other drugs ______ times per week

Vitamins (Please list)

____
____
____
____

Over the counter supplements (Please list)

____
____
____
____

Prescription medications (Please indicate dosage)

____
____
____
____
____

Please describe your current diet:

Breakfast: ________________________________

Lunch: ________________________________

Dinner: ________________________________

Snacks: ________________________________

____

What is your current exercise pattern? What physical activities do you enjoy?

____
____
____
____
____

Have you or any of your family members had any of the following illnesses? Please indicate the person's relationship to you and their age (if living).

High blood pressure:____
Heart problems: ____
Stroke: ____
Diabetes: ____
Cancer: ____
Psychological illnesses: ____

Thank you!