jade river healing arts

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Welcome!

Please help me to provide you with a complete evaluation by taking the time to fill out this form carefully.

Name: Date of Birth: Todays date:

Address: City/State: Zip:

E-mail:

Phone:

Occupation: Employer:

Marital Status: Single Partnered Married Divorced Children/Ages:

Emergency Contact: Relationship: Phone:

Primary Care Physician:

Referred by:

Present Health Concerns

What are the **main** reasons for today's visit in order of importance?

1.

2.

3.

4.

Personal History

Personal Medical History:

Family Medical History:

Any serious or communicable conditions (HIV, HPV, hepatitis, herpes):

Please describe any allergies (drug, food, environmental):

YES	NO	
?	?	Do you have any problems with bruising or bleeding?
?	?	Do you have a pacemaker?
?	?	Women-are you or do you think you may be pregnant?
?	?	Have you ever been treated for drug addiction?
?	?	Have you ever been treated by a mental health care provider?
?	?	Have you ever considered or attempted suicide?

Personal Lifestyle

Please list any medications, vitamins, herbs or supplements you are currently taking:

Please indicate the amount you use of the following:

Water Coffee/tea Alcohol Tobacco Recreational drugs

Diet Restrictions:

Do you exercise? Please describe.

Do you enjoy your job? How many hours do you work?

How is your home life? Support network?

Please indicate any symptoms you have experienced in the past month.

LvQiShi

Stress
moodiness/ mood swings
irritability/frustration
depression
cold hands or feet
Indicate any areas of pain or discomfort: neck, jaw, shoulders, hips, sciatica
nausea, hiccups, belching or flatulence
frequent sighing
nightmares
high-pitch ringing in one or both ears
difficulty making decisions
migraines
jaw: grinding, clenching, tension, pain

Indicate type of headaches you experience:

behind eyes, temples, sinus, top of head, back of head, side of head, band around head, all over, throbbing, dull ache, tight, pulling, pressure, distending

Xsyang

feeling frequently warm or hot
agitation or unease in the chest
mental restlessness
easily angered or explosiveness
thirst for cold drinks
bad breath
bleeding gums
acid reflux or heartburn
vertigo

Ht

difficulty falling asleep
wakes how many times in the night? Can you fall back asleep again easily?
restless sleep
doesn't remember dreams
heart palpitations
anxiety
poor memory or concentration
sores in mouth or tongue
easily startled

SpQi

fatigue/lethargy
nausea
diarrhea
constipation
gas
poor appetite
tired after eating
weak digestion
abdominal distention/bloating
bruises easily
cravings for sweets
easily worried
tendency toward obsessive thinking/rumination

SpYangXu

feeling frequently cold
lack of motivation
excessive desire to sleep
hemorrhoids
edema

LuQiXu

shortness of breath
spontaneous perspiration
cough upon exertion or talking
no desire to talk
How often do you get sick?
asthma

seasonal allergies/hay fever
frequent runny nose or stuffy sinuses

Indicate any skin issues:
rashes, eczema, psoriasis, hives, acne, boils
easily disappointed or offended
sensitive to wind, cold or dryness
sadness, melancholy or nostalgic for the past

KdQiXu
Indicate any of the following areas of pain or discomfort:
low back, knees, ankles or feet
urination: frequency, urgency, leakage, dribbling, weak stream
waking to urinate
low libido
difficulty maintaining or getting an erection
premature gray hair
hair loss
forgetfulness
dark around the eyes
dull or diminished hearing
low humming in one or both ears

Damp
edema, puffy eyes, face, ankles or hands
feeling of heaviness in the head, abdomen or limbs
achy body
no desire to drink liquids
excessive mucus

XueXu
pain or injury to tendons
numbness, tingling of the limbs
dizziness
dry skin, eyes or hair
pale or brittle nails
difficulty seeing at night
see floaters in one or both eyes
cataracts
glaucoma
impaired vision
itchy eyes

Yinxu
symptoms worse in the evening
sensation of heat in the palms, the soles or the chest
feeling warm at night
sweating while sleeping
feeling flushed, especially in the afternoon
hot flashes
sore throat when fatigued or overtired
dry mucous membranes, throat or mouth
nocturnal emissions or premature ejaculation

Gynecological

First day of last menstrual period was:

Number of pregnancies: Births: Miscarriages: Abortions:

Have you ever been on birth control pills? For how long?

What type of birth control do you currently use?

Menopause: When? Symptoms?

Menstrual cycles:

Regular- every _______ days Irregular -tends to be early &/or late

How many days of blood flow:

Volume:

Light Medium Heavy Begins_______ & becomes_______ Hesitant flow (starts & stops)

Color:

Pale Red Bright red Dark red Purple Brown Black

Consistency:

Few clots Many clots Clot size ________ Watery Mucousy Gritty

Pain & Cramps:

Before period After period During period Associated with passing clots

Diffuse achy Sharp and piercing Tight and twisty Other_______________

Localized on the lower abdomen sides of abdomen lower back legs

Feels better with pressure Feels worse with pressure

Better with heat Better with movement Better with rest

Premenstrual Symptoms:

Changes in emotions & moods Fatigue Breast swelling Nipple pain

Abdominal distention Water retention Cravings (salty or sweet?) Acne Herpes

Achy joints Headaches Migraines. Difficulty sleeping Night sweats

Other: Infertility Hysterectomy Tubal ligation

Fibroids Ovarian cysts Endometriosis

Vaginal discharge Yeast infections Breasts lumps