

(Parents should fill out this form for young children based on observation. Children over 4 or 5 years old can be asked some of the questions. Please then write their answers, plus your own observations.)

**FOOD:**

1. What foods do you especially like, or crave (even if you don't eat them)?

2. What foods do you dislike?

3. What foods disagree with or aggravate you in some way?

5. How is your appetite? Poor, average, high? Specify.

6. Any problems with digestion? Specify.

7. Any problems if you go too long without eating (headache, shakiness, etc.), and how many hours can you go without eating before getting these symptoms?



**THERMAL STATE:**

1. Which do you tolerate the LEAST: extreme hot weather, or extreme cold weather? Please specify if either extreme causes or aggravates any symptoms.

Is this a lifelong tendency, or has it changed in recent years?

2. Are you affected by a draft of air? How?

3. Does any particular weather affect you (rainy/damp, hot & humid, dry, windy, etc.)? How?

4. How do you like or tolerate the direct sun? Any symptoms if in it too long?

5. Do thunderstorms affect you? How?

6. How do you feel at the ocean? Any improvement in symptoms there?

7. Any reaction to moon phases?

8. Any dislike for a particular season (Spring, Fall, etc.), or seasonal worsening of symptoms?

9. Any desire for open air (fresh air, open windows, bedroom window cracked, etc.)? How strong?



**PERSPIRATION:**

1. Circle one:      Absent              Mild              Moderate              Heavy

2. In what particular areas to you perspire?

Head              Back              Chest              Groin              Hands              Feet

3. Any particular odor to the perspiration? Describe.

4. Any stains left on clothing or sheets? Describe.

**ENERGY:**

1. On average, where does your energy usually fall on the following scale (circle):

can hardly get out of bed                                      average                                      plenty each day  
1              2              3              4              5              6              7              8              9              10

2. What is your best time of day or night?

3. Worst time of day or night?

4. Does anything else modify your energy (make it better or worse)? Explain.

5. On average, how is your motivation to do the things you need and want to do each day (circle):

none                              could be better                              pretty good                              excellent  
1              2              3              4              5              6              7              8              9              10



**SLEEP:**

1. Any problems falling asleep at night? Describe.

2. Any problems staying asleep all night? Describe, and include if you usually wake at a certain time.

3. What is your preferred position to sleep in? Why?

4. Any position you cannot sleep in? Why not?

5. In your sleep, do you (circle):

snore          talk          grind teeth          sweat          drool          move a lot  
stick feet out of covers          put arm(s) over/under your head

6. Do you wake refreshed in the morning?

7. How easy or difficult do you find it to wake up? How long does it take to feel fully awake most days?

8. Do you prefer to have covers on?          Can you sleep without them in warm weather?

9. Do you recall dreams? If so, relate any recurring dreams or themes (even back in childhood). Also, please describe any recent dream, including any feelings you had in the dream.



**PSYCHOSOCIAL HISTORY:**

Please take your time with this section, and answer with as much honesty as possible. Using specific examples is most helpful. Use the back of the page or attach a page if needed.



1. What about others do you admire the most (or is there someone in particular you admire or have looked up to)? Why?

2. What about others annoys you or do you dislike? This could be a character trait, or something people do that really irks you.

3. How do you express your anger? What triggers it? How have you expressed it at your worst?

4. When upset about something, do you prefer to be left alone, or to have someone available for talking/ consolation?

5. How do you respond to music? How intense is your response?

6. How much do you like or desire to travel?

7. How important is someone else's opinion of you (what others think of you)?



8. Briefly describe your relationship with your father (now and/or in the past):

9. Briefly describe your relationship with your mother (now and/or in the past):

10. Briefly describe any other significant relationships or life circumstances that affect you now (and/or have affected you in the past):

11. Briefly describe your spiritual/religious beliefs:

12. Have you ever dealt with any addiction issues (personally, or with family members)? What addiction?



13. Describe your nature when you were a child? What were you like? What affected you?

14. If you feel this applies to your health, complete the following sentence: "I have never been well since.....":

15. Is there anything else that you feel affects your health now?





**FEARS:** Circle any of the following common fears that you either currently have, or had as a child:

Dark	Storms	Ghosts	Being alone
Basements	Dogs	Cats	Snakes
Spiders	Birds	Mice/rats	Other animals
Doctors	Dentist	Needles	Blood
Health issues in general	Cancer	Heart disease	Germes
Death	Others dying (family)	Accidents	Robbers
Poverty	Failure	Public speaking	Taking tests
Heights	Narrow places (claustrophobia)	Water	Crowds
Bridges	Airplanes	Insanity	Vague sense of foreboding
Please list any other fears:			

Do you have any particular worries that you don't consider fears? Be specific please.



**REVIEW OF SYSTEMS**

Please indicate whether you have any problems in the following areas (or had problems in the past). Please give a brief description, especially if the area is an intense or recurrent problem.

## 1. HEAD:

- Headaches
- Migraines
- Dizziness
- Dandruff
- Other:

## 2. EYES:

- Blurry vision
- Itchy eyes
- Light sensitivity
- Pain
- Dryness
- Redness
- Other:

## 3. EARS:

- Ringing
- Infections
- Hearing problems
- Excess wax
- Discharge
- Itching
- Other:

## 4. NOSE:

- Sense of smell (acute, lost, etc.)
- Sinus pain
- Discharge
- Stuffiness
- Sneezing
- Allergies
- Bloody noses
- Crusts inside
- Other:

## 5. MOUTH/THROAT:

- Sense of taste (altered, lacking, bad taste in mouth, etc.)
- Teeth (pain or other problems)
- Tongue
- Bleeding gums
- Canker sores



- \_\_\_\_\_ Sore throats
- \_\_\_\_\_ Change in voice
- \_\_\_\_\_ Cold sores (herpes)
- \_\_\_\_\_ Bad breath
- \_\_\_\_\_ Trouble swallowing
- \_\_\_\_\_ Lump sensation in throat
- \_\_\_\_\_ Other:

6. NECK:

- \_\_\_\_\_ Sensitive to anything snug worn at neck
- \_\_\_\_\_ Thyroid issues
- \_\_\_\_\_ Neck pain
- \_\_\_\_\_ Stiffness
- \_\_\_\_\_ Other:

7. CHEST:

- \_\_\_\_\_ Chest pains
- \_\_\_\_\_ Heart palpitations
- \_\_\_\_\_ Shortness of breath
- \_\_\_\_\_ Wheezing
- \_\_\_\_\_ Cough
- \_\_\_\_\_ Breast tenderness
- \_\_\_\_\_ Breast lumps
- \_\_\_\_\_ Other:

8. ABDOMEN/GI:

- \_\_\_\_\_ Appetite
- \_\_\_\_\_ Heartburn/reflux
- \_\_\_\_\_ Belching
- \_\_\_\_\_ Nausea
- \_\_\_\_\_ Stomach pain
- \_\_\_\_\_ Bloating/distention
- \_\_\_\_\_ Abdominal pain
- \_\_\_\_\_ Ulcers
- \_\_\_\_\_ Constipation/difficult stool
- \_\_\_\_\_ Diarrhea
- \_\_\_\_\_ Flatulence
- \_\_\_\_\_ Hemorrhoids
- \_\_\_\_\_ Change in stool (color, consistency, shape, etc.)
- \_\_\_\_\_ Sensitive to anything snug worn around waist
- \_\_\_\_\_ Other:



9. GU/FEMALE:

- Heavy Menstruation
- Painful Menstruation
- PMS
- Vaginal discharge
- History of STD's
- Menopause/Perimenopause
- Sex drive (libido)
- Fertility issues
- How old were you at your first period?
- How old at menopause?
- Number of pregnancies
- Number of miscarriages
- Other problems that would get worse around periods
- Other problems with periods
- Urinary tract/bladder infections
- Blood in urine
- Urinary incontinence
- How many times to you urinate in the night?

10. GU/MALE:

- Trouble urinating (starting, force of stream, incomplete emptying, etc.)
- Incontinence
- History of STDs
- Prostate issues
- Testicular pain or swelling
- Blood in urine
- Erections
- Sex drive (libido)
- How many times do you urinate during the night?
- Other:

11. MUSCULOSKELETAL/EXTREMITIES:

- Body stiffness
- Joint pains
- Muscle pain
- Low back pain
- Other back pain
- Sciatica
- Muscle cramps
- Swelling/edema
- Significant injury in the past
- Other:



12. SKIN/INTEGUMENT:

- Acne
- Eczema
- Psoriasis
- Ringworm
- Dry skin
- Itchy skin
- Easy bruising
- Discoloration
- Skin infections/boils/cellulitis
- Moles, skin tags
- Skin cancer
- Nails (soft, slow growing, split, brittle, ridged, etc.)
- Hangnails
- Ingrown toenails
- Toenail fungus
- Sensitivity to metals
- Tendency to poison ivy
- Hair falling out
- Hair went gray early
- Hair very dry/breaks/slow growing
- Other:

13. NEUROLOGIC:

- Fainting or feeling faint
- Seizures
- Tremors
- Balance problems
- Numbness
- Weakness
- Tingling
- Restless legs (awake or in bed)
- Other:

14. MENTAL/EMOTIONAL:

- Depression
- Anxiety
- Anger
- Irritability
- Mood changes
- Concentration/focus
- Memory
- Confusion
- Change in behavior
- Other:



GENERAL:

- Weight gain (unintended)
- Weight loss (unintended)
- Fever
- Chills
- Night sweats
- Sleep problems
- Fatigue
- Anemia
- Reaction to vaccination
- Oversensitive to medications
- Oversensitive to chemicals/odors
- Other:

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