**First Consultation Questionnaire Form**

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| **Name:** | **Date of birth:**  |
| **What is your main reason for seeking treatment?** |
| **Major Symptoms:** Please list in order of importance what symptoms concern you and for how long has this problem been going on? |
| **To what extent do these conditions interfere with your daily activities (work, sleep, socializing, etc.)?** |
| **Have you had other forms of treatment for this condition previously? If yes, what was it and how successful have they been?**  |
| **Previous illness：** |
| **Surgical history:** |
| **Allergy reaction:** | **How was your general health as a child?** |
| **Medication or supplements:** |
| **Please describe your pain**

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| --- | --- | --- | --- |
| Constant ( ) | Comes & Goes ( ) | Fixed ( ) | Moves ( ) |
| Unilateral ( ) | Dull ( ) | Sharp ( ) | Burning ( ) |

Better:

|  |  |  |
| --- | --- | --- |
| Heat ( ) | Cold ( ) | Motion ( ) |
| Rest ( ) | Pressure ( ) | When: am or pm |

**Worse:**

|  |  |  |
| --- | --- | --- |
| Heat ( ) | Cold ( ) | Motion ( ) |
| Rest ( ) | Pressure ( ) | When: am or pm |

**Pain level: (0-better to 10-worse)** **Pain Scale: 0 1 2 3 4 5 6 7 8 9 10** **Function Scale: 0 1 2 3 4 5 6 7 8 9 10** | image10**Circle for pain** |

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| **Do you have:**  |
| Heart Disease/ Pacemaker |  | Kidney disease  |  | Infection disease (HIV) |  | Haemophilia | Epilepsy 0r Seizures  |  |
| Thrombosis (blood clots) |  | Diabetes |  | Hepatitis A B or C |  | Surgical Replacements  | Fear of Needles |  |
| Bleeding disorder |  | Cancer |  | Tuberculosis |  | Implants | Others:  |  |
| **Family history (Mother, Father, Siblings, Grandmother, Grandfather)**  |
| Alcoholism |  | Bleeding disorder |  | Diabetes |  | Kidney Disease |  | Stroke |  |
| Allergies |  | Cancer |  | Heart Disease |  | Mental illness |  | Other: |
| Asthma |  | Depression |  | High Blood Pressure |  | Seizures |  |

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| **For Men** |
| Do you have any bothersome urinary symptoms? YES NOIf yes, please describe: |
| Do you have the following signs / symptoms?

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| Frequent need to urinate at night | Pain of testicles | Premature ejaculation |
| Impotence/ erectile dysfunction | Pain or swelling of the testicles | Feeling of coldness or numbness in genitalia |

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| **For Women** |
| Are you pregnant now? YES NO UNSURE | Age: First period \_\_\_\_\_\_\_\_\_ | Menopause (if applicable) \_\_\_\_\_\_\_\_\_ |
| How many Live Births: | Miscarriages: | Abortions: |  |
| Have you been through IVF? | Do you have any gynecological issues? |
| Date: Last pap smear | Last mammogram |
| Any history of an abnormal pap smear? YES NO | It’s your menstruation regular? |
| How many days of your menstrual cycle? | Average number of days of flow? |
| How many days of your period last? The  | Flow is: NORMAL HEAVY LIGHT |
| The color is: NORMAL DARK PURPLE LIGHT BROWN BROWN  |
| Do you have the following menstruation related signs/symptoms?

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| --- | --- | --- | --- |
| PMS  | Cramps or dull pain  | Breast distention | Blood clots |
| Lower abdominal pain  | Lower back pain with cold sensation  | Cold intolerance  | Nausea or vomiting |
| Bloating or constipation  | Epigastric distending pain | Fatigue | Irritable and restless |
| Mood swings  | Headache or migrants  | Vaginal discharge | Bleeding between periods |

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| Do you get up at night to urinate? YES NO | If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Which conditions do you have now (N) or had in the past (P)** |
|  | N | P |  | N | P |  | N | P |  | N | P |  | N |
| Anemia |  |  | Cataracts |  |  | Gout |  |  | Meningitis |  |  | Stroke |  |
| Appendicitis |  |  | Celiac Disease |  |  | Heart Disease |  |  | Mononucleosis |  |  | Stomach Disorder |  |
| Arteriosclerosis |  |  | Chicken Pox |  |  | Prostate Disorder |  |  | Multiple Sclerosis |  |  | Thyroid Disorder |  |
| Arthritis |  |  | Chronic Fatigue |  |  | Herpes |  |  | Mumps |  |  | Tonsillitis |  |
| Bladder Disease |  |  | Chronic Pain |  |  | High Cholesterol |  |  | Osteoarthritis |  |  | Tuberculosis |  |
| Blood Disorder |  |  | Diabetes I |  |  | Intestinal Disorder |  |  | Osteoporosis |  |  | Ulcers |  |
| Bronchitis |  |  | Diabetes II |  |  | Impotence |  |  | Parkinson’s |  |  | Other:  |  |
| Broken Bones |  |  | Emphysema |  |  | Kidney Disease |  |  | Pneumonia |  |  |  |
| Bulimia |  |  | Epilepsy |  |  | Liver Disease |  |  | Polio |  |  |  |
| Cancer |  |  | Measles |  |  | Lupus |  |  | Hernia |  |  |  |
| Candidiasis |  |  | Goitre |  |  | Lyme Disease |  |  | Scarlet Fever |  |  |  |
| **Please check all the conditions that apply to your health history**: |
| **General:** |
| Low energy level |  | Excessively thirsty |  | Sweaty palms / feet |  | Weight loss |  |
| Spontaneous sweating |  | Chills / Fever |  | Hot flashes |  | Weight gain |  |
| Feel too hot |  | Avoid heat or cold |  | Night sweats |  | Other: |  |
| Feel too cold |  | Cold hands / feet |  | Lack of sweating |  |
| **Do you experience any of these emotions?** |
| Anger |  | Depression |  | Impatience |  | Frustration |  | Worry |  |
| Anxiety |  | Stress / Tension |  | Impulsiveness |  | Mood Swings |  | Sadness |  |
| Bitterness |  | Fear |  | Irritability |  | Over excitement |  | Grief |  |
| **Emotional / Psychological / Mental:** |
| Trouble falling asleep |  | Poor memory |  | Cry uncontrollably |  | Worry a lot |  | Mentally restless |  |
| Trouble staying asleep |  | Trouble concentrating |  | History of abuse |  | Poor coordination |  | Vivid / disturbing dreams |  |
| **Skin and nails:** |
| Rashes |  | Bruise easily |  | Boils |  | Weak or brittle nails |  | Acne |  |
| Itching |  | Slow wound healing |  | Hives |  | Pitted nails |  | Eczema |  |
| Colour change of skin |  | Skin infections |  | Hair falling out |  | Grooves in nails |  | Herpes |  |
| Psoriasis |  |

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| **Head, Eyes, Ears, Nose, Throat:** |
| Headaches |  | Ringing in ears |  | Contacts or glasses |  | Nasal obstruction |  | Mouth ulcers / sores |  |
| Migraines (triggers) |  | Dizziness |  | Tearing of eye |  | Runny nose |  | Bad breath |  |
| Jaw pain/ TMJ |  | Spots in vision |  | Dry or burning eye |  | Sneezing |  | Bleeding gums |  |
| Impaired hearing |  | Poor night vision |  | Itchy eye |  | Nose bleeds |  | Dry mouth |  |
| Hearing loss |  | Double / blurred vision |  | Red or inflamed eye |  | Loss of smell |  | Recurrent sore throat |  |
| Ear aches |  | Eye pain / strain |  | Sinus problems |  | Teeth problems |  | Conjunctivitis |  |
| Any head injury |  |

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| **Respiratory:** |
| Cough / Wheezing |  | Frequent colds / flus |  | Coughing up blood |  | Recurrent sinus infections |  |
| Production of phlegm |  | Shortness of breath |  | Pulmonary hypertension |  | Chronic allergies |  |
| Asthma |  | Cystic fibrosis |  | Lung cancer |  | Others |  |

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| **Cardiovascular:** |
| Chest pain |  | Low blood pressure |  | Palpitations |  | Poor circulation |  | Fainting spells |  |
| High blood pressure |  | High cholesterol |  | Heart racing |  | Irregular heartbeat |  | Blood clots / Thrombosis |  |
| Acute thread veins |  |
| **Digestive:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Nausea |  | Excessive hunger |  | Indigestion |  | Stomach ulcer |  | Abdominal pain |  |
| Vomiting |  | Hypoglycaemia |  | Bloating after meals |  | Gas  |  | Stomach ache |  |
| Low appetite |  | Hyperglycaemia |  | Reflux or heartburn |  | Diarrhea / Loose stool |  | Constipation / Hard stool |  |
| Fatigue after meals |  | Jaundice |  | Haemorrhoids |  | Blood in stool |  | Eating disorder |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Urinary tract:** |  |  |  |  |  |  |  |
| Frequent urination |  | Burning / pain on urinating |  | Cloudy urine |  | Frequent UTI’s |  |
| Frequent night urination |  | Very pale urine |  | Scanty urine |  | Blood in urine |  |
| Poor bladder control  |  | Dark urine |  | Profuse urine |  | Kidney or bladder stones |  |

**Musculoskeletal:** |
| Joints |  | Hips |  | Neck |  | Abdomen |  | Joint stiffness |  |
| Arms |  | Legs |  | Shoulders |  | Lower abdomen |  | Broken bones |  |
| Hands |  | Feet |  | Upper back |  | Lower back |  | Knees |  |
| Spinal problems |  | Wrists |  | Ankles |  | Elbows |  | Other: |

**Life style**

|  |  |  |
| --- | --- | --- |
| Smoking Yes No If yes, how many per day? | Alcohol Yes NoIf yes, how many per day? | Rec Drugs Yes NoIf yes, how often? |

Consumption per day of?

Water: \_\_\_\_\_\_ Coffee: \_\_\_\_\_\_ Tea: \_\_\_\_\_\_ Soda: \_\_\_\_\_\_ Any addiction? \_\_\_\_\_\_

**Are you?** Always thirsty Never Thirsty for sips later in the day

Do you prefer: Cold drinks Warm drinks or both

**Do you DISLIKE:** Cold Wind Dampness Heat Loud Noises Crowds

**What are your typical eating habits?**

|  |  |  |  |
| --- | --- | --- | --- |
| Skip breakfast | Eat in a rush | Eat when not hungry | Eat too fast |
| Eat late at night | Cannot eat when worried/stress | Excess hunger | No desire to eat |

Stress full level ：

What do you do to release your stress:

What kind of exercise do you normally and how often?

**Thank you for taking the time to fill out this form. This will help us assess your health and give you a better treatment. All information is confidential and will not be shared without your explicit permission.**