

10 Questions/Initial Intake

Name: _____ Date: _____

BODY TEMPERATURE & PERSPIRATION

General Body Temp: Hot Cold Where: _____

Chills: _____ Sense of Heat: _____ Hot Flashes: _____

Nightsweats: _____ Spontaneous Sweating: _____

Comments:

DIET & THIRST

What do you eat: _____

What do you NOT eat: _____

How does food affect you: Tired Bloating Gas Burping Pain Other: _____

How is your appetite: _____ Cravings: _____

Eat 3 meals/day: Yes No Skip meals: _____ Taste in Mouth: _____

Thirst: _____ Liquid Consumption: _____ Temp. Preference: _____ Ice: Y N

Caffeine: _____ Tobacco: _____ Alcohol: _____

Comments:

ELIMINATION

Urination: Output=Input: _____ Color: _____ Blood: _____ Cloudy: _____

Urgent: _____ Burning: _____ Retention: _____ Scanty: _____ Dribbling: _____

Night time: _____ Times/Night: _____

Notes:

Stools: Frequency: _____ Hard: _____ Loose: _____ Formed: _____ Complete: Y N

Constipation: _____ Diarrhea: _____ Alternating: _____

Difficulty: _____ Undigested Food: _____ Blood: _____ Mucus: _____

Comments:

SLEEP

Hours/night: _____ Time to bed: _____ Time to wake: _____ Rested when wake up: _____

Trouble falling asleep: _____ Waking at night: _____

Trouble going back to sleep: _____ Dreams: _____ Worries/Thoughts: _____

Heart palpitations: _____

Comments:

ENERGY & EXERCISE

Exercise: Type: _____ How often: _____ Energy Level: _____

Energy best at what time of day _____ Energy worst at what time of day _____

Comments:

EMOTIONS

At this time: _____

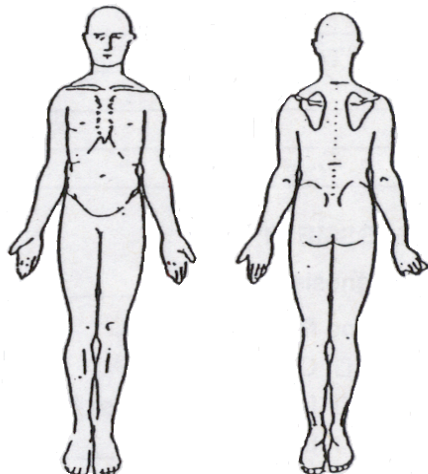
History: _____

Mood swings _____ Anxiety _____ Depression _____ Irritability _____

History of abuse _____ Attempted suicide _____ Stress Level: _____

Comments: _____

PAIN



Location: _____

Better or Worse with:

Pressure _____

Heat _____

Cold _____

Movement _____

Pain Quality: _____

Fixed: _____

Radiation: _____

Comments: _____

BODY SYSTEM REVIEW

Headache: Location: _____ How often: _____ Type of Pain: _____

Dizziness: _____ Numbness/Tingling: _____ **Eyes:** Red: _____ Itchy: _____ Watery: _____

Blurry: _____ Floaters: _____ Decreased Night Vision: _____ Glasses: _____

Ears: Ringing: _____ Pitch: _____ Hearing Loss: _____ Other: _____

Gums: Bleeding: _____ Other: _____ **Teeth:** _____

Throat: Swollen glands/Sore throat: _____

Neck/Shoulder Tension: _____ Joint Pain: Knees: _____ other: _____

Low Back Pain: _____ Shortness of Breath: _____

Asthma: _____ Allergies: _____

Comments: _____

FEMALE

Date of last period: _____ Pregnant? Y N Length of Cycle: _____ #Days Bleeding: _____

Pain: _____ Clots: _____ Flow: _____

Color: _____ PMS: _____ Irritable: _____ Mood Swings: _____

Breasts Tender: _____ Cravings: _____ Fatigue: _____

Birth Control: _____ Pregnancies: _____ Births: _____ Miscarriages: _____

Age of onset: _____ Vaginal Discharge: _____ Yeast Infections: _____

Menopause: Age at Onset: _____ Hot Flashes: _____ Night Sweats: _____

Comments: _____

MALE

Prostate: _____ Sexual Dysfunction: _____

Comments: _____