Please list 5 major health concerns in order of importance to you:

1. 
2. 
3. 
4. 
5. 

<table>
<thead>
<tr>
<th>Family History</th>
<th>Self</th>
<th>Father</th>
<th>Mother</th>
<th>Sibling(s)</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
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<tr>
<td>Asthma</td>
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<td>Cancer</td>
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<td>Allergies</td>
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<td>Heart Trouble</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Stroke</td>
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<td>Diabetes</td>
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If your complaint is pain related, please answer the questions below:

Rate the following on a scale of 0 to 10 (0 being none and 10 being the maximum possible):

Pain intensity right now __________
Usual pain intensity experienced over the past week __________
Amount that the pain interfered with daily activities __________

Frequency of Pain
- [ ] Continuous
- [ ] Several Times / Day
- [ ] Once / Day
- [ ] Three Times / Day
- [ ] Once / Week

Duration of Pain
- [ ] Seconds
- [ ] Minutes
- [ ] Hours
- [ ] Days
- [ ] Continuous

Description of Pain (Check all that apply)
- [ ] Throbbing
- [ ] Gnawing
- [ ] Tender
- [ ] Cramping
- [ ] Hot
- [ ] Cold
- [ ] Dull
- [ ] Burning
- [ ] Heavy
- [ ] Aching
- [ ] Stabbing

Please Mark Your Areas of Pain
Surgical / Hospitalization

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>Comments</th>
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</table>

Medications & Supplements

Please list all prescription medications and supplements you use. Include those that you only use occasionally. Remember inhalers, eye drops, nose sprays, topical creams, and vitamins.

**Medications**

<table>
<thead>
<tr>
<th>Prescription Name</th>
<th>Purpose</th>
<th>How Long</th>
<th>Dose</th>
<th>How Often</th>
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**Supplements**

<table>
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<tr>
<th>Supplement Name</th>
<th>Purpose</th>
<th>How Long</th>
<th>Dose</th>
<th>How Often</th>
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</table>
## LIVER/GALLBLADDER
- Depression/Stress
- Headaches/Migraines
- Red/Dry/Itchy Eyes
- Visual Problems/Blurred Vision
- Dizziness
- Gall Stones Feeling of Lump in Throat
- Clenching of Teeth at Night
- Muscle Cramping/Twitching
- Neck/Shoulder Pain/Tightness
- Joint Pain
- Poor Circulation
- Soft/Brittle Nails
- Bad Taste
- Bad Breath
- Do you crave: Sour
- Irritability/Anger

## KIDNEY/URINARY BLADDER
- Urinary Problems
- Bladder Infection
- Dropped Bladder
- Incontinence
- Lack of Bladder Control
- Weakness/Pain in Low Back
- Decreased Bone Density Feel
- Cold Easily
- Cold Hands/Feet
- Low Sex Drive/Libido
- Excess Sex Drive/Libido
- Poor Memory
- Loss of Hair/Grey Hair
- Hearing Problems
- Cavities
- Hot Flashes/Night Sweats
- Do you crave: Salt
- Fear

## HEART/SMALL INTESTINES
- Heart Palpitations
- Chest Pain
- High Blood Pressure
- Low Blood Pressure
- Insomnia/Sleep Problems
- Vivid Dreams
- Easily Startled
- Do you crave: Bitter
- Restlessness/Agitation

## LUNG/LARGE INTESTINES
- Bloody Cough
- Dry Cough
- Cough with Sputum
- Nasal Discharge — Color:
  - White
  - Yellow
  - Green
- Post Nasal Drip
- Sinus Infection/Congestion
- Itchy, Red or Painful Throat
- Dry Mouth/Throat /Nose
- Skin Rashes/Hives
- Snoring
- Shortness of Breath
- Allergies/Asthma
- Low Resistance to Illness
- Sneezing
- Mild Fever Comes & Goes
- Smoke Cigarettes
- Emphysema
- Bronchitis
- Black or Bloody Stools
- Constipation
- IBS
- Diarrhea
- Colitis/Spastic Colon
- Do you crave: Pungent
- Grief/Sadness

## SPLEEN/STOMACH
- Body Heaviness
- Hard to get up in the Morning
- Muscles Often Feel Tired
- Energy Level : 1–10 (low to high)
- Edema
- Hands
- Feet
- Easily Bruising /Bleeding
- Bad Breath
- Nausea/Vomiting
- Gas/Belching
- Hemorrhoids
- Diarrhea
- Constipation
- Abdominal Pain
- Indigestion/Heartburn
- Brain Foggy
- Tendency to Gain Weight
- Do you crave: Sweet
- Over-thinking/Worry