Traditional Chinese Herbal Medicine Form

The best results with Traditional Chinese Medicine are when we know the most about your body. Please fill in any relevant information that pertains to your body, whether it seems to connect to your current condition or not. Your whole body plays an important role in allowing us to diagnose and properly treat you to help you regain your optimum health.

NERVOUS SYSTEM

1. How are your overall energy levels lately?

_____

2. Do you have any significant stress in your life?

_____

3. How is your mental/emotional state?

_____

4. How is your sleep?

_____

5. Do you suffer from headaches – what is the location?

_____

- Do you experience periods of dizziness or blurred vision_____

6. Regarding your 5 Senses – Any vision problems? Hearing problems? Taste? Smell? Touch (numbness/ tingles?)_____

___

7. How is your body temperature regulation? Do you find you are generally a hot or cold person or alternate between the two?

_____

- Are you particularly sensitive to any type of weather/temperature or climate condition? Damp/ cold/hot/dry/major weather changes?

  _____

8. How is your thirst? Any preference for warm or cold drinks?

_____

- Do you have issues with dryness (eyes, nose, mouth, throat)?

  _____

9. Any unusual sweating? (Too much/too little; day/ night?)_____

10. Any body pain or swelling, masses/nodules, distension or discomfort?

_____

CARDIOVASCULAR and BLOOD SYSTEM

1. Any feeling of discomfort, tightness or pain in the chest?

_____

2. Do you get palpitations/arrythmia?

_____

- Any accompanying symptoms (stress/anxiety/pain)?
  _____

3. Any problems with physical exertion? (*easily* exerted, shortness of breath?)_____
4. How is your general circulation (numbness, tingling, cold hands/feet?)?
_____
   - Do you bruise easily?
     _____
     ___
5. Do you know your blood pressure reading?
_____
6. Have you had any recent blood tests and results?
_____
7. Have you noticed or experienced any abnormal bleeding?
_____

RESPIRATORY SYSTEM

1. Any issues with breathing or sudden shortness of breath?
_____
2. Have you had any issues with coughing, wheezing or phlegm in your Lungs/throat?_____
3. Are you aware of any allergies you have?
_____
4. Do you catch colds easily?
_____

GASTRO-INTESTINAL SYSTEM

1. What is your appetite like? How many meals in a day?
_____
2. How is your digestion? Do you experience bloating, gas, hiccups, reflux?
_____
   - How do you feel in general after a meal (Tired/energized/pain/discomfort/bloated)?
     _____
3. Do you experience any food cravings or food aversions?
_____
4. How many bowel movements do you have a day usually?
_____
   - Can you describe what your stool looks like (loose/firm/with undigested food/strong smell/with mucous or blood/colour)?
     _____
   - Do you have problems passing stool (is there pain/burning/incontinence/hemorrhoids/ prolapse/ itching/anal fissures)?
     _____
5. Do you experience pain in your abdomen or epigastria in general?
_____
6. Do you experience any acid reflux/regurgitation/bitter taste or nausea/vomit?_____

GENITO-URINARY

1. What is your urination like (quality/quantity/colour)?
_____
   - Do you experience problems passing urine (pain/burning sensation/discomfort/incomplete/ dribbling/incontinence)?_____
   - Are you up at night to urinate/how often?
     _____
   - Any history of Urinary Tract infections?
     _____

2. Do you experience water retention or edema?

_____

FOR WOMEN – Have you had issues with fertility?

_____

- Do you suspect you could be pregnant?

  _____
- Number of pregnancies?

  _____
- Number of miscarriages or abotions?

  _____
- Are you on birth control/what kind?

  _____

Menstrual cycle

- At what age did you have your first period?

  _____
- What is the length of your cycle?

  _____
- How many days do you bleed for?

  _____
- What is the quality (colour/clots) and quantity of your blood?

  _____
- Any accompanying symptoms with your period/pains/cramps/mood/emotion, etc.._____

Menopausal symptoms

- When did it begin?

  _____
- What are/were your symptoms?

  _____

FOR MEN – have you had issues with fertility?

_____

- Any problems with sexual function?

  _____
- Have you ever experienced a hernia?

  _____

FOR WOMEN AND MEN – Do you experience any discharge/genital itching?

_____

- Any history of STI's?

  _____
- Are you currently sexually active?

  _____

OTHER

Any issues with skin/hair/nails?

_____

Any mouth ulcers/canker sores?

_____

Are you currently under the care of your Doctor/what for?

_____

List all medications you are taking:_____