Consultation Form

ACUCARE Total Health

First Name (Print) _____ Last Name (Print) _____ Age _____ Sex _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail address _____ Date _____

Referral _____ Nationality _____ Occupation _____

Below, describe all of your complaints on the left side of the page, then list how long you have had them and how you are treating them *directly opposite* on the right side. Be sure to mention any drugs, vitamin supplements, or other medicinal substances you are taking.

Complaints	How long have you had it?	Treatment

Brief Health History: (list major diseases, surgeries, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

How many times per year do you get a cold or the flu?_____

Family Medical History:

_____

_____

_____

_____

_____

_____

What other medication and/or supplements are you taking? How long have you taken them?

_____ _____

_____ _____

_____ _____

Emotions: _____ **Normal** _____ **Problem**

_____Depression _____Sadness _____Panic attack _____Sensitive

_____Worries _____Overly excited _____Angry _____Anxiety

Describe: _____

Energy: _____ **Normal** _____ **Problem**

_____Exhausted _____Hyperactive _____Low

_____Nervous energy _____Up and down _____Abundant

Describe:_____

Sleep Patten: _____ **Normal** _____ **Insomnia**

Falling Asleep: _____Sometimes difficult _____Always difficult _____Sometimes very difficult

_____Always very difficult _____Sleepy in daytime _____Take naps

Waking Up: _____Times per night _____Wake up too early

_____Wake up at night and cannot go back to sleep again

Sleep Quality: _____Deep _____Light _____Poor _____Many dreams

_____Bad dreams _____Grinding teeth _____Talking in sleep _____Other

Describe:_____

Diet: Any special diet?

Food cravings: _____Sugar _____Salt _____Food Allergies

Describe:_____

Temperature: _____ **Normal** _____**Abnormal**

_____Feel cold easily _____Cold hands _____Cold feet _____Feel hot easily

_____Alternating hot & cold _____Hot flash _____Sensitive to weather changes

Describe:_____

Sweating: _____ **Normal** _____**Abnormal**

_____Too easily _____Too much _____Difficult

_____Too little _____Night sweats _____Other

Describe:_____

Sensitivity and Allergy: **_____ No** **_____Yes**

Temperature: _____Cold _____Hot _____Dampness _____Light

_____Noise _____Airborne particles _____Drugs _____Other

Describe:_____

Appetite and Digestion: **_____ Normal** **_____Abnormal**

_____Rapid hungering _____Poor appetite _____Nausea _____Anorexia

_____Hungry, but no desire to eat _____Bloating _____Gas _____Other

Describe:_____

Bowel Movement: **_____ Normal** **_____Abnormal** **_____Time of Day**

_____Constipation _____Diarrhea _____Loose _____Watery _____Incomplete

_____Hard and dry _____Strong smell _____With mucus _____With blood _____Other

Describe:_____

Body Weight: **_____ Normal** **_____Overweight** **_____Underweight**

If overweight: _____ How many pounds would you like to lose?

_____How many years ago did you first start to gain weight?

_____Are you following a weight control program at this time?

Describe:_____

Drinking: **_____ Normal** **_____Abnormal**

_____Thirsty _____Dry Mouth _____Drink a lot

_____Dry mouth but no desire to drink

_____Not thirsty, but drink a lot of water anyway

Describe:_____

Urination: _____ **Normal** _____**Abnormal**

_____Frequent _____Urgent _____Burning _____Painful _____Cloudy

_____Dark color _____Foul Smell _____Bloody _____Difficult _____Retention

_____Number of times per day _____Number of times you get up to urinate at night _____Other

Describe:_____

Eye, Ear, and Nose: _____ **Normal** _____**Abnormal**

Describe:_____

Sex Function: _____ **Normal** _____**Abnormal**

Describe:_____

Menstrual Cycle: Age of onset:_____years old Date of last period: _____/_____/_____

_____ **Regular** _____**Irregular** _____How many days between cycles?

_____How many days did it last?

Color: _____Pale red _____Dark red _____Bright red _____Purplish

Were there clots? _____Yes _____No

Menstrual Pain: _____Yes _____No

_____Before flow _____During flow _____After flow

_____Abdomen _____Back _____Breast

Emotion around period: _____Normal _____Abnormal

_____Before flow _____During flow _____After flow _____Depression

_____Irritability _____Anger _____Sadness _____Crying _____Other

Describe:_____

Addictions: _____Tobacco _____Alcohol _____Others

Describe:_____

Any Other disorders or abnormalities:

Describe:_____

_____