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2530 Colorado Ave, Durango, CO 81301

a. Please **read** and **fill in** all of the information that pertains to you.
b. On pages 2 through 6, under each category, **check all current** (within the last 6 months) symptoms that you have experienced either short- or long-term.
c. **Add** and **total** all of the boxes you checked.
d. **Date** today's day.

	TEST	***DATE***	***TEST RESULTS***
	Physical		
	Cholesterol		
	Prostate		
	Mammography		
	Pap Smear		
	Blood (which test?)		
	HIV/STD		
	Other		

Please indicate if you have (or had) any of the following:							
	Diabetes		Allergies		Rheumatic Fever		Vein Condition
	Heart Disease		CVA (stroke)		Thyroid Disorder		Tuberculosis
	Asthma		Pneumonia		Emphysema		Chicken Pox
	High Blood Pressure		Gonorrhea		Bleeding Tendency		Polio
	Syphilis		Measles		Nervous Disorder		Migraines
	Meningitis		HIV		Mononucleosis		Other Liver Illnesses
	Epilepsy		High Fever		Multiple Sclerosis		Other Heart Illnesses
	Paralysis		Cancer		Jaundice		Other Kidney Illnesses
	Glaucoma		Mumps		Hepatitis		Other Lung Illnesses

How was your childhood health?

Any hospital visits, stays, or surgeries?

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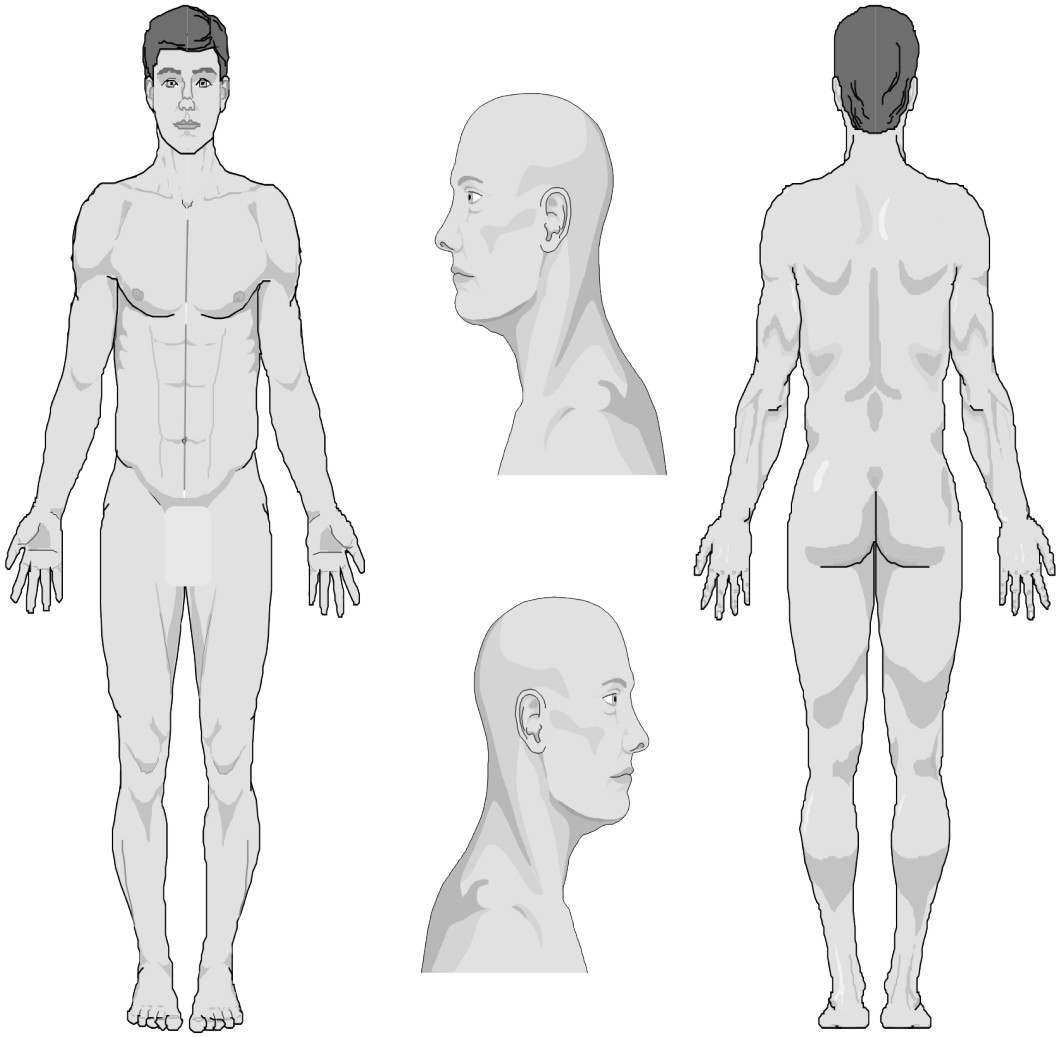
1. Pain:

On the figures below, please mark clearly any areas of pain and indicate any scars.

	What makes the pain better?
	Soft Pressure
	Hard Pressure
	Cold
	Heat
	Exercise
	Rest
	Other

	What makes the pain worse?
	Soft Pressure
	Hard Pressure
	Cold
	Heat
	Exercise
	Other



2. Describe your pain:

- ☐ **Sharp**
- ☐ **Fixed**
- ☐ **Burning**
- ☐ **Moving**
- ☐ **Cramping**
- ☐ **Aching**
- ☐ **Dull**
- ☐ Other:_____

☐ ***Total Boxes Checked***

Date:_____

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3. Kidney Function: (Overall Temperature)

- [ ] Cold Hands
- [ ] Cold Fingers
- [ ] Cold Toes
- [ ] Cold Feet
- [ ] Sweaty Hands
- [ ] Sweaty Feet
- [ ] Hot Body Temperature Sensation
- [ ] Cold Body Temperature Sensation
- [ ] Afternoon Flushes
- [ ] Night Sweats
- [ ] Heat in the hands, feet & chest
- [ ] Hot flashes any time of the day
- [ ] Thirsty
- [ ] Perspire easily
- [ ] Lack of perspiration
- [ ] Do you take water to bed

☐ **Total Boxes Checked**

Date:_____

4. Lung, Kidney Function: (Overall Energy)

- [ ] Shortness of Breath
- [ ] Difficulty keeping eyes open (daytime)
- [ ] General Weakness
- [ ] Easily catch colds
- [ ] Low Energy
- [ ] Feel worse after exercise
- [ ] Chronic (daily) fatigue & malaise

☐ **Total Boxes Checked**

Date:_____

5. Lung Function:

- [ ] Nasal Discharge (color_____)
- [ ] Cough
- [ ] Nose Bleeds
- [ ] Sinus Congestion
- [ ] Dry Mouth
- [ ] Dry Throat
- [ ] Dry Nose
- [ ] Dry Skin
- [ ] Allergies (what?_____)
- [ ] Alternating Chills/Fever
- [ ] Sneezing
- [ ] Headache (location_____)
- [ ] Overall achy feeling in body
- [ ] Stiff Neck
- [ ] Stiff Shoulders
- [ ] Sore Throat
- [ ] Difficulty breathing
- [ ] Smoke cigarettes (# per day_____)
- [ ] Sadness
- [ ] Melancholy

☐ **Total Boxes Checked**

Date:_____

6. Liver, Spleen, Heart Function:

- [ ] Dizziness
- [ ] See floating black spots

☐ **Total Boxes Checked**

Date:_____

7. Heart Function:

- [ ] Anxiety
- [ ] Sores on tip of tongue
- [ ] Restlessness
- [ ] Mental confusion
- [ ] Chest pain traveling to shoulder
- [ ] Frequent dreams
- [ ] Wake unrefreshed
- [ ] Trouble falling and/or staying asleep

☐ **Total Boxes Checked**

Date:_____

8. Dampness trapped in the Body:

- [ ] Bodily sensation of heaviness
- [ ] Mental heaviness
- [ ] Mental sluggishness
- [ ] Mental fogginess
- [ ] Swollen hands
- [ ] Swollen feet
- [ ] Swollen joints
- [ ] Chest congestion
- [ ] Nausea
- [ ] Snoring

☐ **Total Boxes Checked**

Date:_____

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9. Pancreas/ Spleen Function:

- [ ] Low Appetite
- [ ] Abrupt Weight Gain
- [ ] Abrupt Weight Loss
- [ ] Abdominal Bloating
- [ ] Abdominal Gas
- [ ] Gurgling noise in Stomach
- [ ] Fatigue after eating
- [ ] Prolapsed Organs? Which?_____
- [ ] Bruise easily?
- [ ] Over-Thinking
- [ ] Worry

Total Boxes Checked [ ]

Date:_____

10. Stomach Function:

- [ ] Burning sensation after eating
- [ ] Large appetite
- [ ] Bad Breath
- [ ] Canker Sores (mouth)
- [ ] Bleeding, swollen or painful gums
- [ ] Heartburn
- [ ] Acid Regurgitation
- [ ] Ulcer (diagnosed?)
- [ ] Belching
- [ ] Hiccups
- [ ] Stomach Pain
- [ ] Vomiting

Total Boxes Checked [ ]

Date:_____

11. Small/Large Intestine Function

- [ ] Loose Stools
- [ ] Constipated
- [ ] Incomplete Stools
- [ ] Diarrhea
- [ ] Blood in Stools
- [ ] Mucous in Stools
- [ ] Undigested food in the Stools

Total Boxes Checked [ ]

Date:_____

12. Liver Function (eyes):

- [ ] Itchy
- [ ] Bloodshot
- [ ] Hot
- [ ] Dry
- [ ] Watery
- [ ] Gritty
- [ ] Blurry Vision
- [ ] Decreased Night Vision
- [ ] Near-sighted
- [ ] Far-sighted

Total Boxes Checked [ ]

Date:_____

13. Liver, Gall Bladder Function:

- [ ] Alternating Diarrhea & Constipation
- [ ] Chest Pain
- [ ] Tight sensation in the Chest
- [ ] Bitter taste in the mouth
- [ ] Anger easily
- [ ] Depression
- [ ] Frustration
- [ ] Irritability
- [ ] Skin Rashes
- [ ] Headache at the top of the Head
- [ ] Tingling Sensation
- [ ] Numbness
- [ ] Muscle twitching
- [ ] Muscle cramping
- [ ] Muscle Spasms
- [ ] Seizures
- [ ] Convulsions
- [ ] Lump in the throat
- [ ] Neck Tension
- [ ] Shoulder Tension
- [ ] Limited Range-of-Motion (Neck)
- [ ] Limited Range-of-Motion (Shoulder)
- [ ] How much Alcohol / day?_____
- [ ] Recreational drugs (which?_____)
- [ ] High-pitched Ringing in Ears
- [ ] Gallstones (history or current)
- [ ] STD's (which?_____)
- [ ] Unable to adapt to Stress

Total Boxes Checked [ ]

Date:_____

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14. Kidney, Urinary Bladder Function:

- ☐ Frequent cavities, teeth problems
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in the knees
- ☐ Low Back Pain
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Low-pitched ringing in the ears
- ☐ Kidney Stones
- ☐ Bladder Infections
- ☐ Lack of bladder control
- ☐ Wake during the night 2 (or more) times to urinate?
- ☐ Fear
- ☐ Easily startled

☐ ***Total Boxes Checked***

Date:_____

15. Urination (Bladder Function):

Color (please check):

- ☐ Pale____; Dark Yellow__; Clear_____
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong Oder
- ☐ Burning
- ☐ Painful
- ☐ Discharge
- ☐ Difficult
- ☐ Urgent
- ☐ Frequent

☐ ***Total Boxes Checked***

Date:_____

16. Libido:

- ☐ Normal
- ☐ High
- ☐ Low

☐ ***Total Boxes Checked***

Date:_____

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WOMEN ONLY

☐ Yes	☐ No	Do you have a regular menstrual cycle?	_____	Age of first menstruation
☐ Yes	☐ No	Are you pregnant?	_____	Average number of days in flow
☐ Yes	☐ No	Do you have bleeding between periods?	_____	Average number of days in entire cycle
☐ Yes	☐ No	Do you have a vaginal discharge?	_____	Number of children
			_____	Number of pregnancies
			_____	Age of menopause (if applicable)

Please fill in the menstrual chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (choose one):							
normal, pale, bright red, brown							
rust, dark purple, other	_____	_____	_____	_____	_____	_____	_____
Amount of flow (choose one):							
normal, heavy, light	_____	_____	_____	_____	_____	_____	_____
Pain/Cramps (choose one):							
dull, sharp, other	_____	_____	_____	_____	_____	_____	_____
Vomiting (check if yes):	_____	_____	_____	_____	_____	_____	_____
Nausea (check if yes):							

Women Only:
Regarding Menstrual Cycle

- ☐ Nausea
- ☐ Vomiting
- ☐ Food cravings
- ☐ Water retention
- ☐ Breast swelling
- ☐ Breast tenderness
- ☐ Headaches
- ☐ Migraines
- ☐ Dull pain (where?_____)
- ☐ Sharp pain (where?_____)
- ☐ Depression
- ☐ Irritability
- ☐ Anxiety
- ☐ Other (explain_____)

☐ ***Total Boxes Checked***

Date:_____

Men Only:

- ☐ Swollen testes
- ☐ Testicular pain
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Feeling of coldness or Numbness in external genitalia
- ☐ Other? _____

☐ ***Total Boxes Checked***

Date:_____