Personal Health Profile

Name: _____ Date: _____
Address: _____
_____
Phone Numbers: Home: _____ Work: _____
Fax: _____ E-mail: _____
Date of Birth: _____ Age: _____ Weight: ____ Height: _____Blood Type: _____
Occupation: _____
Relationship Status: _____ Partner's Name: _____ Partner's Occupation: _____
Religious Affiliation/Spiritual Practices: _____
Name(s) and Age(s) of Children:
_____

ALLERGIES (include type of reaction)	
Medications	
Foods	
Environmental	

Please list any medications taken regularly, including prescription, recreational or over-the-counter:

_____

Please list any vitamins, minerals, or herbal supplements taken regularly:
_____

_____
Physician's Diagnosis: _____
Physician's Treatment: _____

Present Health Concerns: (The reason for today's visit)

_____

How long have you had it? **_____** Have you had it before? **___yes ___no** Is it getting worse? **___yes ___no**
What makes it better? **_____** What makes it worse? **_____**
What are you doing for it**?** **_____**
Other Practitioner's Response: _____

Whole Body Health:

Circle the following that is true: Do you run hot or cold? Do you prefer to warm up or cool off? Are you the most comfortable in the Summer or Winter? Spring or Fall? Are you the first person to put on a jacket? __yes ___no
Do you tend to be warm at night and cold in the day time? ___yes ___no Do you sweat easily? ___yes ___no
Do you have an appetite for food? ___yes ___no Do you have cravings for meat, sugar, salt, sour, bitter? (circle one)

Do you experience thirst? ___yes ___no Comment: _____
How do you feel after you eat? (within the hour) ___bloated ___nausea ___ crampy ___tired ___gassy

Food Category	Food Use Frequency			Comments
	Never	Sometimes	Often	
Animal Protein (Beef, Pork, Eggs,etc.)				
Dairy (Milk, Cheese, Yogurt)				
Fried Foods				
Sugar				
Alcohol				
Coffee/Caffeine				
Soda				
Artificial Sweeteners				
Tobacco				
Soy Products				
Water				
Type of Oils Used				

Snack Habits: _____

Bowel and Bladder

Do you feel you urinate too frequently for what you drink? ____ yes ____ no Do you wake up at night to urinate? ___yes ___no

If you answered "Yes", how often? _____ How often do you have a bowel movement? _____

Energy:

Do you have enough energy to do what you want to do? ___yes ___no

Do you have high points and/or low points in the day? ___ yes ___no If answered"yes", explain: _____

Do you crash in the afternoon? ___yes ___no Do you have "brain fog"? ___yes ___no If "Yes", for how long? _____

What time do you usually go to bed? _____ Do you have problems getting to sleep? ___ yes ___ no Do you have problems staying asleep? ___ yes ___ no When do you usually wake up? _____ Do you wake up feeling rested? ___ yes ___ no

Do you experience night terrors? ___ yes ___ no

Past Medical History

Please list any operations you have had along with dates. (Include appendectomy, tonsillectomy, etc.)

_____

Please list any major injuries/accidents, including dates: _____

Please list any traumatic experiences not treated medically (divorce, loss of lover, loss of job, death of loved one, etc.):

_____

Family Medical History

Maternal Medical History: _____

Paternal Medical History: _____

Sibling Medical History: _____

Are you or any family member in a recovery program? If yes, which one? _____

Common Physical Activities

Please list: _____

Diet

Please write a diary of your meals on a typical day:

Breakfast: _____

Lunch: _____

Dinner: _____

Body System Health Profile

Please check any item listed below, rating it as follows:

1 = sometimes 2 = often 3 = major concern

Eyes, Ears, Nose & Throat

___ Eye pain, wet/dry
___ Failing vision
___ Earaches
___ Hearing Loss
___ Ringing in the ears/Tinnitus
___ Hay Fever
___ Tonsils
___ Feeling of something stuck in throat
___ Other: _____

Skin

___ Boils
___ Acne
___ Eczema
___ Psoriasis
___ Bruise Easily
___ Herpes Simplex
___ Slow Wound Healing

___ Other: _____

Digestive

___ Mouth ulcers
___ Halitosis – bad breath
___ Hiatal hernia
___ Bloating
___ History of Hepatitis
___ Gall Stones
___ Hypoglycemia (low blood sugar)
___ Indigestion
___ Ulcers
___ Constipation
___ Diarrhea
___ Irritable Bowel Syndrome
___ Polyps
___ Hemorrhoids
___ Bleeding from Anus
___ Flatulence
___ Have you traveled abroad often? ___ Yes ___ No
List where: _____
___ Other: _____

Circulatory

___ High Blood Pressure
___ Low Blood Pressure
___ Palpitations
___ High Cholesterol
___ Triglycerides
___ Varicose Veins
___ Spider Veins
___ Cold Hands and Feet
___ Poor Circulation
___ Pain in chest
___ Previous Heart Attack/ Stroke
___ Swelling in ankles/joints
___ Other: _____

Musculo/Skeletal

___ Difficulty Breathing
___ Stiffness
___ Bursitis
___ Torn ligaments
___ Backache: upper/lower
___ Broken Bones: List: _____
___ Arthritis

Respiratory

___ Allergies
___ Asthma
___ Sore Throat
___ Sinusitis
___ Post Nasal Drip
___ Lung Congestion
___ Cough
___ History of Tuberculosis
___ Recurrent influenza
___ Colds
___ Other: _____

___ Mobility Restriction
___ Gout
___ Sprains
___ Other: _____

Urinary

___ Bladder infections (cystitis)
___ Kidney Stones
___ Water retention/swelling of ankles/legs
___ Incontinence
___ Painful urination
___ Excessive urination
___ Lower Back Pain
___ Dark circles under the eyes
___ Gout
___ Other: _____

Reproductive (Men)

___ Impotence
___ Sexually Transmitted Disease
List type if known: _____
___ Prostatitis
___ Difficulty with urination
___ Benign Prostatic Enlargement
___ Premature Ejaculation
___ Lack of sex drive
___ Low Sperm count
___ Low Sperm motility
___ Other: _____

Reproductive (Women)

___ Pregnancies, Dates: _____ Miscarriage Date: _____ Abortion Date: _____
Contraceptive Use: List type(s) & how long used: _____
Sexually Transmitted Disease, List type if known: _____
Hysterectomy, Date: _____ Reason: _____
___ Uterine fibroids
___ Ovarian cyst
___ Endometriosis
___ Vaginal infection
___ Breast Pain
___ Breast Lump
___ Pelvic Inflammatory Disease
___ Genital herpes
___ Cervical dysplasia
___ Painful intercourse
___ Anemia
___ Vaginal itching/discharge
___ Infertility

Menstruating Women

___ Irregular menstrual cycles
___ Heavy menstrual bleeding
___ Painful menstrual cramps
___ Bleeding between cycles
___ Absence of menstrual cycles
___ Dramatic mood swings around menstrual cycle
___ Lack of sex drive
___ Other: _____

Menopausal Women

___ Hot flashes
___ Dramatic mood swings
___ Dry vaginal lining
___ Osteoporosis
___ Vaginal Bleeding
___ Estrogen Replacement Therapy
___ Lack of sex drive
___ Other: _____

Endocrine Glands

___ Pituitary
___ Pineal
___ Thyroid
___ Hypothyroid
___ Hyperthyroid
___ Pancreas
___ Diabetes (Please indicate type 1 or 2)
___ Hypoglycemia
___ Other: _____

Lymphatic

___ Congestion
___ Swollen glands
___ Infection
___ Drainage
___ Other: _____

Nervous System

___ Anxiety
___ Irritability
___ Stress
___ Headaches
___ Migraines
___ Insomnia
___ Depression
___ Attention Deficit
___ Hyperactivity
___ Mental Sluggishness
___ Irritation to strong light
___ Shingles
___ Other: _____

Immune System

___ Autoimmune disease
___ Chronic Fatigue Syndrome
___ Fibromyalgia
___ Neuralgia
___ Frequent colds
___ Vaccinations
___ Chronic Fatigue Syndrome
___ Other: _____

Staff Use Only – Please Do Not Write Below This Line

Blood Pressure: _____

Tongue:

Body: _____
Coat: _____
Features: _____

Constitution

Type	Sys	Action	Evaluation
Kappha	GI	Relaxation	
Pita	Mus S	Doing	
Vata	Ner S	Thinking	

Pulse

Pos	Left		Right	
I	Sm int	Heart	Lungs	Colon
II	Gall	Liver	Spleen	Stomach
III	Bladder	Kid Yin	Heart Protector	Triple Heater

NOTES: _____

_____