(Parents should fill out this form for young children based on observation. Children over 4 or 5 years old can be asked some of the questions. Please then write their answers, plus your own observations.).

FOOD:

1. What foods do you especially like, or crave (even if you don't eat them)?

2. What foods do you dislike?

3. What foods disagree with or aggravate you in some way?

5. How is your appetite? Poor, average, high? Specify.

6. Any problems with digestion? Specify.

7. Any problems if you go too long without eating (headache, shakiness, etc.), and how many hours can you go without eating before getting these symptoms?

THERMAL STATE:

1. Which do you tolerate the LEAST: extreme hot weather, or extreme cold weather? Please specify if either extreme causes or aggravates any symptoms.

Is this a lifelong tendency, or has it changed in recent years?

2. Are you affected by a draft of air? How?

3. Does any particular weather affect you (rainy/damp, hot & humid, dry, windy, etc.)? How?
4. How do you like or tolerate the direct sun? Any symptoms if in it too long?
5. Do thunderstorms affect you? How?

6. How do you feel at the ocean? Any improvement in symptoms there?

7. Any reaction to moon phases?

8. Any dislike for a particular season (Spring, Fall, etc.), or seasonal worsening of symptoms? 9. Any desire for open air (fresh air, open windows, bedroom window cracked, etc.)? How strong?

PERSPIRATION:

1. Circle one: Absent Mild Moderate Heavy

2. In what particular areas to you perspire?

Head Back Chest Groin Hands Feet 3. Any particular odor to the perspiration? Describe.

4. Any stains left on clothing or sheets? Describe.

ENERGY:

1. On average, where does your energy usually fall on the following scale (circle): 1=can hardly get out of bed, 10=plenty of energy each day: 1 2 3 4 5 6 7 8 9 10

2. What is your best time of day or night?

3. Worst time of day or night?

4. Does anything else modify your energy (make it better or worse)? Explain.

5. On average, how is your motivation to do the things you need and want to do each day (circle): 1=none, 10=excellent: 1 2 3 4 5 6 7 8 9 10

SLEEP:

1. Any problems falling asleep at night? Describe.

2. Any problems staying asleep all night? Describe, and include if you usually wake at a certain time.

3. What is your preferred position to sleep in? Why?

4. Any position you cannot sleep in? Why not?

5. In your sleep, do you (circle any that apply):

snore talk grind teeth sweat drool move a lot

stick feet out of covers put arm(s) over/under your head

6. Do you wake refreshed in the morning?
7. How easy or difficult do you find it to wake up? How long does it take to feel fully awake most days?

8. Do you prefer to have covers on? Can you sleep without them in warm weather?

9. Do you recall dreams? If so, relate any recurring dreams or themes (even back in childhood). Also, please describe any recent dream, including any feelings you had in the dream.

PSYCHOSOCIAL HISTORY:

Please take your time with this section, and answer with as much honesty as possible. Using *specific examples* is most helpful. Use the back of the page or attach a page if needed.

1. What about others do you admire the most (or is there someone in particular you admire or have looked up to)? Why?

2. What about others annoys you or do you dislike? This could be a character trait, or something people do that really irks you.

3. How do you express your anger? What triggers it? How have you expressed it at your worst?

4. When upset about something, do you prefer to be left alone, or to have someone available for talking/ consolation?

5. How do you respond to music? How intense is your response?

6. How much do you like or desire to travel?

7. How important is someone else's opinion of you (what others think of you)?

8. Briefly describe your relationship with your father (now and/or in the past):

9. Briefly describe your relationship with your mother (now and/or in the past):

10. Briefly describe any other significant relationships or life circumstances that affect you now (and/or have affected you in the past):

11. Briefly describe your spiritual/religious beliefs:

12. Have you ever dealt with any addiction issues (personally, or with family members)? What addiction?

13. Describe your nature when you were a child? What were you like? What affected you?

14. If you feel this applies to your health, complete the following sentence: “I have never been well since…….”:

15. Is there anything else that you feel affects your health now?

FEARS: Circle any of the following common fears that you either currently have, or had as a child:

Dark Storms Ghosts Being alone Basements Dogs Cats Snakes

Spiders Birds Mice/rats Other animals Doctors Dentist Needles

Blood Health issues in general Cancer Heart disease Germs Death

Others dying (family) Accidents Robbers Poverty Failure Public speaking

Taking tests Heights Narrow places (claustrophobia) Water Crowds

Bridges Airplanes Insanity

Vague sense of foreboding

Please list any other fears:

Do you have any particular worries that you don't consider fears? Be specific please.

REVIEW OF SYSTEMS

Please indicate whether you have any problems in the following areas (or had problems in the past). Please give a brief description, especially if the area is an intense or recurrent problem.

1. HEAD:
_____Headaches
_____Migraines
_____Dizziness
_____Dandruff
_____Other:

2. EYES:
_____Blurry vision
_____Itchy eyes
_____Light sensitivity
_____Pain
_____Dryness
_____Redness
_____Other:

3. EARS:
_____Ringing
_____Infections
_____Hearing problems
_____Excess wax
_____Discharge
_____Itching
_____Other:

4. NOSE:
_____Sense of smell (acute, lost, etc.)
_____Sinus pain
_____Discharge
_____Stuffiness
_____Sneezing
_____Allergies
_____Bloody noses
_____Crusts inside
_____Other:

5. MOUTH/THROAT:
_____Sense of taste (altered, lacking, bad taste in mouth, etc.)
_____Teeth (pain or other problems)
_____Tongue
_____Bleeding gums

_____Cold sores
_____Sore throats

6. NECK:
_____Sensitive to anything snug worn at neck
_____Thyroid issues
_____Neck pain
_____Stiffness
_____Other:

7. CHEST:
_____Chest pains
_____Heart palpitations
_____Shortness of breath
_____Wheezing
_____Cough
_____Breast tenderness
_____Breast lumps
_____Other:

8. ABDOMEN/GI:
_____Appetite
_____Heartburn/reflux
_____Belching
_____Nausea
_____Stomach pain
_____Bloating/distention
_____Abdominal pain
_____Ulcers
_____Constipation/difficult stool
_____Diarrhea
_____Flatulence
_____Hemorrhoids
_____Change in stool (color, consistency, shape, etc.)
_____Sensitive to anything snug worn around waist
_____Other:

9. GU/FEMALE:
_____Heavy Menstruation
_____Painful Menstruation
_____PMS
_____Vaginal discharge
_____History of STD's
_____Menopause/Perimenopause

_____Sex drive (libido)
_____Fertility issues
_____How old were you at your first period?

10. GU/MALE:
_____Trouble urinating (starting, force of stream, incomplete emptying, etc,)
_____Incontinence
_____History of STDs
_____Prostate issues
_____Testicular pain or swelling
_____Blood in urine
_____Erections
_____Sex drive (libido)
_____How many times do you urinate during the night?
_____Other:

11. MUSCULOSKELETAL/EXTREMITIES:
_____Body stiffness
_____Joint pains
_____Muscle pain
_____Low back pain
_____Other back pain
_____Sciatica
_____Muscle cramps
_____Swelling/edema
_____Significant injury in the past
_____Other:

12. SKIN/INTEGUMENT:
_____Acne
_____Eczema
_____Psoriasis
_____Ringworm
_____Dry skin
_____Itchy skin
_____Easy bruising
_____Discoloration
_____Skin infections/boils/cellulitis
_____Moles, skin tags
_____Skin cancer
_____Nails (soft, slow growing, split, brittle, ridged, etc.)
_____Hangnails
_____Ingrown toenails
_____Toenail fungus
_____Sensitivity to metals

_____Tendency to poison ivy
_____Hair falling out
_____Hair went gray early

13. NEUROLOGIC:
_____Fainting or feeling faint
_____Seizures
_____Tremors
_____Balance problems
_____Numbness
_____Weakness
_____Tingling
_____Restless legs (awake or in bed)
_____Other:

14. MENTAL/EMOTIONAL:
_____Depression
_____Anxiety
_____Anger
_____Irritability
_____Mood changes
_____Concentration/focus
_____Memory
_____Confusion
_____Change in behavior
_____Other:

15. GENERAL:
_____Weight gain (unintended)
_____Weight loss (unintended)
_____Fever
_____Chills
_____Night sweats
_____Sleep problems
_____Fatigue
_____Anemia
_____Reaction to vaccination
_____Oversensitive to medications
_____Oversensitive to chemicals/odors
_____Other