Client Health Questionnaire Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email _____

Did anyone refer you? _____

Chief Complaint – What is the main reason you are seeking care?

_____

_____

Duration of Present Condition? _____

What do you believe caused this Condition? _____

When were you last seen by a Physician? _____

For what purpose? _____

Diagnosis by your Doctor? _____

Any abnormal lab results or tests? _____

Prior surgeries? _____

Medications you are presently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6._____

Supplements or Over the Counter drugs you are taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6._____

Do you use any of the following?			How much and how often?
Coffee	Yes	No	_____
Tea	Yes	No	_____
Alcohol	Yes	No	_____
Chocolate	Yes	No	_____
Cigarettes	Yes	No	_____
Laxatives	Yes	No	_____
Sugar	Yes	No	_____
Artificial Sweeteners	Yes	No	_____

List any foods that you crave: _____

List any known allergies: _____

Do you have a pacemaker Yes No

Are you Pregnant Yes No

Meridian	Question	Never	Sometimes	Often
Lymphatic	Do you experience recurrent infections, sinusitis, postnasal drip, or swollen lymph nodes, etc.?			
Lungs	Do you experience recurrent respiratory infections, coughs, bronchitis, pneumonia, asthma, etc.?			
Large Intestines	Do you experience bouts of diarrhea or constipation, gas, bloating, etc.?			
Nervous	Do you experience irritability, nervousness, trembling, anxiety, or memory problems?			
Circulation	Do you have cold fingers or toes, blood pressure problems, varicose veins, arteriosclerosis, etc.?			
Allergies	Do you react to pollens, molds, foods, seasonal irritants, perfumes, animal dander, etc.?			
Cellular Metabolism	Do you have slow metabolism, are you always hungry, have low energy at specific times of day?			
Endocrine System	Do you have mood swings, problems sleeping, are you always cold, have chemical imbalances, etc.?			
Heart	Do you experience palpitations, arrhythmia, impairments from prior infections, weak valves, etc.?			
Conception Vessel	Do you have impotence, miscarriage, sterility, gynecological disorders, genital disorder, etc?			
Small Intestine	Do you have recurrent yeast infections, frequent antibiotic use, poor diet gas, bloating, etc.?			

Meridian	Question	Never	Sometimes	Often
Governing Vessel	Do you experience spinal stiffness or pain, headaches, mental confusion, depression, etc.?			
Pancreas	Do you have diabetes, hypoglycemia, irritability, shaking if you skip a meal, etc.?			
Spleen	Do you experience chronic fatigue, recurring infections, lowered immune response, etc.?			
Liver	Do you experience jaundice, high cholesterol, discomfort in the liver region, blood disorder, etc.?			
Joints	Do you have arthritis, back pain, discomfort when moving, weather triggered ailments, etc.?			
Stomach	Do you have digestive disturbances, high acidity, bloating or gas after meals, etc?			
Muscle, Ligaments, Tendons	Do you have fibromyalgia, rheumatism, carpel tunnel, slow recovery after exercise, etc.?			
Skin	Do you have rashes, dryness or cracking, scaly patches, eczema, acne, psoriasis, etc.?			
Fatty Tissue	Do you have lipomas, degenerative liver disease, breast tumors, problems burning fat, etc.?			
Gall Bladder	Do you have a history of gallstones, discomfort after eating rich foods low fat metabolism, etc.?			
Kidney	Do you experience edema, gout, pain in the lower back, burning urination, kidney stones, etc.?			
Urinary	Do you have recurring infections, itching or yeast problems, painful urination, “leaking”, etc.?			
Female	Do you have PMS, menstrual pains or discomfort, irregular periods, mood swings, hot flashes, menopausal symptoms, etc.?			
Male	Do you experience urinary discomfort, frequency of urination, etc.?			
Teeth	Do you have sensitive teeth or experience pain or discomfort in the teeth, gums, or jaw region?			
Stress	Do you experience stress from work, finances, society, or relationships that you feel cause physical ailments?			
Energy	Do you lack motivation, drive, perseverance, stamina, or endurance?			
Well-Being	Do you lack a sense of happiness, joy, feelings of fulfillment, a positive outlook on life?			
Immune	Are you susceptible to infections, allergies, or sensitive to pollution, or work environment?			