## General Information

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| --- | --- | --- | --- | --- | --- |
| Name: | Name here | Date: | Enter date  | DOB: | Enter DOB  |

|  |  |
| --- | --- |
| Address: | Enter address |

|  |  |  |  |
| --- | --- | --- | --- |
| Email: | Enter email |  Phone: | Enter Phone |

|  |  |
| --- | --- |
| Physician & Phone: | Enter physician and phone number here |
| Emergency contact: | Enter name, relationship, and phone number here  |

## Prior Diagnoses

|  |  |
| --- | --- |
| Medical Conditions: | Enter here  |
| Medications & Supplements: | Enter notes |

## Questionnaire

1. Are you more hot or cold natured?
2. Do you sweat? How does it make you feel when you do sweat?
3. Any head or body injuries? Any past pain or current pain?
4. How is your digestion? How often? Any concerns? Urine color?
5. What is your eating habit like? red meat? pork? What do you drink throughout the day?

	1. Do you crave any foods?
	2. Has your taste for certain foods changed over the years or recently?
6. Any pain in the chest or back?
7. How is your hearing? Eyesight?
8. Are you thirsty at night or at certain periods of the day?
9. Any childhood disease or trauma? Explain at a high-level.

	1. Did you experience measles and chicken pox as a child?

1. Where do you want to be health wise?
2. Anything else you need to add?