A picture containing text, clipart

Description automatically generated

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Inquiry of Health Status**

1. What is your overall energy level? □low □normal □high □other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What is your overall stress level? □low □normal □high □other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Does your body tend to be cold or warm? □cold □normal □warm □other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do your hands or feet tend to feel cold or warm? □cold □normal □warm □other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Do you tend to sweat? □yes □normal □no If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Do you currently have night sweats? □yes □no If yes, frequency:\_\_\_\_\_\_\_\_\_\_ amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Do you generally feel thirsty? □thirsty □normal □not thirsty
8. What kind of drink do you generally crave? □cold □warm □room temperature □no cravings for drink
9. How is your appetite overall? □low □normal □high
10. Do you generally have cravings for food? □yes □no If yes, specific: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Please describe your urination.

Frequency: □low □normal □high Amount: □short □normal □excessive Odor: □normal □abnormal \_\_\_\_\_\_\_\_\_

Appearance: □clear □yellowish □dark yellow □cloudy □other, specific: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concomitant sensation: □difficulty □pain □other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please describe your bowel movement.

Frequency: \_\_\_\_ times/\_\_\_\_day(s) Stool: □dry □well-formed □loose □watery □undigested food □other\_\_\_\_\_\_\_\_

Odor: □normal □abnormal \_\_\_\_\_\_\_\_ Concomitant sensation: □difficulty □pain □other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many hours do you sleep everyday? \_\_\_\_ hours
2. Do you feel you have enough sleep? □yes □no If no, how many hours per day would be enough for you? \_ hours
3. Please describe your sleep quality.

□good □poor □difficulty □disturbed dreams: □few □many dreams □can not remember

When you get up, how do you feel? □tired □refreshed □other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your libido level? □low □normal □high □other
2. Have you experienced heart palpitation? □yes □no If yes, frequency\_\_\_\_\_\_\_\_\_ duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you experienced shortness of breath? □yes □no If yes, frequency\_\_\_\_\_\_\_\_\_ duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you recently have any change in □vision □hearing □memorization □focus □no change □other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?

If any, details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any other symptoms or signs regarding your health?

□yes □no If yes, details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dr. Allison Greene, DC, CAC: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed \_\_\_\_\_\_\_\_\_\_\_\_\_