Patient Name: _____ Date: _____ ID:_____

Office Use Only

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 _____
12. 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 _____
13. How many hours do you sleep everyday? ____ hours
14. Do you feel you have enough sleep? □yes □no If no, how many hours per day would be enough for you? _ hours
15. 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 _____
16. What is your libido level? □low □normal □high □other
17. Have you experienced heart palpitation? □yes □no If yes, frequency_____ duration_____
18. Have you experienced shortness of breath? □yes □no If yes, frequency_____ duration_____
19. Do you recently have any change in □vision □hearing □memorization □focus □no change □other:_____?

    If any, details: _____
20. Do you have any other symptoms or signs regarding your health?

    □yes □no If yes, details: _____

_____

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Clinician Name: _____ Signature: _____ Date Signed _____