Reveal Wellness

Date: / /

Name:_____
Date of Birth_____Sex M/F
Address:_____
_____
Phone:_____
Email:_____
Soc Sec #_____
Occupation:_____
Employer:_____
Emergency Contact:_____
#:_____Relation:_____
Do you have children? Y/N
How many?
Referred by: _____
When was your last physical?
What is your blood type? A, B, AB, O
Do you have mercury filings?
Allergies (drug, chemical, food and the result):
_____
_____
_____
Is your immune system compromised by any condition at this time? Y/N
Explain:_____
_____

What are the main problems you would like to address today?_____
___ _____
When did this begin?_____
What makes it better?_____
What makes it worse?_____
Have you been given a diagnosis for this problem? Y/N
What was it?_____
What kinds of treatment have you tried?
_____
List all surgeries:_____
_____
_____
Significant trauma:_____
_____
_____

Medicines taken within the last 3 months (vitamins, drugs, herbs, etc.)
_____
_____
_____
_____

Please check any symptoms that have been persistent in the last three months.

General
○Chills
○Fever
○Sweat easily
○Night sweats
○Bleed or bruise easily
○Odd tastes or smells
○Strong thirst
○Sudden energy drop- time:_____
○Poor sleep
○Edema
○Tremors
○Cravings
○Change in appetite
○Weight loss
○Weight gain

Muscu-Skeletal
Pain in :
○Neck
○LShoulder
○RShoulder
○Back
○Elbow
○Wrist/Hand
○Hip
○Knee
○Ankle/Foot
○Muscle Pain
○Muscle
Weakness
Other_____

Skin and Hair
○Rashes
○Itching
○Change in skin or hair
○Ulcerations
○Eczema
○Lesions
○Hives
○Pimples
○Recent moles
○Loss of hair

Head,Eyes,ENT
○Dizziness
○Migraines
○Headaches
○Facial pain
○Glasses
○Contacts
○Poor vision
○Night blindness
○Seeing spots
○Eye pain
○Cataracts
○Eye dryness
○Extra tearing or discharge
○Lasik

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ENT Cont.
○Poor hearing
○Ringing in ears
○Ear aches
○Discharge from ear
○Nose bleeds
○Nasal drainage
○Teeth grinding
○Jaw clenching
○Concussion
○Sores on lips or tongue

Cardiovascular
○High BP
○Low BP
○Phlebitis
○Chest pain
○Palpitations
○Cold hands
○Cold feet
○Blood clots
○Fainting
○Difficulty Breathing
Other_____

Respiratory
○Asthma
○Cough
○Coughing Blood
○Wheezing
○Pain with breath
○Difficulty breathing when lying down
○Production of phlegm
○Color_____
○Pneumonia
○Bronchitis
Other_____

Gastro- Intestinal
○Bad Breath
○Nausea
○Vomiting
○Heartburn
○Belching
○Indigestion
○Diarrhea
○Constipation
○Blood in stools
○Abdominal
○Cramps
○Upper Gas
○Lower Gas
○Rectal pain
○Hemorrhoids
Other_____

Sleep
○Fall asleep too easily
○Trouble falling asleep
○Wake repeatedly
○Wake often to urinate
○Vivid dreams
○Wake not rested
○Supplements needed to sleep

NeuroPsych
○Seizures
○Areas of numbness
○Weakness
○Sleep disorder
○Concussion
○Short temper
○Violent
○Behavior
○Lack of coordination
○Depression
○Easily stressed
○Loss of balance
○Poor memory
○Anxious
○Substance abuse
Other_____

Uro-Genital
○Pain upon urination
○Frequent urination
○Blood in the urine
○Decrease in flow
○Unable to urinate
○Unable to hold urine
○Kidney stones
○Change in sex drive
○Sores on genitals
Other_____

Male
○Impotence
○Lumps in testicles
○Epididymitis
○Testicular torsion
○Prostatitis
○Varicocele
○Hernia
Other_____

Female
Pregnancies
Births
Days between periods_____
Days of flow_____
Flow is:
○Heavy
○Light
○Irregular
○Clots
○Painful
○Vaginal sores
○Breast lumps
○STD's
○Fibroids
○Change in bowels
○Emotional
○Change
○Odor
○Discharge
○Yeast
○Birth Control
Other_____
_____
_____

Height:
Weight:
BP:
Heart Rate:

Internal Medicine Examination

Please answer the following questions as accurately as possible. In Oriental Medicine, we look at the whole body so your diagnosis depends on each answer. If there is something you are not sure about, please ask during the session.

Do you often feel fatigue or lethargic? Y/N

What time of day in particular?

Rate your energy level (1-10)

Do you have a healthy appetite? Y/N

Are you thirsty throughout the day? Y/N

Do you generally prefer hot or cold drinks?

Do you experience generalized muscle pain? Y/N

Do you experience stiffness in the morning or with weather changes? Y/N

Do you often have stomach gurgling after a meal? Y/N

How often do you have a bowel movement?

What is the consistency (circle one) firm, tooth-paste-like, watery, hard and difficult to pass

Do they feel complete? Y/N

What is the color?

Do you ever have ulcers or cold sores in the mouth, on the tongue? Y/N

What do your stools resemble: long and thin, marble-like, fibrous and broken, normal

Do your gums bleed? Y/N

Do you bruise easily? Y/N

What is the overall condition of your skin? dry, oily, clammy, sweaty, itchy, normal

Do you experience shortness of breath? Y/N

Is your throat often dry? Y/N

Do you have a tendency to clear your throat?

Do you get headaches? Y/ N How often?

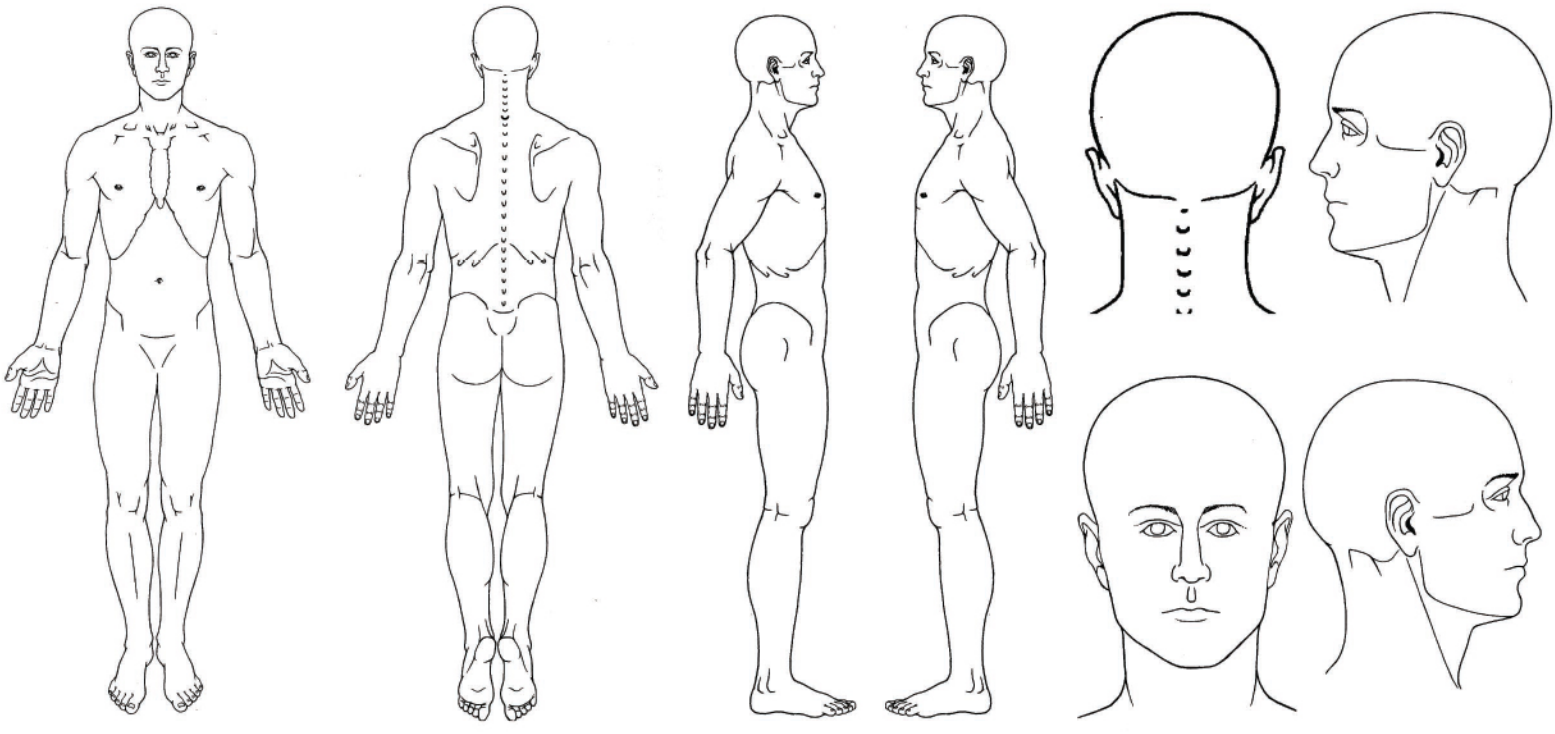
Where are they located?

Do you experience knee weakness or pain? Y/N

How often do you urinate?

Please indicate the location and sensation of your body pain using the following symbols:

^ ^ ^ ^ ^ ^ Numbness
o o o o o o o Pins and Needles
x x x x x x Burning
* * * * * * Aching/Dull
/ / / / / / Stabbing/Sharp
EEEEE Electrical



Reveal Wellness
EVOLVE FROM WITHIN
28633 S. Western Ave #202 Rancho Palos Verdes, CA 90275

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Print Patient's Name_____

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If you need to reschedule, we request that you do so 24 hours, or more, before the scheduled appointment time. A standard appointment rate is charged for a late (same day) cancellation or a missed appointment. We often have a waiting list of people to get in so a missed appointment is a loss for everyone. Please be sure to arrange accordingly.

Running Late? If you arrive 15 minutes or more after your scheduled appointment time, we will unfortunately have to reschedule and you will be charged for the appointment as, again, another person could have used that time slot. Thank you for understanding.

You MUST call 24 hours or more prior to the appointment time to avoid this charge.

Signature of Patient or Representative: _____ Date: _____

Witness: _____ Date: _____