HOW TO USE THE DIAGNOSTIC ASSESSMENT FORM

The form is self-explanatory and will flow on its own. Take your time, be thorough, and provide details where space is provided. There is a space at the end where you can write absolutely anything you like, so there is no reason not to include everything pertaining to you and your health on the form. We will also have the opportunity to communicate through E-mail as a follow up to the initial form. When you are ready for your follow up simply book yourself into the schedule.

Date: Name: Email:

Phone: Fax: Date of Birth:

Gender: ☐ Male ☐ Female Age: Ethnicity: Height: Weight:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Are you or could you be pregnant: YES ☐ NO ☐

Main complaint/reason for consult: (Please be as detailed as possible)

Date of onset:

Events surrounding onset:

Duration:

What makes it worse or better

Your physicians name and phone, fax, email

Name: Email:

Phone: Fax:

Date of last visit: Diagnosis:

List any other healthcare providers you have seen in the last year along with their phone, fax, email and what they did for you

1) Name: Email:

Phone: Fax:

Date of last visit: Diagnosis:

2) Name: Email:

Phone: Fax:

Date of last visit: Diagnosis:

List any allergies

List current medications, their dosage, and why you take them:
(including: prescription and nonprescription drugs, birth control pills, supplements and herbs)

Past medical history: please list any surgery, illness, injuries, medical problems, or hospitalizations

Have you ever had:

☐ asthma, ☐ bladder problems, ☐ diabetes, ☐ epilepsy or seizures, ☐ gallbladder problems, ☐ headaches, ☐ heart problems,

☐ hepatitis a,b,c, ☐ high/low blood pressure, ☐ Kidney problems, ☐ lg. Intestine problems, ☐ Liver problems, ☐ lung problems,

☐ menstrual problems, ☐ HIV/AIDS, ☐ prostate problems, ☐ sm. Intestine problems, ☐ stomach problems ☐ thyroid problems

Family medical history: please list any medical problems of your:

Mother, Father, siblings and relations:

Do you have relatives with any of the following illnesses:

☐ heart attack, ☐ high cholesterol, ☐ high blood pressure, ☐ diabetes, ☐ ovarian cancer, ☐ breast cancer,

☐ prostate cancer, ☐ colon cancer, ☐ skin cancer, ☐ sickle cell disease,

The relationship of the person.

Social history: occupation with details

Current stress level(0 – 10) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10

What are the causes of this stress?

What do you do to ameliorate or deal with the stress?

Are you a ☐ current or ☐ previous smoker?

How much? How many years? Quit date?

Do you drink alcohol? ☐ Drinks per week:

Do you use recreational drugs? ☐ Which ones?

How long? How often?

What do you do for exercise?

How often do you do it? How long does the workout last?

How long have you done it for?

ABOUT YOUR CURRENT MEDICAL CONDITION

Any ☐ fever or ☐ chills? Do you feel ☐ warm ☐ cold or ☐ comfortable most of the time?

Does warm or cold affect your medical condition in any way?

Do you have ☐ cold fingers and ☐ toes?

Do you experience sweats: ☐ day or ☐ night? How much? How often?

What is your thirst level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10

and what do you like to drink?

How many 8oz. cups of coffee do you drink a day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10

How much soda? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10 12oz. can

What kind?

Do you have a ☐ dry throat or ☐ mouth?

How much water do you drink each day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10 8oz. glasses

Keep a diet journal for 5 days. You can use our form for convenience: Diet Journal

How would you characterize your appetite? ○ poor ○ normal ○ excessive

How many meals per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10

Do you have any cravings?

Do you experience any: ☐ belching, ☐ hiccups, ☐ heartburn, ☐ bloating, ☐ gurgling, ☐ pain, ☐ gas ☐ nausea or ☐ vomiting?

Anything to add about your digestion?

How many bowel movements per day do you have? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10

What is their quality – are they ☐ dry or ☐ loose ☐ diarrhea or ☐ constipation? Hard to push?YES ☐ NO ☐

Any ☐ mucous or ☐ blood? Any undigested food?YES ☐ NO ☐ Do they feel complete?YES ☐ NO ☐

Any hemorrhoids? YES ☐ NO ☐ Any other related bowel information?

How many times do you urinate per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10

Is the color ☐ light yellow, ☐ dark yellow, ☐ clear, or ☐ cloudy?

Do you experience any ☐ incontinence or ☐ dribbling?

Any difficulty to start the flow? YES ☐ NO ☐ Any burning ☐ sensation or ☐ pain?

Any related urinary/ bladder information?

How is your libido? ○ none ○ poor ○ normal ○ excessive

How is your energy level? ○ exhausted ○ low ○ normal ○ hyper

What time of day is it lowest:
☐ Hard to wake, ☐ after lunch, ☐ after bowel movements, ☐ afternoon, ☐ evenings, or ☐ after dinner.

How long has it been this way? Any ☐ lethargy or ☐ mental cloudiness?

Any memory problems? YES ☐ NO ☐

How do you sleep:
Any difficulty to fall asleep? YES ☐ NO ☐ Any wake-ups? YES ☐ NO ☐

How many hours do you average? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10

Do you dream?YES ☐ NO ☐ Any themes you can share?

Do you experience any ☐ pain, ☐ headaches, ☐ numbness or ☐ tingling?

Where specifically? When did it start?

Has it been getting progressively ☐ better or ☐ worse or is it ☐ stable?

Is the pain ☐ hot or ☐ cold? Does ☐ hot make it ○ better or ○ worse?

Does ☐ cold make it ○ better or ○ worse?

Is the pain ☐ sharp or ☐ dull, ☐ throbbing, ☐ shooting, ☐ cramping, ☐ stiff, ☐ swollen,

☐ aching, or, ☐ burning?

Is the pain ☐ constant or does it ☐ come and go?

How would you characterize your emotional state?

☐ Happy, ☐ sad, ☐ anxious, ☐ depressed, ☐ grief, ☐ joy, ☐ fearful, ☐ worried, ☐ angry, ☐ confused,

☐ nervous, ☐ restless, ☐ rage, or a combination of several of the above?

Please feel free to give a detailed description:

GYNECOLOGICAL:

Do you feel you might be ☐ perimenopausal or in ☐ menopause?

If so do you experience ☐ hot flashes, ☐ night sweats, ☐ dryness etc.

How many pregnancies have you had? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10

Any ☐ miscarriages or ☐ abortions? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ >10

Do you have breast implants? YES ☐ NO ☐ What type?

Date of your last menses?

○ 2000 or earlier ○ 2001 ○ 2002 Are your periods regular? YES ☐ NO ☐

Any vaginal ☐ discharge or ☐ “spotting”? Color: ☐ white ☐ yellow ☐ pink ☐ red ☐ brown

Odorous? YES ☐ NO ☐

Amount: ○ lite ○ moderate ○ heavey Consistency? ☐ thin ☐ thick

How many days is your whole menstrual cycle? (i.e. 28)

How long does the flow last? Is it ☐ heavy ☐ moderate or ☐ light?

Is the color ☐ light red, ☐ bright red, ☐ dark red, or ☐ brown?

Do you experience any clotting? YES ☐ NO ☐

Do you experience any PMS? YES ☐ NO ☐

Any ☐ Bloating, ☐ breast distention, ☐ cramping, ☐ emotional changes etc.

Any ☐ pain or ☐ cramping with your menses?

RESPIRATORY:

Do you experience any cough? YES ☐ NO ☐ Any asthma? YES ☐ NO ☐ Sputum production? YES ☐ NO ☐

Its color? ☐ clear ☐ white ☐ yellow ☐ blood streaked ☐ green Amount? ☐ small ☐ medium ☐ large

Any shortness of breath? YES ☐ NO ☐ Any nasal congestion? YES ☐ NO ☐

Any chest pain or tightness? YES ☐ NO ☐

CARDIOVASCULAR:

Any palpitations? YES ☐ NO ☐ Any swelling of legs? YES ☐ NO ☐

Do you experience any ☐ dizziness, ☐ lightheadedness or ☐ vertigo?

EYES:

☐ bloodshot ☐ dull ☐ yellow ☐ clear bright white?

Any difficulty to see at ☐ night or problems with ☐ bright lights?

Do you have any ☐ loss of vision or ☐ double vision?

GENERAL:

Any weakness of your ☐ arms and ☐ legs? Any ☐ dull low backache?

FACE:

Do you have ☐ rosy cheeks? Is your face ☐ pale? Any ☐ dark circles under eyes?

Any ☐ acne or ☐ pimples? Where? Do they come to a head? YES ☐ NO ☐

EARS:

Do you have any ear ☐ ringing or ☐ hearing lose? Describe:

IMMUNE:

Frequent colds? YES ☐ NO ☐ Any ☐ lumps, ☐ nodules or ☐ cysts? Any swollen ☐ lymph glands?

SKIN:

Any skin problems – ☐ eczema, ☐ itching, rashes or ☐ psoriasis? Easy to bruise? YES ☐ NO ☐ Is it dry? YES ☐ NO ☐

HAIR:

Any hair ☐ loss ☐ thinning or ☐ graying? Any hair dryness? YES ☐ NO ☐

NAILS:

Any ridges? YES ☐ NO ☐ Any white spots? YES ☐ NO ☐ Easy to chip or break? YES ☐ NO ☐

Do you meditate? YES ☐ NO ☐ For how long? ○ less than one year ○ more than one year

How often? ☐ daily ☐ weekly ☐ infrequently How long is each session? ☐ > 0-10, ☐ 10-30; ☐ >30

What style?

TONGUE: see Tongue Plates, is it swollen? *Please pick one photo that most matches your tongue.*

☐ Plate 1 ☐ Plate 2 ☐ Plate 3 ☐ Plate 4 ☐ Plate 5 ☐ Plate 6 ☐ Plate 7 ☐ Plate 8 ☐ Plate 9 ☐ Plate 10

☐ Plate11 ☐ Plate12 ☐ Plate13 ☐ Plate 14 ☐ Plate 15 ☐ Plate16 ☐ Plate 17 ☐ Plate 18 ☐ Plate 19 ☐ Plate 20

☐ Plate21 ☐ Plate22 ☐ Plate23 ☐ Plate 24 ☐ Plate 25 ☐ Plate26 ☐ Plate 27 ☐ Plate 28 ☐ Plate 29 ☐ Plate 30

☐ Plate31 ☐ Plate32 ☐ Plate33 ☐ Plate 34 ☐ Plate 35 ☐ Plate36 ☐ Plate 17 ☐ Plate 38 ☐ Plate 39 ☐ Plate 40

Is the body ☐ red, ☐ pale , ☐ purple, or ☐ pink? Is there a coat? YES ☐ NO ☐

Is it ☐ white or ☐ yellow ☐ shiney ☐ bown? Are there any ☐ sores, ☐ bumps, ☐ cracks, or ☐ markings?

Is it ☐ moist ☐ dry or ☐ normal? Does it ☐ burn or is there ☐ pain?

PULSE:

Take your pulse at each wrist, what is the rate per minute? ☐ >60; ☐ 60-80; ☐ 80-90; ☐ 91-100; ☐ 101 or more

Does your pulse feel? ☐ weak ☐ strong ☐ normal How much pressure do you apply? ☐ lite ☐ moderate ☐ heavy

Does it feel smooth, steady and regular? YES ☐ NO ☐ Does it feel ☐ thin ☐ normal ☐ large?

Use this space below to tell us what your second and third most pressing issues are (that you listed above) that you would like us to help you with; of course the main complaint you listed initially is the most important. Also, add or ask anything you feel is pertinent to your case.

Billing Address: Street

City, State Zip Code

Country

Everything happens in the state thats the assessing D.O.M . resides.

Please Fax Form to: **Email questions to: doctor@HerbalConsults.com**

Thank you for taking the time to fully fill out this diagnostic assestment form .

Your results will be Email to you.