Ten Questions

Body Temperature: Hot Cold Usually comfortable Cold Hands/Feet

Perspiration: WNL Profuse Scanty Spontaneous Odorous

Thirst WNL High Low _____Oz. per day Cold Hot

Appetite WNL High Low

Cravings Sweet Salty Sour Bland Spicy None

Typical Day's Intake—Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Anything you do NOT eat? _____

Eat A LOT of? _____

Urination _____Times/Day _____Times/Night Color_____

Profuse Scanty Cloudy Burning

Bowel Movements _____Times/Day _____am/pm Formed Loose

Undigested food Difficult to move Painful Odorous

Energy level _____/10 Fluctuates Steady

Sleep _____hours/night Difficulty initiating sleep Wake up in the night

No complaints

Exercise _____times/week Type of exercise_____

Chief Complaint:

What worsens symptoms?

What helps symptoms?

Duration of Symptoms:

Anything notable at time of onset: