

**Many Lives Chinese Medicine**  
**499 Seaport Court, Suite 101**  
**Redwood City, CA 94063**

**beth.schiffman@gmail.com**

**650.366.4299**

Name: \_\_\_\_\_

Chief complaint: \_\_\_\_\_

Date of onset (when you first noticed the problem): \_\_\_\_\_

How long have you had this condition: \_\_\_\_\_

Have you had this in the past?  No  Yes When: \_\_\_\_\_

Pain is:  Minimal  Moderate  
 Slight  Severe Scale of 1 to 10: \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Your condition is:  Getting worse  Constant  Comes and goes

Medications/drugs/herbs you are currently taking: \_\_\_\_\_

List surgeries/operations you have undergone, with dates: \_\_\_\_\_

**Family History**

	<b>Father</b>	<b>Mother</b>	<b>Sibling</b>	<b>Children</b>	<b>Self</b>
Arthritis					
Asthma					
Cancer					
Allergies					
Heart trouble					
High blood pressure					
Stroke					
Diabetes					

<b>General</b>		
<input type="checkbox"/> Chills	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Aversion to heat/cold
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Excess thirst	<input type="checkbox"/> Low-back pain
<input type="checkbox"/> Catch colds easily	<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Joint disorders
<input type="checkbox"/> Allergies	<input type="checkbox"/> Dizziness	

<b>Energy level</b>	<b>Stress</b>
<input type="checkbox"/> High (time of day) _____	<input type="checkbox"/> None
<input type="checkbox"/> Low (time of day) _____	<input type="checkbox"/> Moderate
	<input type="checkbox"/> Severe
	What causes it? _____

Sleep problems		
<input type="checkbox"/> Trouble falling asleep	<input type="checkbox"/> Trouble staying awake	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Trouble staying asleep	<input type="checkbox"/> Excess dreaming	
<input type="checkbox"/> How many hours do you sleep each night? _____		

Sweating	Circulation
<input type="checkbox"/> Rarely sweat	Feelings of: <input type="checkbox"/> Hot
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Cold    What area? _____
<input type="checkbox"/> Excess sweating	
<input type="checkbox"/> Spontaneous sweating	Hands and feet get cold easily: <input type="checkbox"/> Yes <input type="checkbox"/> No

Skin		
<input type="checkbox"/> Dry	<input type="checkbox"/> Changing moles/lumps (cysts/tumors)	<input type="checkbox"/> Dry scalp
<input type="checkbox"/> Itchy	<input type="checkbox"/> Boils	<input type="checkbox"/> Skin puffy/wrinkled
<input type="checkbox"/> Moist, clammy	<input type="checkbox"/> Frequent rashes	<input type="checkbox"/> Dark circles under eyes
<input type="checkbox"/> Burning	<input type="checkbox"/> Acne	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Blood not clotting	<input type="checkbox"/> Bruise easily (black-and-blue spots)	
<input type="checkbox"/> Hives	<input type="checkbox"/> Hair loss/thinning	

Head & neck		
<input type="checkbox"/> Memory loss	<input type="checkbox"/> Double vision	<input type="checkbox"/> Headaches (list where): _____
<input type="checkbox"/> Eye pain	<input type="checkbox"/> "Floaters" (spots in vision)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Loss of balance	
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Burning eyes	

Ears & nose		
<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Ringing/buzzing in ears	<input type="checkbox"/> Congestion/allergies
<input type="checkbox"/> Ear aches	<input type="checkbox"/> Frequent nose bleeds	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Ear discharge/infections	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Other: _____

Chest		
<input type="checkbox"/> Trouble breathing	<input type="checkbox"/> Mucous rattle when breathing	<input type="checkbox"/> Swollen ankles
<input type="checkbox"/> Trouble breathing at night	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Coughing phlegm Color: _____
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Pain/pressure in chest	<input type="checkbox"/> Chest pain	
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Coughing blood	

Genito-urinary		
<input type="checkbox"/> Frequent urination <input type="checkbox"/> Day <input type="checkbox"/> Night	<input type="checkbox"/> Strong-smelling urine	<input type="checkbox"/> Water retention
<input type="checkbox"/> Difficult to urinate	<input type="checkbox"/> Pain or burning on urination	<input type="checkbox"/> Abnormal color
	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Frequent infections/dysfunction	

Neurological		
<input type="checkbox"/> Tremors	<input type="checkbox"/> Pain; where: _____	<input type="checkbox"/> Poor coordination
<input type="checkbox"/> Numbness; where: _____	<input type="checkbox"/> Paralysis; where: _____	<input type="checkbox"/> Stroke
<input type="checkbox"/> Tingling; where: _____	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other: _____

Emotional & mental		
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Moody	<input type="checkbox"/> Fearful
<input type="checkbox"/> Depressed	<input type="checkbox"/> Mind not clear	<input type="checkbox"/> Terrors
<input type="checkbox"/> Easily angered	<input type="checkbox"/> Manic	<input type="checkbox"/> Difficulty expressing emotions
<input type="checkbox"/> Easily irritated	<input type="checkbox"/> Obsessive	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Frequent crying	<input type="checkbox"/> Compulsive	
<input type="checkbox"/> Disoriented	<input type="checkbox"/> Anxiety	

**Gastro-intestinal** (check all that apply)

	Often	Seldom	Severe	Mild	None
Poor appetite					
Excessive appetite					
Nausea					
Vomiting					
Belching					
Indigestion					
Stomach pain					
Lower-abdominal pain					
Bloody stools					
Black stools					
Mucus in stools					
Stools have foul odor					
Hemorrhoids					
Lower bowel gas					
Colon problems					
Diarrhea					
Constipation					

**Lifestyle habits** (please indicate how much, how many, how often)

Cigarettes (packs): \_\_\_\_\_ Coffee/tea (cups): \_\_\_\_\_

Alcohol (type/amount per week): \_\_\_\_\_

Prescription drugs: \_\_\_\_\_

Over-the-counter drugs: \_\_\_\_\_

Recreational drugs: \_\_\_\_\_

Vitamins/herbs: \_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

Food cravings: \_\_\_\_\_

Exercise (type and frequency): \_\_\_\_\_

Briefly describe your diet: \_\_\_\_\_