

Examination Record

Name: _____ Age: _____ Male Female Date: ____/____/____

Chief Complaints (What are the chief complaints you would like us to help you with?)

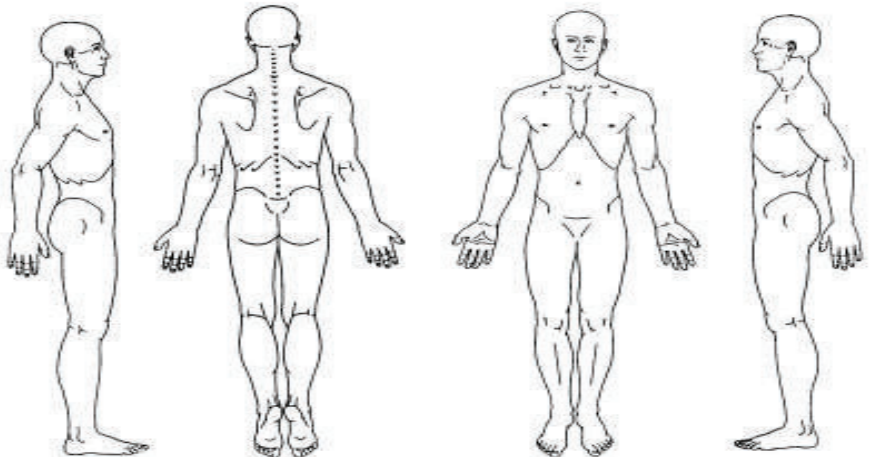
CIRCLE THE APPROPRIATE RESPONSE:

Emotion	Stable Anxious/Fear Worried Depressed Grief Irritable Easy Stressed Exuberant
Energy	Overall Energy: Low 1 2 3 4 5 6 7 8 9 10 High
Hot/Cold	Body: Hot Cold Warm Even Hands/Feet: Hot Cold Warm Even
Thirst	Never Usual Always Prefers drinking liquids: Cold Hot
Sweat	Normal Spontaneous Extremities Night Neck Up Whole body
Appetite	Normal Excessive Poor None Craves: Sweet Sour Bitter Salt Spicy
Digestion	Normal Bloating Gas Hiccup Reflux Nausea Vomiting Stomache
Stools	Soft Constipation Diarrhea Blood Mucous Incomplete Hemorrhoids Burn/Itch Rectum
Stool Frequency	less than 1 X day 1-2 X day more than 2 X day
Urine	Color without vitamins: Clear Light Dark Blood in urine Keydney/Gull Stones Wakes at night
Urine Frequency	Day Time: 1-5 X day 5-10X day more than 10 X day Night Time: 1-2 times more than 2 times
Urination Flow	Good Scant Incontinent Hesitant Frequent Urgent Pain Burning Night Bedwetting
Genital	Libido: Increased Decreased Impotence Premature ejaculation Vaginal: Dryness Discharge
Sleep	Restful Interrupted Restless Dreams Difficult: falling asleep staying asleep waking up
Neuro	Dizziness Unbalanced Tremors Seizures Spasms Poor Memory Foggy headed Confused
Headache	None Front Top Side Back Whole head Band-type Behind Eyes Sinus Pressure Stabbing
Eyes	Normal Dry Itchy Blurred Spots Red Painful Watery Corrected vision: Yes No
Mouth	Grinding teeth TMJ Facial Pain Gum problem Sores Dry Excess saliva
Ears	Normal Poor hearing Deaf Earache Discharge Pressure ringing in the Ear: Low pitch High pitch
Nose	Normal Dry Bleeds Congestion Postnasal drip Sneezing Allergies Difficult breathing Asthma
Throat	Swollen glands Sore Lumps Enlarged thyroid Cough Burning Irritated
Heart	Palpitations Racing Irregular HTN Fainting Low BP Blood clots Chest: Tightness Pain
Circulation	Normal Numbness Tingling Loss of Feeling: Hands Feet Arms Legs Fingers Toes
Mucous	None Thick Thin Profuse Scanty Nonproductive Color: yellow green white clear
Menses	Postmenopausal Last Menstrual Period: Cramps Clots Early Heavy Scanty Absent
Menses	#of day in cycle: #of Days Bleeding: Blood Color: Red Dark red Brown Light red
Pregnancy	#of Pregnancies: #of birth: #of premature birth: #of miscarriages:
Weight	Weight Gain/Loss in a year: lbs

For Patients with Pain Describe: Heavy Empty Aching Distending Stabbing Moving Burning Gripping Pulling

MARK THE AREA WHERE YOU HAVE PAIN.

X = Sharp Pain O = Dull Pain



Pain Scale: Please indicate below

