Katie Clifton, L.Ac.

Please check any conditions that you currently have. Underline any you've had in the past:

Diabetes ☐ Glaucoma ☐ Heart Trouble ☐ High blood pressure ☐ Cancer ☐
Vein Trouble ☐ Asthma ☐ Jaundice ☐ Tuberculosis ☐ Bleeding Tendencies ☐
Mumps ☐ Pneumonia ☐ Allergies ☐ Polio ☐ Kidney Disease/Stones ☐
Measles ☐ HIV/AIDS ☐ Rheumatic Fever ☐ Nervous Disorder ☐ Chicken Pox ☐
Meningitis ☐ Hepatitis ☐ Multiple Sclerosis ☐ High Fever ☐ Antibiotic Use ☐
Thyroid Medication ☐ Steroid Medication ☐ Other ☐ _____

Please check if you are **currently** experiencing the following:

GENERAL: Tremors/Tics ☐ Headache ☐ Migraine ☐ Fever ☐ Sweats ☐ Fainting ☐
Dizziness ☐ Convulsions ☐ Fatigue ☐ Loss of Sleep ☐ Anxiety ☐ Depression ☐
Weight Loss ☐ Forgetfulness ☐ Confusion ☐ Numbness ☐ Paralysis ☐ Chronic
Chilliness ☐ Chronic Stress ☐ Irritability/Touchiness ☐ Weak Fingernails ☐ Intense
Thirst ☐ Sensations of Heaviness in Limbs ☐

EYES, EARS, NOSE, THROAT: Failing/Diminished Vision ☐ Eye Pain ☐ Blurry Vision ☐
Floaters ☐ Poor Night Vision ☐ Light Sensitivity ☐ Red Eyes ☐ Eye Inflammation ☐
Glaucoma ☐ Cataracts ☐ Deafness ☐ Earache ☐ Hearing Loss ☐ Tinnitus/Ringing
in Ears ☐ Ear Discharge ☐ Dry Eyes ☐ Nose Bleeds ☐ Nasal Drainage ☐ Loss of
Smell ☐ Sore Throat ☐ Hoarseness ☐ Dry Throat/Mouth/Nose ☐ Difficulty
Swallowing ☐ Loss of Taste ☐ Dental Decay ☐ Gum Inflammation ☐ Frequent Colds
☐ Enlarged Thyroid ☐ Enlarged Glands ☐ Sinus Infection ☐

SKIN: Skin Eruptions ☐ Clammy Skin ☐ Spontaneous Sweating ☐ Dryness ☐ Bruise
Easily ☐ Boils ☐ Rashes ☐ Sensitive Skin ☐ Hives/Allergies ☐ Swelling/Edema ☐
Mouth Ulcers ☐ Damp/Greasy Skin/Hair ☐ Acne ☐

RESPIRATORY & CARDIOVASCULAR: Chronic Cough ☐ Spitting Up Phlegm ☐ Excessive Mucus ☐
Sneezing ☐ Chest Pain ☐ Difficulty Breathing ☐ Wheezing ☐ Asthma ☐
Rhinitis/Sinusitis ☐ Chest Tightness/Heaviness ☐ Palpitations ☐ Irregular Heartbeat ☐
High Blood Pressure ☐ Low Blood Pressure ☐ Stroke ☐ Poor Circulation☐ Varicose
Veins ☐ Hardening of Arteries ☐ High Cholesterol ☐ Shortness of Breath ☐

GENITOURIINARY: Frequent Urination □ Scanty Urine □ Blood in Urine □ Urinary Tract Infections □ Painful Urination □ Difficult Urination □ Cloudy Urination □ Bed Wetting □ Incontinence □ Burning Urination □ Dribbling □ Urgency with Urination □ Night Urination □ Concentrated Urine □

FEMALE: Painful Menstrual Cycle □ Early Periods □ Heavy Bleeding □ Lack of Blood □ Late Menses □ Watery/Thin Blood □ Pale Blood □ Clotting □ Water Retention □ Breast Pain□ Abnormal Bleeding □ Hot Flashes □ Vaginal Discharge □ Vaginal Burning □ Infertility □ Hormone Replacement Therapy □ PMS □ Rib Pain/Distention □ Prolapsed Uterus/Organs □ Soft Nodules or Masses □ Cysts □ Polycystic Ovaries □
Other_____
Are you currently on birth control? Y/N If so, what are you using?_____
Age you started menses:_____ Menopause Age:_____
Are you Pregnant Y/N/Maybe If yes, how many weeks?_____
Are you experiencing reduced libido (sexual energies)? Yes/No
# of Pregnancies:_____ # of Children:____ Abortions:_____ Miscarriages:_____
Please list any surgeries involving: Ovaries Uterus Tubes Vagina Breast

MALE: Reduced Libido (sexual energy) □ Premature Ejaculation □ Seminal Emission □ Impotence □ Discharges □ Urgent Urination □ Genital Pain □ Prostate Problems □

GASTROINTESTINAL: Poor Appetite □ Excessive Hunger/Cravings □ Gas/Bloating □ Belching □ Nausea □ Vomiting □ Hunger Without Desire to Eat □ Lack of Taste Discrimination □ Abdominal Pain □ Colitis □ Constipation □ Diarrhea □ Irregular Bowel Movements □ Loose Stools □ Hemorrhoids □ Worms/Parasites □ Liver Trouble □ Gall Bladder Trouble □ Irritable Bowel Heartburn/Acid Reflux □ Weight Gain □ Weight Loss □ Emaciation □ Desire to Eat Strange Things □ Feeling Cold in the Abdomen □

MUSCULO-SKELETAL: Stiff Neck □ Pain Between Shoulders □ Mid-Backache □ Lower Back Pain □ Lower Back Weakness □ Foot Trouble □ Hernia □ Arthritis □ Sore Muscles □ Weak Muscles □ Sciatica □ Spinal Curvature □ Knee Pain □ Knee Weakness □ Bone Disorders □ Cold Hands/Feet □

FAMILY HISTORY: Asthma □ Allergies □ Cancer □ Diabetes □ Digestive Problems □ Emotional Problems □ Heart Disease □ High Blood Pressure □ Seizures □ Stroke □ Substance Abuse □ Other:_____

LIFESTYLE:

Do you exercise? Y/N
Please indicate the level of habit and frequency of the following:

	Heavy	Moderate	Light	None
Coffee	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Tea	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Appetite	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Stress	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Other	_____	_____	_____	_____

DIET:
(circle one) omnivore carnivore vegetarian vegan raw foods paleo other:_____
Breakfast: _____
Lunch: _____
Dinner: _____
Between Meals: _____

Are you now on (or have undertaken) a restricted diet? Please describe and indicate when/why: _____