Examination Record

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

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

Last Visit's Symptom Progress:

New Symptoms:

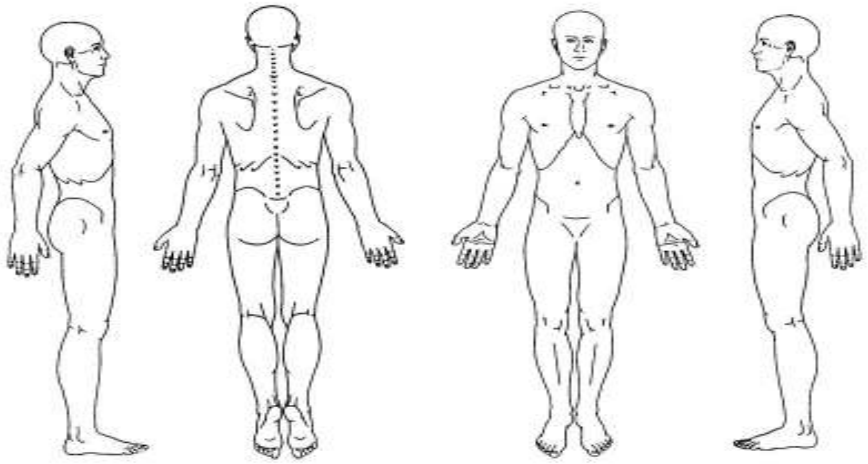
CIRCLE THE APPROPRIATE RESPONSE:

Emotion	Stable Anxious/Fear Worried Depressed Grief Irritable Easy Stressed Exuberant
Energy	Best: AM/afternoon/PM Worst: AM/PM **Overall Energy:** Low 1 2 3 4 5 6 7 8 9 10 High
Hot/Cold	**Hands:** Hot Cold Warm Sweaty **Feet:** Hot Cold Warm **Tends to:** Chill Flush **Heat Sensation**: Palms Soles
Thirst	Never Usual Always **Fluid intake adequate**: Yes No **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 Bloated Gas Hiccup Reflux Nausea Vomiting Stomache
Stools	Soft Constipation Diarrhea Blood Mucous Incomplete Hemorrhoids Burn/Itch Rectum
Urine	**Color without vitamins:** Clear Light Dark Blood in urine Stones in urine Wakes at night
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
Skin	Flush Pale Dusky Shiny Acne Bruised Ulcer Bleed Rash Hives Dry Oily Scaling Itchy
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	Dental Caries 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
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

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***