





## Patient Information Form

The following questions will greatly assist in our being able to correctly identify your imbalances. Please circle the option that best describes you and give detail where required.

### 1. Bowel Movements

- Do you move your bowels daily?                      Yes     /             No
- Is your bowel movement roughly  
at the same time of day?                      Yes     /             No
- When?                      Morning                      Afternoon                      Evening
- Would you say you are constipated?                      Yes     /             No
- Do you have Diarrhea                      Yes     /             No
- Do your stools:                      float     /             sink
- Have you observed the color?
- Could you describe the odor?

### 2. Appetite

- How many meals do you have daily                      1                      2                      3                      4
- Which is your main meal?
- When do you get hungry?
- Do you eat most meals at:                      home                      out
- What are the foods you eat regularly?
- What time do you eat your last meal (usually)?

### 3. Sleep

- How many hours sleep do you get a night?
- Do you                      dream                      have nightmares
- How would you say you sleep? .....
- Do you wake in the night to go to the toilet?                      Yes                      No
- Do you wake up feeling -                      fresh                      tired                      still sleepy
- What time do you go to sleep?



**4. Periods/ reproductive information**

Is your monthly period regular? Yes / No

Do you suffer any P.M.S? .....

If so briefly state how this affects you... ..

Are you sexually active Yes / No

**5. Exercise**

What kind of exercise or games do you participate in?

.....

How often do you exercise?

.....

**6. Emotional state**

What words would you use to describe your current state of mind?

What words would you use to describe your emotions?

**7. Fluid intake**

How many glasses of water do you drink in the day?

Do you wake in the night to drink water? Yes / No

**8. Physical Pains**

Are you suffering form aches or pains in any part of your anatomy? If so state where

**9. Nature of work**

How active are in your job? Describe briefly if you interact with others if you sit or are on the move all day etc...

**10. Travel**

Do you have to travel as part of your work Yes / No Often

Do you travel a lot for holidays Yes / No