



## HEALTH MATTERS CONSULTING

MaryJane O'Byrne, D.TCM  
1262A Oxford Street  
Victoria, BC V8V 2V5  
Tel: (250) 514-8901  
Email: [maryjane@telus.net](mailto:maryjane@telus.net)  
[www.health-matters.ca](http://www.health-matters.ca)

**This is a confidential record of your medical history. The information contained herein will not be released to anyone, without your prior written authorization. Please complete the questionnaire as thoroughly as possible.**

### I. GENERAL INFORMATION

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_

POSTAL CODE \_\_\_\_\_ TELEPHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_

OCCUPATION \_\_\_\_\_

DOB \_\_\_\_\_ SEX: M  F

MARITAL STATUS SINGLE  MARRIED  DIVORCED  WIDOWED

NUMBER OF CHILDREN \_\_\_\_\_ AGES AND SEX \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ TELEPHONE \_\_\_\_\_

REFERRED TO THIS CLINIC BY \_\_\_\_\_

GENERAL PRACTITIONER \_\_\_\_\_

Date of last visit \_\_\_\_\_

CHIROPRACTOR \_\_\_\_\_

Date of last visit \_\_\_\_\_

DENTIST \_\_\_\_\_

Date of last visit \_\_\_\_\_

PHYSIOTHERAPIST \_\_\_\_\_

Date of last visit \_\_\_\_\_

MASSAGE THERAPIST \_\_\_\_\_

Date of last visit \_\_\_\_\_

SPECIALISTS \_\_\_\_\_

Date of last visit \_\_\_\_\_

WHAT ARE YOUR PRIMARY HEALTH CONCERNS? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

WHAT IS THE PRIMARY REASON YOU ARE SEEKING CONSULTATION/TREATMENT? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU HAD PREVIOUS TREATMENT FOR THIS CONDITION? YES  NO

IF YES DESCRIBE \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

WHAT HAS BEEN HELPFUL FOR THIS CONDITION \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

WHY ARE YOU CHOOSING THIS TYPE OF TREATMENT? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**II. YOUR HEALTH HISTORY**

PREVIOUS ILLNESSES \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

SURGERIES (SPECIFY DATES) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

CHILDHOOD ILLNESSES \_\_\_\_\_

\_\_\_\_\_

TRAUMAS (ACCIDENTS/FALLS/ETC.) \_\_\_\_\_

CURRENT MEDICATION OR SUPPLEMENTS (VITAMIN / HERBSIETC.) \_\_\_\_\_

\_\_\_\_\_

IS THERE ANY REASON WHY YOU CANNOT TAKE ALCOHOL BASED REMEDIES \_\_\_\_\_

\_\_\_\_\_

DESCRIBE ANY OCCUPATIONAL RELATED STRESS \_\_\_\_\_

\_\_\_\_\_

ALLERGIES (FOOD AND/OR DRUGS) \_\_\_\_\_

\_\_\_\_\_

**III. HEALTH HABITS**

DESCRIBE TYPE AND FREQUENCY OF EXERCISE PROGRAM \_\_\_\_\_

\_\_\_\_\_

CHECK THE ITEMS YOU USE AND INDICATE FREQUENCY (IE. DAILY/MONTHLY/ETC.),

AND LENGTH OF USAGE:

COFFEE  \_\_\_\_\_ TEA  \_\_\_\_\_

CIGARETTES  \_\_\_\_\_ ALCOHOL  \_\_\_\_\_

RECREATIONAL DRUGS  \_\_\_\_\_

PRESCRIPTION DRUGS  \_\_\_\_\_

OTHERS \_\_\_\_\_

HAVE YOU DISCONTINUED USING ANY OF THE ABOVE? IF SO WHICH ITEMS AND WHEN?

\_\_\_\_\_

\_\_\_\_\_

**IV. DIET**

DESCRIBE YOUR TYPICAL DAILY DIET

BREAKFAST \_\_\_\_\_

LUNCH \_\_\_\_\_

DINNER \_\_\_\_\_

TYPICAL SNACKS \_\_\_\_\_

ARE YOU A VEGETARIAN? YES  NO  LACTO  OVO  VEGAN

DO YOU FOOD COMBINE? YES  NO

DO YOU FOLLOW MACROBIOTICS? YES  NO

ARE YOU CELIAC? (GLUTEN INTOLERANT) YES  NO

APPETITE: NORMAL  POOR  ALWAYS HUNGRY

WEIGHT: NORMAL  INCREASED  DECREASED

HUNGRY WITH NO DESIRE TO EAT

ARE YOU OFTEN THIRSTY? YES  NO

WHICH DO YOU PREFER? COLD DRINKS  WARM DRINKS

DESCRIBE FOOD CRAVINGS IF ANY \_\_\_\_\_

\_\_\_\_\_

FAVORITE FOODS \_\_\_\_\_

\_\_\_\_\_

DESCRIBE THE PREDOMINANT TASTE IN YOUR MOUTH:

SWEET  SOUR  BITTER  PUNGENT  TASTELESS

## **V. HEALTH FUNCTIONS**

### **STOOLS:**

NORMAL  HARD  SOFT

BURNING  BLOODY  PAINFUL

BURNING SENSATION IN ANUS YES  NO

UNDIGESTED FOOD IN STOOL YES  NO

EARLY MORNING DIARRHEA YES  NO

CONSTIPATION YES  NO

FOUL ODORS FROM STOOL YES  NO

STOOL COLOR: YELLOW  LIGHT BROWN  DARK BROWN  OTHER

FREQUENCY OF BOWEL MOVEMENT: \_\_\_\_\_ X PER DAY

**URINE:**

LIGHT YELLOW  DARK YELLOW  RED

AMOUNT: NORMAL  LITTLE  PROFUSE

FREQUENCY OF URINATION: \_\_\_\_\_ X PER DAY \_\_\_\_\_ X PER NIGHT

INCONTINENCE (POOR BLADDER CONTROL) YES  NO

**VI. HEALTH CONCERNS**

HAVE YOU OR ANY MEMBER OF YOUR FAMILY SUFFERED FROM:

KIDNEY DISEASE  HEART DISEASE  CANCER  PARKINSON'S

ARTHRITIS  ASTHMA  ULCERS  MS

T.B.  STROKES  HIGH BLOOD PRESSURE

DIABETES  MENTAL OR EMOTIONAL CONCERNS

THYROID DISEASE  SEIZURES  BRONCHITIS

OTHER \_\_\_\_\_

FOR THE FOLLOWING LIST OF SYMPTOMS CHECK:

- 1 - NEVER EXPERIENCED  
 2 - IF EXPERIENCED OCCASIONALLY OR MILDLY;  
 3 - IF EXPERIENCED FREQUENTLY OR MODERATELY SEVERELY;  
 4 - IF PERSISTENT OR DISABLING.

SORES IN MOUTH OR ON TONGUE	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
DIFFICULTY SWALLOWING	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
BAD BREATH	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
ACNE	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
DRY SKIN	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
SKIN ERUPTIONS (IE. BOILS / EXCEMA)	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
RASHES	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
CHRONIC SORE THROAT	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
NOSEBLEEDS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
SINUS INFECTION	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
DECREASED SENSE OF <i>SMELL</i>	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
NASAL DRIPPING	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>

BITTER TASTE IN MOUTH	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
LYMPHATIC SWELLING (ARM OR GROIN CREASES)	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
TINNITIS (EAR RINGING)	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HEARING LOSS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
LOOSE TEETH	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HAIR LOSS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
GRAYING HAIR	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
LOSS OF BALANCE	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
BLURRED VISION	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
SORE OR DRY EYES	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
CHRONIC EYE INFECTION	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
CHEST DISCOMFORT	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
NECK AND/OR SHOULDER TENSION	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
COUGH	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
WHEEZING	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
ASTHMA	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HEART PALPITATIONS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HEARTBURN	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
ABDOMINAL DISCOMFORT OR PAIN	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
NAUSEA	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
ACID REGURGITATION	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
VOMITING	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HICCUPS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
ABDOMINAL DISTENTION	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
FLATULENCE	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
INDIGESTION	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
BINGE EATING	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
BULIMIA	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
ANOREXIA	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HEMORRHOIDS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HERPES	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
DEEP SIGHING	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HYPOCHONDRIAC PAIN (RIB OR SIDE PAIN)	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
BACK PAIN:				
LOWER BACK	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
MID BACK	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
UPPER BACK	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
WEAK KNEES AND/OR LEGS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
NUMBNESS OR TINGLING OF LIMBS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
MUSCULAR WEAKNESS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
MUSCULAR SPASMS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HOT PAINFUL JOINTS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
EASY BRUISING	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
WALKING DIFFICULTIES	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HAND TREMORS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HEAT IN CHEST, SOLES AND PALMS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
EDEMA (WATER RETENTION)	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>

(SPECIFY WHICH BODY PART IS AFFECTED) \_\_\_\_\_

SOFT OR BRITTLE NAILS 1- 2- 3- 4-

COLD EXTREMITIES	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
DIZZINESS	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
FAINTING	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>
HEADACHES	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>

(SPECIFY LOCATION) \_\_\_\_\_

MEMORY:                      NORMAL     POOR             VERY GOOD

CONCENTRATION:            NORMAL     POOR             VERY GOOD

ENERGY LEVEL:              NORMAL     POOR             VERY GOOD

EASILY TIRED:              YES             NO

IF YES WHEN \_\_\_\_\_

FREQUENCY OF SEXUAL INTERCOURSE \_\_\_\_\_

#### **FEVERS AND CHILLS:**

(CHECK APPROPRIATE BOXES)

- EXTREME CHILLS AND SLIGHT FEVER
- SLIGHT CHILLS AND HIGH FEVER
- CHILLS AND NO FEVER
- FEVER AND NO CHILLS
- PROLONGED LOW FEVER
- ALTERNATE SPELLS OF CHILLS AND FEVER
- AVERSION TO HEAT
- AVERSION TO COLD

#### **SWEATING:**

(CHECK APPROPRIATE BOXES)

- SPONTANEOUS (WITHOUT EXERTION)
- NIGHT SWEATS
- PROFUSE
- AFTER SHIVERING
- LOCAL (SPECIFY LOCATION) \_\_\_\_\_
- FIVE CENTER (CHEST, PALMS AND SOLES)

#### **EMOTIONS:**

(CHECK APPROPRIATE BOXES FOR MOST COMMON)

- ANGER

- INDECISIVENESS
- JEALOUSY
- IRRITABILITY
- JOY
- WORRY
- SADNESS
- FEAR
- CALMNESS
- OVERLY ANALYTICAL
- OTHER \_\_\_\_\_

**SLEEP:**

HOW MANY HOURS PER NIGHT? \_\_\_\_\_

DO YOU FALL ASLEEP EASILY? \_\_\_\_\_

IS YOUR SLEEP EASILY DISTURBED? \_\_\_\_\_

DO YOU WAKE AT NIGHT? IF YES HOW MANY TIMES PER NIGHT AND AT WHAT TIMES? \_

DO YOU HAVE INSOMNIA? YES  NO

DO YOU DREAM? YES  NO

DO YOU REMEMBER YOUR DREAMS? YES  NO

**WEATHER:**

WHICH DO YOU ENJOY THE MOST? HOT  COLD  DAMP

DRY  WINDY

WHICH DO YOU ENJOY THE LEAST? HOT  COLD  DAMP

DRY  WINDY

**COLORS:**

WHICH IS YOUR FAVOURITE COLOR? \_\_\_\_\_

WHICH IS YOUR LEAST FAVOURITE COLOR? \_\_\_\_\_

AT WHICH TIME OF DAY DO YOU FEEL YOUR BEST? (CHECK ) AND WORST? (CROSS )

- |            |                          |           |                          |
|------------|--------------------------|-----------|--------------------------|
| 0300 -0500 | <input type="checkbox"/> | 1500-1700 | <input type="checkbox"/> |
| 0500- 0700 | <input type="checkbox"/> | 1700-1900 | <input type="checkbox"/> |
| 0700 -0900 | <input type="checkbox"/> | 1900-2100 | <input type="checkbox"/> |
| 0900-1100  | <input type="checkbox"/> | 2100-2300 | <input type="checkbox"/> |

1100-1300   
 1300 -1500

2300-0100   
 0100-0300

DO YOU SPEND TIME ALONE? YES  NO

IF YES HOW OFTEN \_\_\_\_\_

---

**FOR FEMALES ONLY**

DATE OF LAST PERIOD \_\_\_\_\_

ARE YOU PREGNANT? YES  NO

HAVE YOU EVER BEEN PREGNANT? YES  NO

IF YES HOW MANY TIMES AND WHEN \_\_\_\_\_

---

HAVE YOU HAD ANY MISCARRIAGES? YES  NO

IF YES HOW MANY TIMES AND WHEN \_\_\_\_\_

---

BREAST DISCOMFORT? YES  NO

IF YES DESCRIBE \_\_\_\_\_

---

DO YOU HAVE A PERIOD? YES  NO

REGULAR CYCLE (EVERY 28 DAYS) YES  NO

IRREGULAR CYCLE (EVERY 36 DAYS) YES  NO

(EVERY 21 DAYS) YES  NO

AMOUNT NORMAL  LIGHT  HEAVY

COLOR LIGHT RED  DARK RED

CLOTS YES  NO

CRAMPING? YES  NO

IF YES WHEN? BEFORE  DURING

ALLEVIATED BY WARMTH? YES  NO

PAIN? YES  NO

LOW BACK PAIN YES  NO

ALLEVIATED BY WARMTH? YES  NO

PMS? YES  NO

IF YES DESCRIBE YOUR SYMPTOMS \_\_\_\_\_

VAGINAL DISCHARGE COLOR WHITE AND THIN  PINK (WITH BLOOD)

YELLOW THICK

MENAPAUSE? YES  NO

IF YES AT WHAT AGE \_\_\_\_\_

AGE OF FIRST PERIOD \_\_\_\_\_

DESCRIBE ANY OTHER DIFFICULTIES \_\_\_\_\_

(ANSWERING THE FOLLOWING QUESTIONS WILL NOT PREVENT YOU FROM RECEIVING TREATMENT, BUT WILL ALLOW US TO TAKE THE APPROPRIATE PRECAUTIONS)

HAVE YOU EVER BEEN DIAGNOSED WITH:

AIDS YES  NO

HEPATITIS YES  NO

OTHER STD'S \_\_\_\_\_

DATED THIS \_\_\_\_\_ OF \_\_\_\_\_ 200\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE