Name_____ Date_____ Age_____ Sex _____

Chief Concerns	Appetite
_____ _____ _____ _____ _____ _____ _____ History of Illness _____ _____ Paternal Health History _____ _____ Maternal Health History _____ _____	_____ Vegetarian { } Non-Vegetarian { } Diet _____ _____ _____ Bowel Movement _____ Urination _____ Menstruation_____ Emotion_____ Sleep_____ Dream_____ Addiction and Drug_____ _____

OFFICE USE ONLY

Eyes:	Tongue:	Ears:	Nose:	Lips & Nails:	Sensitive Point
R: L:		R: L:		Lips Nails	

R Pulse	L Pulse
1. 2. 3.	1. 2. 3.

Urine Sediments	Smell	Color	Bubbles

Diagnosis
1._____
2._____
3._____
Treatment

Medicine	External Therapy
1._____ 2._____ 3._____	1._____ 2._____ 3._____

Diet	Lifestyle
1._____ 2._____ 3._____	1._____ 2._____ 3._____