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Pain: Alleviated by: <input type="checkbox"/> Pressure <input type="checkbox"/> Temp <input type="checkbox"/> Climate	<input type="checkbox"/> Dull <input type="checkbox"/> Lingering <input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing <input type="checkbox"/> Migrates <input type="checkbox"/> Burning	<input type="checkbox"/> Distending <input type="checkbox"/> Contracting <input type="checkbox"/> Aggravated	
Head and Body:	<input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Body aches <input type="checkbox"/> Joint Pain	<input type="checkbox"/> Neck pain <input type="checkbox"/> Back pain <input type="checkbox"/> Low back pain <input type="checkbox"/> Muscle pains	<input type="checkbox"/> Weak limbs <input type="checkbox"/> Numbness <input type="checkbox"/> Heaviness <input type="checkbox"/> Stiffness	
Cold and Heat:	<input type="checkbox"/> Neither <input type="checkbox"/> Cold <input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Cold back <input type="checkbox"/> Chills <input type="checkbox"/> Heat	<input type="checkbox"/> Clammy hands/feet <input type="checkbox"/> Fever <input type="checkbox"/> Tidal fever	
Sweating:	<input type="checkbox"/> Spontaneous <input type="checkbox"/> With exertion	<input type="checkbox"/> Night sweats <input type="checkbox"/> No sweating	<input type="checkbox"/> Hot flashes <input type="checkbox"/> Local sweats	
Energy: 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> Fatigue <input type="checkbox"/> Fatigues easily <input type="checkbox"/> Sudden energy drops	<input type="checkbox"/> Dizziness <input type="checkbox"/> Excess <input type="checkbox"/> Drowsy	<input type="checkbox"/> Dyspnea / SOB <input type="checkbox"/> Fainting <input type="checkbox"/> Heavy Feeling	
Sleep: _____ Hrs/night	<input type="checkbox"/> Sound, restful <input type="checkbox"/> Insomnia	<input type="checkbox"/> Heavy sleep <input type="checkbox"/> Dream-disturbed	<input type="checkbox"/> Not restful <input type="checkbox"/> Grinds teeth	
Urine:	<input type="checkbox"/> Normal <input type="checkbox"/> Polyuria <input type="checkbox"/> Urgency <input type="checkbox"/> Incontinence <input type="checkbox"/> Infrequent	<input type="checkbox"/> Sleep disturbed <input type="checkbox"/> Painful/Difficult <input type="checkbox"/> Blood in urine	<input type="checkbox"/> Clear <input type="checkbox"/> Dark <input type="checkbox"/> Excess <input type="checkbox"/> Scanty	
Stool:	<input type="checkbox"/> Regular <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Loose/watery <input type="checkbox"/> Foul Smell <input type="checkbox"/> Gas	<input type="checkbox"/> Dry, hard <input type="checkbox"/> Burning <input type="checkbox"/> Explosive	
Thirst:	<input type="checkbox"/> Thirsty w desire <input type="checkbox"/> Thirsty w no desire	<input type="checkbox"/> Likes cold drinks <input type="checkbox"/> Likes hot drinks	<input type="checkbox"/> Dry mouth <input type="checkbox"/> Bitter taste	
Appetite:	<input type="checkbox"/> Cravings <input type="checkbox"/> Abdominal pain/cramps <input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting <input type="checkbox"/> Gas <input type="checkbox"/> Bloating	<input type="checkbox"/> Heartburn <input type="checkbox"/> Bad breath <input type="checkbox"/> Food Preferences	
Eyes:	<input type="checkbox"/> Blurry vision <input type="checkbox"/> Spots in front of eyes <input type="checkbox"/> Poor vision	<input type="checkbox"/> Eye pain <input type="checkbox"/> Eyestrain <input type="checkbox"/> Dry eyes	<input type="checkbox"/> Burning <input type="checkbox"/> Red <input type="checkbox"/> Yellow	
Ears:	<input type="checkbox"/> Poor Hearing	<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Earaches	
Skin and Hair:	<input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Dry skin	<input type="checkbox"/> Ulcerations <input type="checkbox"/> Eczema <input type="checkbox"/> Hives	<input type="checkbox"/> Dandruff <input type="checkbox"/> Hair Loss <input type="checkbox"/> Changes in skin/hair	
Gynecology:	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Amenorrhea	<input type="checkbox"/> Clots <input type="checkbox"/> Heavy / Light flow <input type="checkbox"/> Pale / Dark Colour	<input type="checkbox"/> Discharge <input type="checkbox"/> PMS <input type="checkbox"/> Pain	
General Emotional State:	<input type="checkbox"/> Even, balanced <input type="checkbox"/> Sorrow, grief <input type="checkbox"/> Worry, anxiety	<input type="checkbox"/> Sad <input type="checkbox"/> Fearful, frightful, timid <input type="checkbox"/> Anger, frustration, irritability, jealousy	<input type="checkbox"/> Depression <input type="checkbox"/> Other _____ _____	
Notes				