Bright Path
Integrative Medicine
& Healing Arts

DATE: ______________________________

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answer will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the comments section. Thank you.

Name: ______________________________ E-Mail: ______________________________

Home phone: ________________ Work: __________________ Cell: ____________________

Address: ____ Zip__________

Age: _______ Date of Birth: ____________ Place of Birth: ____________________________

Height: _________ Weight: ____________ Sex: ☐ Female ☐ Male Blood Type: _______

Employer name: ____________________________ Occupation: ____________________

Primary Physician: ___________________________ Referred by: ____________________

In emergency, notify: ________________________ Phone: ________________________

Have you ever been treated by Acupuncture or Oriental Medicine before? _______________

Main problem(s) you would like us to help you with __________________________________

____

____

How long ago did this problem begin (be specific) ___________________________________

To what extent does this problem interfere with your daily activities (work, sleep, sex)

____

Have you been given a diagnosis for this problem? If so, what ________________________

____

What kinds of treatments have you tried: ____

____

____

Past Medical History: (please include dates)

Cancer ________ Diabetes ___________ Hepatitis __________ Thyroid Disease _________
High Blood Pressure _____________ Heart Disease ___________ Seizures _________
Rheumatic Fever ____________ Venereal Disease ___________
Other ____

Surgeries: (type and dates): ____
____
____

Significant Trauma (auto accidents, falls, etc.): ______________________________
____

Significant Dental work (type and dates): ______________________________

Birth History (prolonged labor, forceps delivery, etc.): ______________________

List any known allergies: ____
____
____

Family Medical History: Diabetes _______ Cancer ______ High Blood Pressure _______

Heart Disease ______ Stroke ___ Seizures______ Asthma _____ Allergies ___________
____

Other: ____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.) ____________
____

Occupational Stress (chemical, physical, psychological, etc.) ______________________
____

Chemical Exposures (Recent or Past) ______________________________

Do you regular exercise program? _______ Please describe___________________
____

Have you ever been on a restricted diet? ______ What kind? ____________________
____

Please describe your average daily diet:
Morning ____
Afternoon ____
Evening ____
Snacks ____
How many packs of cigarettes do you smoke per day? ______________________
How much coffee, tea, or cola do you drink per week? ______________________
How much alcohol do you drink per week? ______________________________
Please describe any use of drugs for non-medical purpose: __________________
____

COMMENTS: ____
____
____

IN THE LAST THREE MONTHS, please check any of the following symptoms you have had:

GENERAL

- ☐ Chills
- ☐ Fevers
- ☐ Sweat Easily
- ☐ Light Sweats
- ☐ Localized Weakness
- ☐ Bleed or Bruise Easily
- ☐ Peculiar Tastes or Smells
- ☐ Strong Thirst (Cold or Hot)
- ☐ Thirst, No Desire to Drink
- ☐ Fatigue
- ☐ Sudden Energy Drop
  Time of Day ___________
- ☐ Edema, Where? __________
- ☐ Poor Sleeping
- ☐ Tremors
- ☐ Poor Balance
- ☐ Cravings
- ☐ Change in Appetite
- ☐ Poor Appetite
- ☐ Weight Gain ☐ Weight Loss

HEAD, EYES, EARS, NOSE & THROAT

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
  When? _______________ Where? _____________
- ☐ Facial Pain
- ☐ Glasses
- ☐ Poor Vision
- ☐ Night Blindness
- ☐ Blurry Vision
- ☐ Color Blindness
- ☐ Blind Field
- ☐ Spots in Front of Eyes
- ☐ Eye Pain
- ☐ Eye Strain
- ☐ Cataracts
- ☐ Eye Dryness
- ☐ Excessive Tearing
- ☐ Discharge from Eyes
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Nasal Drainage
- ☐ Dental Amalgams # ____
- ☐ Amalgams Removed # ____
- ☐ Loss of Sense of Taste
- ☐ Loss of Sense of Smell
- ☐ Hoarseness
- ☐ Grinding of Teeth
- ☐ Teeth Problems
- ☐ Jaw Clicks
- ☐ Concussions
- ☐ Sores on Tongue
- ☐ Sores on Lips
- ☐ Other head or Neck Problems ___________________________

SKIN & HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Change in Hair or Skin
- ☐ Ulcerations
- ☐ Oozing of Skin Lesion
- ☐ Hives
- ☐ Pimples
- ☐ Loss of Hair
- ☐ Recent Moles
- ☐ Dandruff
- ☐ Other Hair or Skin Problems

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CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Discomfort/Pain
- ☐ Blood Clots
- ☐ Fainting
- ☐ Heart Palpitations
- ☐ Difficulty in Breathing
- ☐ Swelling of Hands
- ☐ Swelling of Feet
- ☐ Cold Hands or Feet
- ☐ Other Heart or Blood Vessel Problems

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MUSCULOSKELETAL

- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Back Pain
- ☐ Hip Pain
- ☐ Hand / Wrist Pain
- ☐ Elbow Pain
- ☐ Knee Pain
- ☐ Foot / Ankle Pains
- ☐ Muscle Pains
- ☐ Muscle Weakness
- ☐ Toe Pains

RESPIRATORY

- ☐ Cough
- ☐ Asthma / Wheezing
- ☐ Pain with a Deep Breath
- ☐ Difficulty Breathing When Lying Down
- ☐ Clear Your Throat Often
- ☐ Production of Phlegm
  What Color ___________
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Other Lung Problems ___________

NEUROPSYCHOLOGICAL

- ☐ Anxiety
- ☐ Seizures
- ☐ Areas of Numbness
- ☐ Weakness
- ☐ Sleep Disorder
- ☐ Loss of Balance
- ☐ Depression
- ☐ Vertigo
- ☐ Concussion
- ☐ Lack of Coordination
- ☐ Poor Memory
- ☐ Bad/Short Temper
- ☐ Substance Abuse – Type ________________
- ☐ Reduced Ability to Focus
- ☐ Easily Susceptible to Stress
- ☐ Loss of Control/Violence Potential
- ☐ Treated for Emotional Problems
- ☐ Considered or Attempted Suicide
- ☐ Other Neurological or Psychological Problems:
  ____

GASTROINTESTINAL

- ☐ Bad Breath
- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Belching
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic Laxative Use
- ☐ Chronic Anti-Acid Use
- ☐ Blood in Stool
- ☐ Black Stool
- ☐ Abdominal Pain or Cramps
- ☐ Gas
- ☐ Rectal pain
- ☐ Other Stomach or Intestinal
  Problems: ________________
  ____

GENITO-URINARY

- ☐ U.T.I (Urinary Tract Infection)
- ☐ Decrease in Flow
- ☐ Unable to Hold Urine
- ☐ Dribbling
- ☐ Kidney Stones
- ☐ Pain on Urination
- ☐ Change of Sexual Drive
- ☐ Other Genital or Urinary Problems ________________
- ☐ Urgency to Urinate
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Sores on Genitals

FEMALE ONLY (PREGNANCY & GYNECOLOGY)

- ☐ # of Pregnancies ____________
- ☐ # of Births ________________
- ☐ Pre-Mature Births ____________
- ☐ Miscarriages _______________
- ☐ Abortions ________________
- ☐ Age of First Menses _________
- ☐ Period between Menses ______
  Duration ___________________
- ☐ First Date of Last Menses _____
- ☐ Unusual Character - ☐ Heavy or ☐ Light
- ☐ Painful Periods
- ☐ Irregular Periods
- ☐ Changes in Body/Psyche Prior to Menstruation
- ☐ Menopause: Age ____________
- ☐ Vaginal Discharge ☐ Yeast Infections
- ☐ Post-Coital Bleeding ☐ Vaginal Sores
- ☐ Breast Lumps ☐ Nipple Discharge
- ☐ Last PAP Test _______________
- ☐ Practice Birth Control

What type & how long ______________________

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MALE ONLY (PADAM)

- ☐ Erectile Dysfunction
- ☐ Enlarged Prostate
- ☐ Impotency
- ☐ Do You have Decreased Libido?
- ☐ Do You have Lack of Energy?
- ☐ Do You had a Decrease in Strength and/or Endurance?
- ☐ Have You Lost Height?
- ☐ Have You Noticed a Decreased "Enjoyment of Life"?
- ☐ Are You Sad and/or Angry?
- ☐ Are Your Erections Less Strong?
- ☐ Have You Noted a Recent Deterioration in Your Ability to Play Sports?
- ☐ Are You Falling Asleep After Dinner?
- ☐ Has there been a Recent Deterioration in Your Work Performance?

Comments: ____

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DHATU ASSESSMENT

Check each applicable box and total the number of symptoms for each tissue category.

1	**BLOOD PLASMA (RASA)** The clear, serum portion of the blood
	Excessively dry skin
	Dehydration
	Premature graying of the hair
	Cold skin
	Fever
	Wrinkling of the skin at an early age
	Dizziness, vertigo
	Exhaustion
	Colds
	Congestion, cough
	Excess mucus or respiratory congestion
	A feeling of weakness and tiredness
	Lack of stamina, fluctuating energy levels
	Ovarian or breast cysts, now or in the past (fluid-filled only)
	Lymphatic congestion
	TOTAL
2	RED BLOOD CELLS (RAKTA)Red blood cells and bile.
	Severe hot flashes
	Frequent feeling of excessive heat
	Anemia
	Very heavy bleeding or “flooding” during the period
	Bleeding disorders
	Easy bruising
	Pitta type of hypertension
	Frequent or chronic skin rashes, acne, pustules, hives
	Gallstones now or in the past (or have had gallbladder removed)
	Bleeding hemorrhoids
	Constant or problematic thirst
	Lack of thirst
	Gout
	TOTAL
3	MUSCLES (MAMSA) Muscle tissue
	Constant muscle aches or pain, or easily fatigued muscles
	Muscle tics or spasms
	Muscle atrophy
	Chronically swollen tonsils or lymph glands in the neck
	Bursitis
	Tendonitis
	Itchy ear canals or eczema of ear canal or excess ear wax
	Fibroids or the uterus (now or in the past)
	Hemorrhoids
	Fibrous or glandular lumps in the breasts
	Severely dry, cracking lips
	Fibromyalgia
	TOTAL
4	FAT AND HORMONES (MEDA) Fat, hormone, and carbohydrate metabolism
	Weight gain (at least 10 pounds overweight)
	Inability to lose weight even on low-calorie diet
	Fatty liver
	High blood sugar (diabetes)
	High cholesterol
	Boils and abscesses
	Chronic or frequent problem with malodorous sweat or body odor
	Lipomas
	Fibrocystic breasts

4	Continued.. FAT AND HORMONES (MEDA) Fat, hormone, and carbohydrate metabolism
	Nephritis
	Thyroid disorder (diagnosed by a physician, including abnormal blood tests)
	Frequent night sweat or sweats during the day associated with hot flashes
	Emaciation Loss of synovial fluid
	Weak ligaments
	TOTAL
5	BONES (ASTHI) Bone, cartilage, hair, and nail tissues
	Low bone density (osteopenia) or osteoporosis
	Cracking or popping of the joints
	Degenerative or osteoarthritis
	Hair breaking a lot (many split ends) or hair very dry and lacking luster
	Problems with your teeth (breaking easily, many cavities, etc.)
	Nails breaking frequently
	Hair loss
	Fungal infections of the nails
	Tooth abscesses
	Constant joint pains or arthritic condition
	Deep pain in the bones
	TOTAL
6	BONE MARROW(MAJJA)Central nervous system tissue and immune system
	Frequent or recurring infections
	Chronic Fatigue Syndrome
	“Adrenal” exhaustion
	Excess secretions of the eyes
	Insomnia
	Dryness of skin on upper eyelids
	Parkinson’s Disease
	Epilepsy
	Paralysis
	Constant spacey and distractible feeling, inability to focus or concentrate
	Frequent feeling of faintness or dizziness
	Multiple Sclerosis
	Neuritis
	Neuralgia
	Sciatica
	Herpes Zoster
	Schizophrenia
	Bipolar Disorder
	TOTAL
7	REPRODUCTIVE ESSENCE (SUKRA) Reproductive fluids
	Absence of libido (no sex drive)
	Premature ejaculation
	Severe vaginal dryness
	Hysterectomy
	Overall feeling of lack of attractiveness
	Dull, unclear eyes
	Prostatitis
	Endometriosis
	Cervical dysplasia
	Vaginitis
	Infertility
	History of more than one miscarriage
	Amenorrhea
	TOTAL