

Date: _____

INTEGRATED MEDICINE INSTITUTE (HK) Ltd.

CONFIDENTIAL PERSONAL HISTORY FORM

Please could you tell us where you heard of our clinic? _____

NAME: _____
(tile) (first name) (second name) (family name)

SEX: (✓) male ___ female ___ **BIRTHDATE:** _____ **AGE:** _____
(date) (month) (year)

Each child's year of birth: _____

STATUS: (✓) Single: ___ De Facto: ___ Married: ___ Divorced: ___

Guardian / Parents' Name (if patient under 18) _____ Spouse _____

OCCUPATION: _____ **COMPANY:** _____

Phone work: _____ fax work: _____

Mobile: _____ fax home: _____

Phone home: _____ email: _____

HOME ADDRESS: _____

PRESENT HEALTH COMPLAINTS, QUESTIONS: list health concerns -

1. _____

2. _____

3. _____

HOW LONG have you had the problem(s) ? (1) _____ (2) _____ (3) _____

CURRENT MEDICATIONS:

VITAMINS/HERBS: _____

DRUGS/DOCTORS MEDICINES: _____

ALL PREVIOUS MEDICINES: (include how many courses of antibiotics)

DENTAL:

Dental: how many root canals (root removed teeth): 0 ___ 1-2 ___ 3-4 ___ 5+ ___

How many silver fillings/mercury amalgams: 0 ___ 1-2 ___ 3-4 ___ 5+ ___

PREVIOUS OPERATIONS: _____

Known **ALLERGIES** to: _____

DIET:

Please list your most regular foods OR write yesterdays diet :

Breakfast : _____

Lunch : _____

Dinner : _____

Snack Foods : _____

Fruits (eaten daily) : _____

Serves of Vegetables daily ; 1 cup = 1 serve- 0__ 1__ 2__ 3__ 4__ 5__

Refined white foods (white bread, sweet breakfast cereals, pasta, noodles, biscuits, buns, cakes, white rice). Serves per day : 0__ 1-2__ 3-4__ 5+__

Sugar/candies/chocolate serves per day : 0__ 1-2__ 3-4__ 5+__

Red Meat (beef, pork, lamb, sausages, bacon, ham) per week : 0__ 1-2__ 3-4__ 5+__

Seafood (shrimps, crab, lobster, scallops, tuna) per week : 0__ 1-2__ 3-4__ 5+__

Water (# glasses) : ____ **Coffee** ____ **Tea** ____ **Soft Drinks** ____

Alcohol (# glasses) : _____ **How Often** : _____ **What type** : _____

Cigarettes/Cigars (per day) : ____ **Other Recreational Drugs?** _____

Exercise (20 min.+) # times per week : _____ **What sport?** _____

Bowel motions per week: _____

Sleep (# hours nightly) : _____

times you usually wake at night (✓) : 0__ 1__ 2__ 3+__

Do you snore regularly ? Yes__ No__

Work: # Hours (per day) : _____ # Days Off /week _____

Meditation (✓) : Yes__ No__ or **Time to Relax Daily** (✓) : Yes__No__

What STRESSFUL factors (including difficult relationships, moves, deaths, births, marriages etc) have you been experiencing over the last year(s)?

ENJOYING LIFE? (✓) Definitely ____ Mostly Yes ____ Not Sure ____ Mostly Not ____

NOTE PAST AILMENTS of YOURSELF (the PATIENT) please write " Y " below.

For your MOTHER write **M** and your FATHER = **F** Grandparents = **GF/GM**

-
- | | |
|--|--|
| <input type="checkbox"/> Allergies /Hay fever | <input type="checkbox"/> Kidney Disorders / Bladder Infections |
| <input type="checkbox"/> Accident /Fall / Break | <input type="checkbox"/> Liver / Gall Bladder disorders |
| <input type="checkbox"/> Arthritis /Rheumatism /Gout | <input type="checkbox"/> Lupus / Auto Immune Disease |
| <input type="checkbox"/> Asthma /Emphysema | <input type="checkbox"/> Osteoporosis / Cartilage or Disc Damage |
| <input type="checkbox"/> Cancer /Tumors /Cysts /Lymphoma | <input type="checkbox"/> Jaw / Back / Neck /Hip / Knee Problems |
| <input type="checkbox"/> Candida /Thrush /Yeast infections | <input type="checkbox"/> Multiple Sclerosis /Parkinsons |
| <input type="checkbox"/> Dysentary/Giardia/Parasites/Diarrhoea | <input type="checkbox"/> Nervousness / Anxiety Attacks |
| <input type="checkbox"/> Constipation/Haemorrhoids/Fissure | <input type="checkbox"/> Numbness / Tingling / Tremors |
| <input type="checkbox"/> Nausea /Gas /Colic /Irritable bowel | <input type="checkbox"/> Frequent Influenza /Head Colds |
| <input type="checkbox"/> Diabetes /Low Blood Sugar | <input type="checkbox"/> Sinusitis / Ear Infections |
| <input type="checkbox"/> Poor Circulation /Bruising /Varicose V'ns | <input type="checkbox"/> Tonsillitis / Sore throat (chronic) |
| <input type="checkbox"/> Eczema /Dermatitis/Acne /Boils | <input type="checkbox"/> Pneumonia /Frequent Bronchitis |
| <input type="checkbox"/> Edema /Fluid Retention /Swollen Ankles | <input type="checkbox"/> Tuberculosis / Mycoplasma Infection |
| <input type="checkbox"/> Heartburn / Acidity or Gastritis | <input type="checkbox"/> Psoriasis/Fungal Infections Nails/Skin |
| <input type="checkbox"/> Headaches /Migrains | <input type="checkbox"/> Pre Menstrual Syndrome /Painful Period |
| <input type="checkbox"/> Hearing Loss /Sounds in Ears /Dizziness | <input type="checkbox"/> Gynecological /Male Prostate_____ |
| <input type="checkbox"/> Heart Problems /Stroke /Blood Clot | <input type="checkbox"/> Thyroid Problems _____ |
| <input type="checkbox"/> High Blood Pressure /High Cholesterol | <input type="checkbox"/> Ulcers /Ulcerative Colitis/Canker sores |
| <input type="checkbox"/> Incontinence (frequent urination) | <input type="checkbox"/> Virus; Herpes, HIV, HPV, Other_____ |
| <input type="checkbox"/> Insomnia / Poor sleep | <input type="checkbox"/> Glandular Fever /Mononucleosis/CMV |
| <input type="checkbox"/> Hepatitis A or B or C | <input type="checkbox"/> Lymes Disease /Malaria |
| <input type="checkbox"/> Exhaustion /Frequent Fatigue | <input type="checkbox"/> Venereal /Tropical Disease:_____ |
| <input type="checkbox"/> Nervous Breakdown / Depression | <input type="checkbox"/> Polio /Rheumatic Fever |
| <input type="checkbox"/> Irritability /Anger / Hostility | <input type="checkbox"/> Violence/Abuse/Alcohol/Shame |
| <input type="checkbox"/> Loneliness/Grief | <input type="checkbox"/> Trauma/Shock /Post Traumatic Shock |

Other Conditions: _____

Any Special Biochemistry needs _____

Worst period of health _____ Why? _____

If patient is UNDER 10 add the following information:

Was the patient BREASTFED for 6 months or more before having formulas, solids etc? Yes___ No ___

Was the patient delivered with FORCEPS? Yes___ No ___

Was there any BIRTH TRAUMA (eg low APGAR Score)? Yes___ No ___

Was the delivery by CESERIAN SECTION? Yes___ No ___

Was the child JAUNDICED requiring treatment with lights? Yes___ No ___

Was the child VACCINATED WITH HEPATITIS B at age under 6 months? Yes___ No ___

Has the child reacted to any VACCINATION badly? Yes___ No ___

Has the child suffered UNUSUAL amounts of restlessness, colic, crying etc? Yes___ No ___

How many courses of ANTIBIOTICS has the child been given in their life to date? _____

Does the patient have any brothers or sisters? Yes___ No ___

What position is the patient among the children? _____

Office Use Only:

CAUSE(S): _____

Diet: Fruit/ Veg/ Fibre/ Fat/ Starch/ Dairy _____

B.P.:

Pulse:

Cardiac:

Focal Infections suspect: Sinus/ Tonsil/ Tooth/ Appendix/ Colon / _____

Tongue: _____ Toxins 1 2 3 4 5

Psyche history: _____

Psychosomatics; Grief/ Guilt/ Anger/ Frust/ Directn/ Fear/ Shock/ Trauma/ Depression

Structural: _____

Heavy Metals, Pesticides, Geopathic Stress, Vaccinosis,
Birth Trauma: _____

Exercise Rest Detox
Energetic/Chacra Environ't Spiritual

Allergies: Dust, Egg, Dairy, Wheat, Sugar, Candida/Yeast, Mould, Shellfish, Citrus, Nuts, Salicylates, Chocolate, Caffeine, Tyramine, Nightshades: _____

ORGANS/EAV:

Immunity	Lymph	Lung/bronchi	Sinus
Liver	Gall Bladder	Colon/Caecum	S. Intestine
Heart	Circulation	Kidney	Bladder
Joints & Inflammatory		Adrenal	Nerves
Pancreas	Blood Sugar L	Stomach	Spleen
Ovary/Test	Ut/Prost	Thyroid/Parathy	Pituit/Pineal

NUTRIENTS:

Omega 3	Omega 6	GLA	R.N.A.
K	Na	Vit E	Se
B complex	Mg	Zn	Chr. Mn
Vit A	VitC	Bioflav	
Vit D	Ca	Bo.	Sr
Fe	Cu	Iod	

IRIS: Resilt/ Shakers/ Flower. Cramp/ accomplishm't. Lymph/harmony

Lipids/ determination ANS/open expression H, Br, Or, Wh, Ye Bronchial/trust

Liver/ passn/ anger/ frust Kidney/security/est