core healing llc
ryan marshall
M.A.T.C.M., Dipl.A.c, L.A.c

Sleep, Internal Systems
Surgeries, Illnesses

_____
Your first initial and last name

_____
Today's date

Please indicate (current (C), past (P):

C P
- ☐☐ disturbing dreams
- ☐☐ not rested upon waking
- ☐☐ can't stop thinking
- ☐☐ difficulty falling asleep
- ☐☐ restless sleep
- ☐☐ drowsiness during the day

Other:_____

How many hours do you sleep at night? _____

Do you usually wake up during the night? _____

If yes, at what time(s)?
_____

- ☐☐ coughing frequently
- ☐☐ spitting up mucus/blood
- ☐☐ wheezing
- ☐☐ shortness of breath
- ☐☐ chest pain
- ☐☐ pneumonia/bronchitis/pleuisy
- ☐☐ difficulty breathing

Other:_____

- ☐☐ frequent urination
- ☐☐ difficulty urinating
- ☐☐ getting up to urinate at night
- ☐☐ bedwetting
- ☐☐ incomplete urination/dribbling
- ☐☐ narrowing of stream
- ☐☐ hard to start stream
- ☐☐ change in color/odor of urine
- ☐☐ incontinence
- ☐☐ pain/burning when urinating
- ☐☐ bladder infections
- ☐☐ kidney infections
- ☐☐ kidney stones

Other:_____

- ☐☐ increased appetite/thirst
- ☐☐ loss of appetite/thirst
- ☐☐ difficulty swallowing
- ☐☐ nausea or vomiting
- ☐☐ bad breath
- ☐☐ metallic/bitter taste in mouth
- ☐☐ cannot eat fats/greasy foods
- ☐☐ jaundice
- ☐☐ heartburn/acid reflux
- ☐☐ indigestion or distress
- ☐☐ gas or bletching
- ☐☐ bloating
- ☐☐ stomach/abdomen tender/painful
- ☐☐ symptoms relieved by eating
- ☐☐ anorexia
- ☐☐ bulimia
- ☐☐ headache/dizziness/irritability if meals are skipped meals
- ☐☐ diarrhea or loose stools
- ☐☐ constipation
- ☐☐ alternating constipation/diarrhea
- ☐☐ light colored or greasy stools
- ☐☐ dark stools
- ☐☐ blood or mucus in stools
- ☐☐ feeling of incomplete evacuation
- ☐☐ undigested food in stool
- ☐☐ foul odor or accompanying gas
- ☐☐ hemorrhoids
- ☐☐ anal itching and/or bleeding
- ☐☐ use of laxatives

Other:_____

How often do you have a bowel movement**?** _____

- ☐☐ heart beats faster/irregularly
- ☐☐ tightness/full/heavy chest feeling
- ☐☐ dizzy/weak when standing up
- ☐☐ swollen feet, ankles/legs
- ☐☐ cold hands or feet
- ☐☐ hands or feet turn blue/white
- ☐☐ varicose veins, phlebitis
- ☐☐ heart murmur
- ☐☐ high blood pressure
- ☐☐ low blood pressure

Other:_____

Surgeries, Illnesses

Please list any serious health issues, and the year(s) they affected you. Please also indicate if current (C) or past (P).

_____ year(s):_____

_____ year(s):_____

_____ year(s):_____

_____ year(s):_____

Illnesses that required hospitalization:
(surgeries, accidents)

_____ year(s):_____

_____ year(s):_____

_____ year(s):_____

_____ year(s):_____