 Sherill Sullivan 750 East 9th Ave, Suite 106

Denver CO 80203

720-273-1067

**NAME:** Click here to enter text.

**ADDRESS:**

Click here to enter text.

**Phone number, email, and additional contact information:**

Click here to enter text.

**DOB:** Click here to enter text.

**Ht:** Click here to enter text. **Wt:** Click here to enter text.

**Hair, eye, complexion coloring:** Click here to enter text.

**Usual Occupation:** Click here to enter text.

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When listing symptoms and ailments,sensations are very important information! State what kind, where, at what time they are better or worse, and whatever makes them better or worse. Tell about all sensations, however slight, strange, rare or peculiar, such as "as if\_\_\_\_\_\_\_\_\_\_\_," e.g., sensations as if floating, sensations as if cobwebs on face, sensations as if a body part is enlarged or feels smaller, sensations as if something alive inside the abdomen or inside the chest or inside the head, sensations as if someone behind you, etc.

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**Main C/o:** Summarizing your principle complaints and the "reason" you think you became ill. When applicable, include: **Sensations such as sharp/dull, stabbing, sticking, burning, buzzing, throbbing, etc.; Times** when complaint is better or worse or even gone; **Modalities** are any related information that is usually in the form of this ailment is better or worse under certain conditions **or this complaint is accompanied by… Use as much space as you want.**

Click here to enter text.

**PERSONAL MEDICAL HISTORY:** LIST any significant illnesses, surgeries, shocks/traumas, and tendency toward some specific ailment or illness. Did you have childhood illnesses and if so which. Did you have immunizations/vaccinations; if so which and did you have any reactions?

 Click here to enter text.

**Family Medical History**

**Family members and your position both from family of origin including parents and grandparents. Please list current family members and any significant health events:**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME and/or relationship to you** | **Gender/age. Alive? Cause of death if not.** | **Health status** | **Diseases or chronic illnesses** |

Click here to enter text.

**Generals:**

 **Temperature: Do you tend to run warmer or cooler than others around you? Examples?**

Click here to enter text.

 **Anything characteristic or unusual about perspiration?** Click here to enter text.

**Food:**

 **Cravings or aversions:** Click here to enter text.

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 **Allergies/Aggravations from foods?** Click here to enter text.

 **Anything characteristic or unusual about thirst or lack of?** Click here to enter text.

 **Time:** time of day, night, month or season that affects you for better/worse/ annual reoccurrences of conditions? Click here to enter text.

**Anything characteristic or unusual about weather and how it affects you such as** cold, heat, dryness, humidity, an approaching storm, during and/or after storms, thunderstorms, frost, cloudiness, seashore, low or high altitudes…

Click here to enter text.

 **WOMEN ~ Menses:** Describe your cycle to include timing, flow, blood color and possibly consistency, duration, difficulties or irregularities. Click here to enter text.

**Sleep/position/clothing** characteristics or peculiarities associated with sleep, such as what position is typical. Click here to enter text.

Is there teeth grinding,perspiration,salivation (drooling), jerking, restlessness, talking or walking?

Click here to enter text.

Do you dream? Do you have any recurring dreams or dreams of a similar nature; i.e., similar theme, same object or personrecurrently appears? Click here to enter text.

**Libido: High, low, anything characteristic or presence of difficulties:** Click here to enter text.

**Mentals:**

 **Fears/Phobias/Anxieties:** Click here to enter text.

 **Outlook//personality, how would you or others describe you?** Click here to enter text.

 **When upset or distressed how do you feel about consolation?** Click here to enter text.

 **Describe childhood and family relationships,** particularly difficult ones**:** Click here to enter text.

**Body Systems** Scan your entire body and note additional issues or problems not already listed:

 **Head** Click here to enter text.

 **ENT** Click here to enter text.

 **Chest/Breast** Click here to enter text.

 **Stomach** Click here to enter text.

 **Digestive** Click here to enter text.

 **Reproductive** Click here to enter text.

 **Bowels and urinary** Click here to enter text.

 **Skin** Click here to enter text.

 **Moles, birth marks** Click here to enter text.

**Thanks! Bring any questions to your intake session.**

**Sherill**