



**Symptom Survey:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> poor sleep         | <input type="checkbox"/> depression       | <input type="checkbox"/> night sweats      | <input type="checkbox"/> bruise easily        |
| <input type="checkbox"/> poor appetite      | <input type="checkbox"/> heavy sleep      | <input type="checkbox"/> body heaviness    | <input type="checkbox"/> headache/migraine    |
| <input type="checkbox"/> heavy appetite     | <input type="checkbox"/> lots of dreams   | <input type="checkbox"/> cold hands & feet | <input type="checkbox"/> breathing difficulty |
| <input type="checkbox"/> like cold drinks   | <input type="checkbox"/> fatigue          | <input type="checkbox"/> poor circulation  | <input type="checkbox"/> wheezing             |
| <input type="checkbox"/> like hot drinks    | <input type="checkbox"/> lack of strength | <input type="checkbox"/> fever             | <input type="checkbox"/> eye problems         |
| <input type="checkbox"/> recent weight loss | <input type="checkbox"/> anxiety          | <input type="checkbox"/> chills            | <input type="checkbox"/> night blindness      |
| <input type="checkbox"/> recent weight gain | <input type="checkbox"/> poor memory      |  |   |

- |   |  |   |                                       |   |
|---|--|---|---------------------------------------|---|
| <input type="checkbox"/> teeth problems | <input type="checkbox"/> chronic sore throat | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> vomiting     | <input type="checkbox"/> diarrhea             |
| <input type="checkbox"/> grind teeth    | <input type="checkbox"/> excess phlegm       | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> acid reflux  | <input type="checkbox"/> constipation         |
| <input type="checkbox"/> TMJ            | <input type="checkbox"/> swollen glands      | <input type="checkbox"/> tachycardia        | <input type="checkbox"/> gas          | <input type="checkbox"/> blood in stool/urine |
| <input type="checkbox"/> facial pain    | <input type="checkbox"/> ringing in ears     | <input type="checkbox"/> fainting           | <input type="checkbox"/> hiccup       | <input type="checkbox"/> abd. pain/cramping   |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> poor hearing        | <input type="checkbox"/> nausea             | <input type="checkbox"/> bloating     | <input type="checkbox"/> hemorrhoids          |
|   |  |   | <input type="checkbox"/> irritability | <input type="checkbox"/> kidney stones        |

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|---|---|---|---|--------------|
| <input type="checkbox"/> neck/shoulder pain | <input type="checkbox"/> skin rash        | <input type="checkbox"/> fungal infection   | <input type="checkbox"/> wake up to urinate | Other: _____ |
| <input type="checkbox"/> upper back pain    | <input type="checkbox"/> hives            | <input type="checkbox"/> numbness           | <input type="checkbox"/> decreased libido   | _____        |
| <input type="checkbox"/> lower back pain    | <input type="checkbox"/> eczema/psoriasis | <input type="checkbox"/> tingling           | <input type="checkbox"/> impotence          | _____        |
| <input type="checkbox"/> joint pain         | <input type="checkbox"/> acne             | <input type="checkbox"/> tics               | <input type="checkbox"/> prostate disorders | _____        |
| <input type="checkbox"/> foot pain          | <input type="checkbox"/> shingles         | <input type="checkbox"/> frequent urination |   | _____        |
| <input type="checkbox"/> carpal tunnel      |   |   |   | _____        |

◆ I have read the above information and certify it to be true to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

◆ I understand it is my responsibility to inform this office of any changes in my medical status.

◆ I understand that the policy of this office requires payment in full for all services rendered at the time of visit. I authorize the release of any information requested to process the claim.

◆ I understand that an appointment commits the physician's time to me and unless 24 hours advanced notice is given, I am financially responsible for canceled or missed appointments.

**◆ ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

I hereby acknowledge that I have received a copy of Wendi Miyashiro, L.Ac. Notice of Privacy Practices. I further acknowledge that a paper copy of the current notice will be on file at the office and will be available to me at my request during office hours.

\_\_\_\_\_  
Patient's signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date