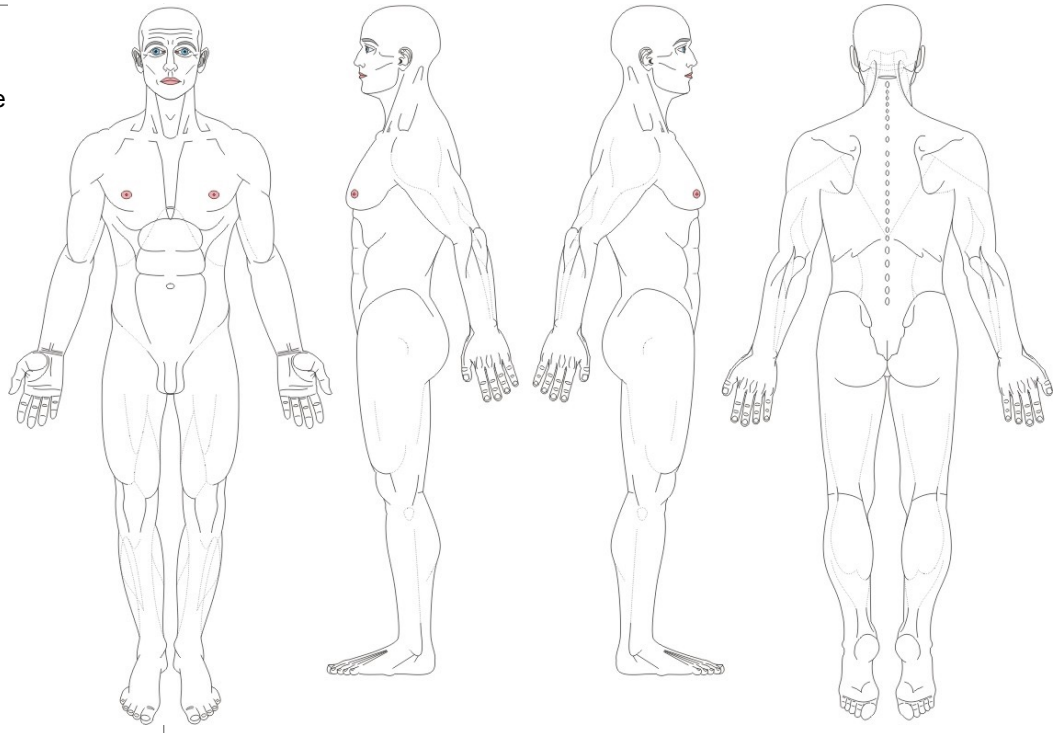
Name **Address** Post code	Home Work Mob E-mail	Occupation DOB / / Age
Dr. Practice	Referral	D.O.F.C. / / 20

Complaint	Duration
Complaint	Duration
Onset and clinical manifestations of presenting condition(s)	
Past Medical History	
Medication	Family history

Headache	ENT
Pain	Sleep
Appetite	Digestion
Energy	Bowels / Urine
Hot / cold	Thirst / sweat
Shen	Menstruation



Diet B L D

Pulse

Tongue

Tea	Alcohol
Coffee	Tobacco
Water	Other
Exercise	

Working diagnosis

Points prescription

Recommendations to patient

Number of agreed visits review

patient 's consent yes / no

☐ : acupuncture ☐ : herbal medicine ☐ : homeopathy ☐ : massage ☐ : osteopathy
☐ : physiotherapy ☐ : shiatsu ☐ : chiropractic ☐ : other