Name:_______________________________________ Date_________________

Shen - Part 1a

Primary Complaint: Psychological - Emotions

Instructions: There are six (6) pages of 'Fill-In' pdf forms. Please provide as much information as possible - this is your opportunity to tell me what has been occurring in the past, your current condition as well as concerns you have for your future should this condition continue.

Mark ALL that apply: ☐ Depression or GRIEF ☐ Anxiety or OCD ☐ Bi-Polar or Mood disorder ☐ PTSD or Panic Attacks ☐ Hypersensitive ☐ ADHD Other________________________________

Indicate all abnormalities or exacerbated conditions that occur simultaneously with your Primary Complaint:

☐ Balance	☐ Appetite	☐ Blood pressure	☐ Energy	☐ Addiction	☐ Fertility
☐ Hearing	☐ Defecation	☐ Arrythmias	☐ Libido	☐ Attitude change	☐ Pain (physical)
☐ Smell	☐ Digestion	☐ Angina	☐ Menses	☐ Behavior change	☐ Twitching-Tics
☐ Speech	☐ Thirst	☐ Breathing	☐ Vaginal fluids	☐ Cravings	☐ Hiccups
☐ Swallowing	☐ Urination	☐ Skin	☐ Semen flow	☐ Emotions	☐ Self Esteem
☐ Taste	☐ Bleeding	☐ Hair	☐ Sleep	☐ Mental function	☐ Self Image
☐ Touch	☐ Mucus flow	☐ Nails	☐ Excess naps	☐ Memory	☐ Motivation
☐ Vision	☐ Swelling			☐ Pain (from emotions)	

Is this your first time seeking treatment for the primary complaint? ☐ Yes ☐ No, I have sought ______ prior.
No. of times

When did the primary complaint become disruptive to your ADL, caused significant impairment or prompted treatment?

____
How many days, weeks, months or years ago or the date.

When did the primary complaint or associated symptoms begin before the condition became disruptive to your Activities of Daily Living or caused significant impairment?

____
Indicate the number of days, weeks, months or years or the date.

How frequently does the primary complaint or associated symptoms interfere with Activities of Daily Living?

____
Indicate number of minutes, hours in a day or number of days/weeks

What do you think is the origin or cause of the primary complaint? ________________________________

____

What provides relief to the primary complaint? _________

____

____

____

Please answer the following:

Are you willing to have blood tests?	☐ No	☐ Yes	☐ Unknown
Are you angry or frustrated?	☐ No	☐ Yes	☐ Unknown
Are you revved-up today?	☐ No	☐ Yes	☐ Unknown
Do you feel worried or very uneasy?	☐ No	☐ Yes	☐ Unknown
Are you sad or lonely?	☐ No	☐ Yes	☐ Unknown
Are you feeling fearful or scared?	☐ No	☐ Yes	☐ Unknown
Are your feeling overwhelmed?	☐ No	☐ Yes	☐ Unknown
Are you fearful of needles?	☐ No	☐ Yes	☐ Unknown
Are you lactose intolerant?	☐ No	☐ Yes	☐ Unknown
Are you gluteomorphin reactive?	☐ No	☐ Yes	Unknown
Are you caseomorphin reactive?	☐ No	☐ Yes	
Do you have a food allergy?	☐ No	☐ Yes	
Are you on prescription medication?	☐ No	☐ Yes	
Are you taking OTC medicines?	☐ No	☐ Yse	
Are you taking illicit drugs?	No	Yes	
Are you taking herbs?	No	Yes	
Do you smoke tobacco?	No	Yes	

If you need to include more information, write it in a MSWord documents and title it with your name and Primary Complaint. Example: John_Doe_Shen Part 1a

Name:______________________________________ Age____ Sex_____ Date:________________

Shen - Part 1b

Primary Complaint: Psychological - Emotion

Section: I

Over the last two weeks have you noticed the following;

Never	Rarely	Sometimes	Often	Most of time	Always	
☐	☐	☐	☐	☐	☐	I feel sad, down in the dumps or unhappy
☐	☐	☐	☐	☐	☐	I can't concentrate of focus
☐	☐	☐	☐	☐	☐	Nothing seems to give me much pleasure
☐	☐	☐	☐	☐	☐	I feel tired; have no energy
☐	☐	☐	☐	☐	☐	I have thoughts of suicide
						Changes in sleep pattern
☐	☐	☐	☐	☐	☐	I have difficulty sleeping
☐	☐	☐	☐	☐	☐	I have been sleeping too much
						Changes in appetite
☐	☐	☐	☐	☐	☐	I have lost some appetite
☐	☐	☐	☐	☐	☐	I have been eating more
☐	☐	☐	☐	☐	☐	I feel tense, anxious or can't sit still
☐	☐	☐	☐	☐	☐	I feel woried or fearful
☐	☐	☐	☐	☐	☐	I have attackes of anxiet or panic
☐	☐	☐	☐	☐	☐	I worry about dying or loosing control
☐	☐	☐	☐	☐	☐	I am nervous or shaky in social situations
☐	☐	☐	☐	☐	☐	I have nightmares or flashbacks
☐	☐	☐	☐	☐	☐	I am jumpy or feel startled easily
☐	☐	☐	☐	☐	☐	I avoid places that strongly remind me of a bad experience
☐	☐	☐	☐	☐	☐	I feel, dull, numb or detached
☐	☐	☐	☐	☐	☐	I can't get certain thoughts out of my mind
☐	☐	☐	☐	☐	☐	I feel I must repeat certain acts or rituals
☐	☐	☐	☐	☐	☐	I feel the need to check and recheck things

In Parts 2 through Part 5 reference ANY sypmtoms on this page that:
- Interferes with work or school
- Affects your relationship with friends or family
- Has led to using alcohol to get by
- Has led to using drugs, ilicit or prescription

Section: II

At anytime in your life have there been phases or periods when you have:

☐ Yes	☐ No	Had more energy than ususal
☐ Yes	☐ No	Felt unusually irritable
☐ Yes	☐ No	Felt unusually excited, revved up or high
☐ Yes	☐ No	Needed less sleep than usual

Never	Rarely	Sometimes	Often	Most of time	Always	
☐	☐	☐	☐	☐	☐	I do everything slowly
☐	☐	☐	☐	☐	☐	My future seems hopeless
☐	☐	☐	☐	☐	☐	I find it hard to concentrate when reading
☐	☐	☐	☐	☐	☐	All joy and pleasure seem to have disappeard from my life
☐	☐	☐	☐	☐	☐	I find it hard to make decisions
☐	☐	☐	☐	☐	☐	I have lost interest in things that used to mean a lot to me
☐	☐	☐	☐	☐	☐	I feel sad, depressed and unhappy
☐	☐	☐	☐	☐	☐	I feel restless and cannot relax
☐	☐	☐	☐	☐	☐	I feel bored or disinterested
☐	☐	☐	☐	☐	☐	I find it hard to do trival things
☐	☐	☐	☐	☐	☐	I feel guilty and deserve to be punished
☐	☐	☐	☐	☐	☐	I feel like a failure
☐	☐	☐	☐	☐	☐	I feel empty - more dead than alive
☐	☐	☐	☐	☐	☐	I sleep poorly: too litle, too much or distrubed during sleep
☐	☐	☐	☐	☐	☐	I wonder HOW I could commit suicide
☐	☐	☐	☐	☐	☐	I feel confined and imprisoned
☐	☐	☐	☐	☐	☐	I feel down even when something good happens to me
☐	☐	☐	☐	☐	☐	

Name:____ Age____ Sex_____ Date:_________________

Shen - Part 1b

Primary Complaint: Psychological - Emotional

Section: III

Do you experience:

- ☐ Yes ☐ No A distict and ongoing fear of social situations or people
- ☐ Yes ☐ No Worry excessive about many events for no apparent reason
- ☐ Yes ☐ No Have age-apprpriate relationships with family and friends
- ☐ Yes ☐ No Anxious when interacting with peers and avoid them
- ☐ Yes ☐ No Persistent and unrrewsonable fear of an object or situation: flying, heights or animals
- ☐ Yes ☐ No Freezing, clinging or irrational outbursts when encoutering feared objects, situations, animals
- ☐ Yes ☐ No Worry excessively about competency or performance
- ☐ Yes ☐ No Cry, irrational outburst or refuse to leave/part with a person that the normally must
- ☐ Yes ☐ No Decline in work performance, procrastinate, or avoid social situations
- ☐ Yes ☐ No Extended periods of time each day repeating activities: washing hands, checking things, counting
- ☐ Yes ☐ No Exaggerated fears of people: possible burglars, kidnappers, car accidents
- ☐ Yes ☐ No Exaggerated fears of crowded places like elevators
- ☐ Yes ☐ No High number of nightmares, headaches, GI disturbances, or Frequent urination
- ☐ Yes ☐ No Repetivitly accuse others of actions or behaviors that are identical from a past disturbing event
- ☐ Yes ☐ No Redo tasks because of excessive dissatisfaction with less-than-perfect performance

Section: IV

How much of the time (minutes or hours) each day during the past two weeks you have been bothered by:

- ☐ Yes ☐ No Nervousness, tension or inner unrest____
- ☐ Yes ☐ No Worry too much about even the most insignificant things in daily life________________________
- ☐ Yes ☐ No Having to avoid things,places or activities as anxiety provoking___________________________
- ☐ Yes ☐ No Recurrent, unpleasent compulsive thoughts that won’t stop______________________________
- ☐ Yes ☐ No Having to check everything you do, again & again______________________________________
- ☐ Yes ☐ No Having to repeat the same action: washing, countnig___________________________________
- ☐ Yes ☐ No Feel very shy in company, when eating or drinking in front of people_______________________
- ☐ Yes ☐ No Feel other people are assessing you or watching you___________________________________
- ☐ Yes ☐ No Have difficulty performing ADL due to these symptoms_________________________________

Section: V

When experiencing any of the above do you:

- ☐ Yes ☐ No Sense impending doom or danger
- ☐ Yes ☐ No Fear loss of control or death
- ☐ Yes ☐ No Reactively exit the local, flee
- ☐ Yes ☐ No Increased ot rapid heart rate
- ☐ Yes ☐ No Sweat
- ☐ Yes ☐ No Tremble
- ☐ Yes ☐ No Shortness of breath
- ☐ Yes ☐ No Hyperventilation
- ☐ Yes ☐ No Chills
- ☐ Yes ☐ No Hot flashes
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Abdominal cramps
- ☐ Yes ☐ No Chest pain
- ☐ Yes ☐ No Headache
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Faintness
- ☐ Yes ☐ No Tightness in your throat
- ☐ Yes ☐ No Difficulty swallowing

Section: VI Other Comments

Note any thoughts evoked by the question on this page or any additional information you want us to know.

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Van Harding L.Ac.
2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064 tel/fax info@vanharding.com

Name:______________________________________ Age____ Sex_____ Date:________________

Shen - Part 1b

Primary Complaint: Psychological - Emotional

Section: VII

Do you experience the following::

☐ Yes ☐ No Repeated, disturbing memories, thoughts or images of a stressful experience from the past
☐ Yes ☐ No Repeated, distrubing dreams of a stressful past experience
☐ Yes ☐ No Sudden acting or feeling as if s stressful situation were happening again, as if you were reliving it
☐ Yes ☐ No Feeling very upset when something reminded you of a past stressful event
☐ Yes ☐ No Havng physical reactions (Heart pounding, trouble breathing,or sweating) when something reminded you of past stressful event
☐ Yes ☐ No Avoid thinking about or talking about a stressful past event to avoid havnig feelngs about it
☐ Yes ☐ No Difficulty remembering important parts of a stressful past expereince
☐ Yes ☐ No Loss of interest in things you used to enjoy
☐ Yes ☐ No Feeling distant or cut-off from other people
☐ Yes ☐ No Feeling emotionally numb or unable to have loving feelings for those close to you
☐ Yes ☐ No Unable to be sexually active
☐ Yes ☐ No Feeling as if your future will somehow be cut short
☐ Yes ☐ No Difficulty falling or staying asleep
☐ Yes ☐ No Feeling irritable or having angry outbursts
☐ Yes ☐ No Difficulty concentrating
☐ Yes ☐ No Being 'super alert' or watchful on guard
☐ Yes ☐ No Feeling jumpy or easily startled

Section: VIII

When experiencing any of the above do you:

☐ Yes ☐ No Sense impending doom or danger
☐ Yes ☐ No Fear loss of control or death
☐ Yes ☐ No Reactively exit the local, flee
☐ Yes ☐ No Increased ot rapid heart rate
☐ Yes ☐ No Sweat
☐ Yes ☐ No Tremble
☐ Yes ☐ No Shortness of breath
☐ Yes ☐ No Hyperventilation
☐ Yes ☐ No Chills
☐ Yes ☐ No Hot flashes
☐ Yes ☐ No Nausea
☐ Yes ☐ No Abdominal cramps
☐ Yes ☐ No Chest pain
☐ Yes ☐ No Headache
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Faintness
☐ Yes ☐ No Tightness in your throat
☐ Yes ☐ No Difficulty swallowing

Section: IX Note any thoughts evoked by the questions on this page:

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Van Harding L.Ac.
2990 South Sepulveda Blvd Suite 310 Los Angeles, CA 90064 310-310-8096 tel/fax info@vanharding.com

Name:_____________________________________ Age____ Sex_____ Date:___________________

Shen - Part 1b

Primary Complaint: Psychological - Emotional

Section: X

Has there been a period of time when you were not your usual self and...

☐ Yes ☐ No You felt so good or so hyper that other people thought your were not your normal self or you
☐ Yes ☐ No were so hyper that you got into trouble
☐ Yes ☐ No You were so irritable that you shouted at people or started fights or arguments
☐ Yes ☐ No You felt much more self-confident than usual
☐ Yes ☐ No You got much less sleep than usual and found you didn't really miss it

☐ Yes ☐ No You were much more talkative or spoke much faster than usual
☐ Yes ☐ No Thoughts raced through your head or you couldn't clow you mind down
☐ Yes ☐ No You were so easily distracted by things around you that you had trouble concentrating or staying on track
☐ Yes ☐ No You had much more energy than usual
☐ Yes ☐ No You were much more active or did many more things than usual
☐ Yes ☐ No You were much more social and outgoing than usual, Example: you telephoned friends in the middle of the night
☐ Yes ☐ No You were much more interested in sex than usual
☐ Yes ☐ No You did things that were unusual for you or that other people might have thought were excessive, foolish or risky
☐ Yes ☐ No Excessive spending money that caused you or your family financial harm

If you checked "yes" to more than one of the above, have several happened during the same time period? ☐ Yes ☐ No

How much of a problem did any of these cause you:

Unable to work	☐ None	☐ Minor	☐ Moderate	☐ Serious
Family conflict	☐ None	☐ Minor	☐ Moderate	☐ Serious
Money or legal troubles	☐ None	☐ Minor	☐ Moderate	☐ Serious
Excessive arguements or fights	☐ None	☐ Minor	☐ Moderate	☐ Serious

Have any of your blood relatives had manic-depressive illness or bi-polar? ☐ Yes ☐ No
Has a health professional ever told you that you have manic-depressive illness or bi-polar? ☐ Yes ☐ No

Section: XI

Has there been a period of time when you were not your usual self and...

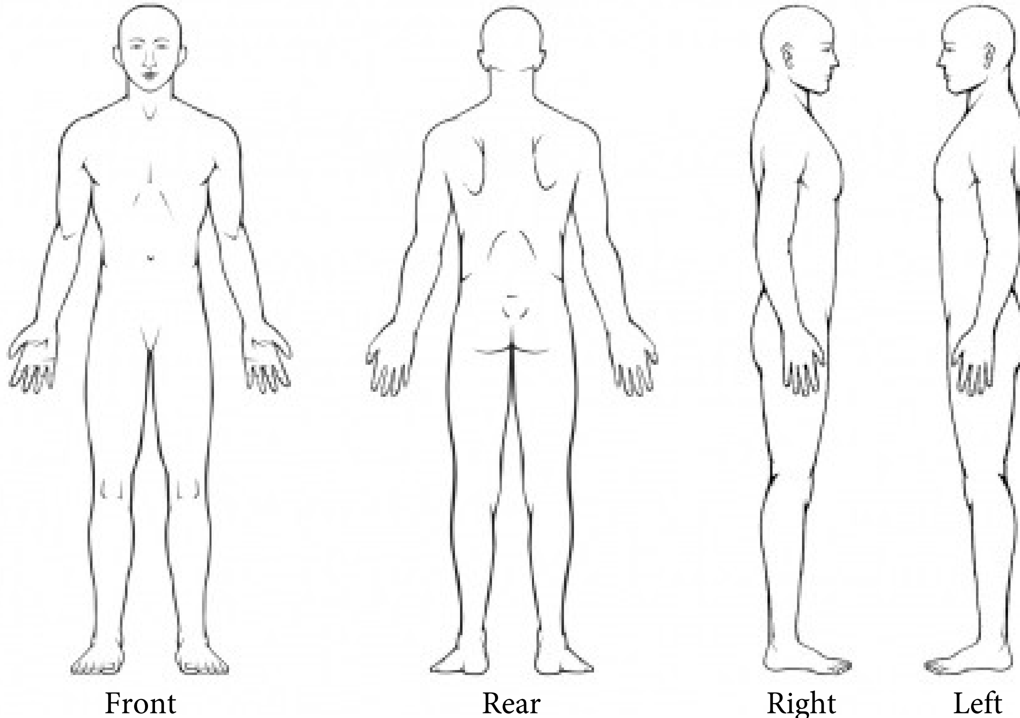
☐ Yes ☐ No Difficulty getting organized
☐ Yes ☐ No Reckless driving and traffic accidents
☐ Yes ☐ No Marital difficulties
☐ Yes ☐ No Extreme distractibility
☐ Yes ☐ No Poor listening skills
☐ Yes ☐ No Restlessness, Difficulty relaxing
☐ Yes ☐ No Difficulty starting tasks
☐ Yes ☐ No Chronic lateness
☐ Yes ☐ No Anger outbursts
☐ Yes ☐ No Prioritzing issues
☐ Yes ☐ No Unable to complete tasks

Name:______________________________________ Date________________

Shen - Part 1c

Secondary Complaint: Physical Sensations

Instructions: Please place a "X" on the area of Pain or Sensation.



Type of Pain or Sensation:

- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing
- ☐ Burning
- ☐ Dull
- ☐ Aching
- ☐ Tingling
- ☐ Numbness
- ☐ Cramping
- ☐ Tightening
- ☐ Stiffness
- ☐ Swelling
- ☐ Heat
- ☐ Cold
- ☐ Crawling
- ☐ Itching

Quality.of Primary Complaint:

- ☐ Constant ☐ Fixed
- ☐ Intermittent ☐ Moving

Trigger or Aggrivated by:

- ☐ Cold ☐ Heat
- ☐ Physical activity
- ☐ Emotional upset
- ☐ Stress ☐ Weather

Rate your pain at it’s most and least painfulness:

- ☐ 0 None
- ☐ 1 Mild - nagging, annoying, interferes little with ADLs
- ☐ 2 Mild - nagging, annoying, interferes little with ADLs
- ☐ 3 Mild - nagging, annoying, interferes little with ADLs
- ☐ 4 Moderate - Interfere’s significantly with ADLs
- ☐ 5 Moderate - Interfere’s significantly with ADLs & need OTC med
- ☐ 6 Moderate - Interfere’s significantly with ADLs & need OTC med
- ☐ 7 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 8 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 9 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 10 Severe - Disabling, unable to perform ADLs & Need hospital

Are you hands or feet too sensitive to touch? Yes No

Does it hurt at night when bed covers touch? Yes No

Do your symptoms worsen at night? Yes No

Do your legs feel weak when you walk? Yes No

Do you feel 'heavy'? Yes No

Are your eyes sensitive to light? Yes No

Are your hands and/or feet usually cold ? Yes No

Does your nose get cold, or do you ave a constant nasal drip? Yes No

Are you unable to orient your self with directions? Yes No

Do you sigh frequently or feel something stuck in throat? Yes No

What provides relief of Pain or sensation?_____________

____

____

____

____

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Physical Sensation Part 1b

Name:____ Date_________________

Use the next four (4) pages to embellish upon the details of your PAIN and Life Experiences.

Shen - Part 2

Primary Complaint: Psychological - Emotion

Instructions: The Day your Primary Complaint became disruptive to your ADL or caused significant impairment

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order starting with the morning of and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012. Then describe the following:

- where you were located when you noticed the Primary Complaint (or a medical diagnosis that was given),
- how you felt and any emotional responses
- what ADL you could not do or what bodily functions were significantly impaired
- the duration of the Physical Sensation(s) and characteristics (qualities)
- anything that seemed to make it worsen or improve it
- any observations by other people of your behavior, emotions or physical condition

Date your Primary Complaint or associated symptoms became disruptive to your ADL or caused significant impairment:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Shen Part 2

Name:____ Date_________________

Shen- Part 3

Primary Complaint: Psychological - Emotion

Instructions: Your Life Prior to the Day the Primary Complaint became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back to the earliest date when you noticed the Primary Complaint and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your Primary Complaint became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moving your home changing jobs marriage divorce separation
  pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters
  child rearing problems children leaving home for college child custody illness accidents incarceration
  institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date of earliest recall of Primary Complaint or associated symptoms:

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If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Shen Part 3

Name:____ Date_________________

Shen - Part 4

Primary Complaint: Psychological - Emotion

Instructions: **Your Life 1 year Prior to the Earliest Date you noticed the Primary Complaint or associated symptoms cited in Part 3.**

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back 1 year prior to the earliest date when you noticed the Primary Complaint and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your Primary Complaint became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarcerated institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date 1 year prior to the earliest recall of the Primary Complaint or associated symptoms:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Shen Part 4

Name:____ Date_________________

Shen - Part 5

Primary Complaint: Psychological - Emotion

Instructions: Your Symptoms and Actions since the day your Primary Complaint or associated symptoms became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Describe to best of you abilities the chronological sequences of the following starting from the Day the Primary Complaint or associated symptoms became disruptive to your ADL or caused significant impairment through to today. Include the following:
  - changes of the symptoms over time (duration, intensity, improvements, worsening, etc)
  - the actions you have employed to treat the problem via MD, ND, DO, DC, LAc, PT and other therapists as well as home remedies. Include the diagnosis, therapies, medications and natural remedies (herbs, homeopathy, nutritional) that have been used. Include any and all improvements or worsening of the problem/condition due to any of the actions you employed.
- Include the events of your life that occurred during this tme period. These events include:
  travel in or outside the USA or Canada   moved your home   changing jobs   marriage   divorce   separation
  pregnancy   miscarriage   abortion   death of a friend, relative or pet   financial stresses   legal matters
  child rearing problems   children leaving home for college   child custody   illness   accidents   incarcerated
  institutionalized   natural disaster   crime victim   domestic violence or abuse   substance abuse   other
- Any observations by other people of your behavior, emotions or physical condition

Symptoms and Actions since the Primary Complaint or associated symptoms became disruptive to ADL or causative to significant impairment.

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If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Shen Part 5