

To: OPTIMUM HEALTH CENTER

I, _____ (ID/PPT# _____), understand that Dr. Yuan Tai Ming, Alexander, who is the clinic director of Optimum Health Centre, has been qualified as Doctor of Chiropractic in Canada from Canadian Memorial Chiropractic College in 1982; as Doctor of Naturopathy in Canada from Ontario College of Naturopathic Medicine in 1986; and received the Diploma in Homeo-Therapeutics (D.HT) from Bengal Allen Medical Institute in India in 1987. Dr. Alexander Yuan is the vice-president of the Asian Homeopathic Medical League and is the vice-president and consultant of the World Federation of Chinese Naturopathy.

I also understand that, Dr. Alexander Yuan, Homeopath / Naturopath / Registered Chiropractor / Listed Chinese Medicine Practitioner, is not registered as an Allopathic medical practitioner under the Medical Registration Ordinance (Chapter 161) section 14 and 14A in Hong Kong.

All the products provided by Optimum Health Centre are for the promotion of health only. None of the products is for use in:

- (a) the diagnosis, treatment, mitigation, alleviation or prevention of disease or any symptom thereof;
- (b) the diagnosis, treatment, mitigation, alleviation of any abnormal physical or physiological state or any symptom thereof;
- (c) altering, modifying, correcting or restoring any organic function,

in human beings or in animals.

_____ Date _____
Patient's signature

Purpose for consultation:

- Just look after the existing health concern
- To improve myself constitutionally as a whole
- Anti-aging to achieve optimum health

**Indicate your general feeling well-being at this moment,
(worst: 0 ⇔ 10: best): _____**

- Optimum Health Family VIP member** (To be filled by staff)

大康自然健康中心

OPTIMUM HEALTH CENTRE

香港銅鑼灣渣甸街 54-58 號富盛商業大廈二樓
2/F, Prosperous Commercial Building, 54 - 58 Jardine's Bazaar, Causeway Bay, Hong Kong
電話 Tel: (852) 2577-3798 圖文傳真 Fax: (852) 2890-8469
電子郵件 Email : info@naturalhealing.com.hk
網址 Web Site: www.naturalhealing.com.hk

Homeopathic Case Record

No.:

Date:

Name:

Age:

Sex: _____ Date of Birth: _____ yr _____ mth _____ day

Birth Time: _____ hr _____ min (AM / PM)

H.K.I.D. No.: _____ Occupation: (Nature of Work)

Telephone No.:

Address:

Home-

Flat/Room _____ Floor _____ Block _____

Office-

Building _____

Mobile-

No. _____ Street/Road _____

Fax-

District _____

Country _____

Postal Code _____

Referred by:

Email: _____

I would like to receive newsletter from :

Optimum Health Centre

Sourcewadio.com

In what language :

Chinese English

採用: 自然療法、脊骨神經科、同類療法、針灸、營養療法、按摩、芳香療法、水療、浣腸療法、草藥療法、電腦測試及各類健康用品食物、書籍等。

Practice of: Naturopathy, Chiropractic, Homeopathy, Acupuncture, Nutrition, Massage, Aromatherapy, Hydrotherapy, colonics, Herbalogy, Computerized Therapeutic Testing, Various Health Products, Food, Books, etc.

(Confidential)

* (Please read each question carefully and then give your considered answers)

MAIN COMPLAINT AND OTHER ASSOCIATED TROUBLES: (AND DETAILED HISTORY OF THE PRESENT ILLNESS, THE ONSET AND COURSE WITH DATES)

- **ORIGIN OR CAUSE:** Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident or mental upset? (e.g. Shock, worry, errors in diet, overexertion, exposure to cold, heat etc.)

Mention the other following details of your health. Describe particularly and in detail ALL THE CHANGES OR STRANGE SYMPTOMS NOTICED after the onset of the present illness. Omit nothing. Try to describe the EXACT LOCATION and EXACT SENSATION of each complaint and the VARIOUS FACTORS AND CIRCUMSTANCES WHICH INCREASE OR DECREASE each trouble.

- Do you ever feel faint? If so, under what circumstances?
- Do you have giddiness? If so, describe how and when it is worse?
- Have you anything to complain about your head?
- Do you get headaches? If so, describe in detail when it comes, how it increases, where it starts and spreads etc. (mention if you have any trouble with your:)
- Eye or Vision:
- Ears or Sense of hearing:
- Nose or Sense of smell:
- Face or Facial expression:
- Mouth or Sense of taste:
 - Is there Dryness or Salivation?
 - Tongue: (Describe its appearance)
 - Is there any crack, indentation, trembling etc.?
 - If coated, describe colour and nature of coating:
 - Teeth:
 - Lips
 - Gums, e.g. bleeding:
 - Throat or Swallowing (including tonsils)

*When answering the questions GIVE MAXIMUM POSSIBLE INFORMATION INCLUDING ALL DETAILS. If the space provided for the answers is insufficient write on a separate paper and attach. Describe particular ALL PECULIARITIES you might have noticed about yourself. Remember the prescription depends upon the fullness and correctness of the information you give?

APPETITE: What particular foods or drinks do you strongly crave for or you are strongly averse to: e.g. salty, sour, hot chilli, sweet, savory food, milk, eggs, fatty and fried food, cold drinks, coffee, tea, alcohol etc.?

How hungry do you feel: less, normal or unbearable? And what time?

What is the quantity of food you take now; same as, less or more than your original?

Is there any trouble after food; such as pains, burning, heaviness, sleepiness etc.?

THIRST: How much water do you take at a time and how many times in a day?

Do you prefer warm, ordinary, cold or iced?

ABDOMEN: Do you have bloating of abdomen? If so, when?

Do you pass gas? Up or down? Does it give relief?

RECTUM & ANUS: Is there any pain, burning, prolapse, piles, etc.?

If so, is it more before, during or after stool?

STOOLS: How many times do you pass?

Mention the quantity, colour and consistency.

Has it any bad smell?

URINE: Mention frequency, quantity, colour, smell etc.;

Any difficulty in passing? Is the flow slow to start, interrupted, feeble, dribbling etc.?

Do you find it easier to pass in any particular position?

How often do you pass at night?

Any involuntary urination?

Is there burning? If so, is it worse before, during or after urination?

SEXUAL SPHERE: Have you Excessive desire, Aversion etc.?

Do you suffer from sexual disturbances?

Do you suffer in any way after intercourse? If so, describe how.

For Men:

Do you have night emission?

Any inability to perform or quick ejaculation?

For Women:

Menses: How are the periods; regular or irregular?

At what age did it start?

Was there any trouble then?

Mention interval between and No. of days of flow:

Menstrual flow: Is there any change now in quantity, colour, smell or consistency?

If the menses have stopped, state how you feel after that.

Do you suffer in any way before, during or after Menses? If so, describe:

Do you feel better or worse, during or after the Menses?

Do you feel the internal parts coming down?

Is there any leucorrhoeal (white) discharge?

If so, mention the nature, colour, consistency and smell of the discharge and when and under what circumstances it is more or less.

Do you catch cold often? If so, how?

Is there any trouble in your chest or heart?

Is there any trouble with your voice or speech?

Is there any difficulty in breathing?

If so, when, in which position and under what circumstances is it worse?

Do you have cough?

Describe when and under what circumstances the cough is worse.

Is it dry or moist? Describe the nature of the sputum if any.

Do you have any trouble in your back, limbs or joints? Describe in detail.

If you have any pains, do they shift? In what direction do they extend?

Is there any complaint of skin: such as discolouration, itching, eruptions, ulcers, warts etc. (Describe its nature)

Is there any complaint with the Nails?

Is there any complaint with the Hair such as falling, graying, poor or excessive growth etc.?

SLEEP: How is your sleep?

Your posture in sleep: lying on the back, side, abdomen etc.:

Are you able to sleep in any position?

Do you feel refreshed or worse after sleep?

Do you get dreams?

If frequent, mention nature of dreams and objects generally seen.

SWEAT: How much, on what parts and when?

Is it warm or cold?

Is it sour-smelling or bad smell?

Does it stain the clothes?

Do you get fever or chill frequently? If so, what brings it on?

When does it come on?

Have your weight or size increased or reduced recently or after onset of the illness?

If so, is it noted more in any particular part?

Are you troubles one-sided?

Or more on one side?

Do they proceed from one to the other side?

Or do they alternate or shift?

Do wounds heal slowly?

Do wounds tend to form pus?

Have you a tendency to bleed?

Is there any trembling? If so, when and under what circumstance?

STATE HOW YOU ARE AFFECTED BY OR HOW YOU REACT TO THE FOLLOWING: ARE YOU UPSET OR RELIEVED BY ANY OF THESE?

1. Warmth in general: warmth of bed, of room etc.:
2. Cold in general: cold air, winds etc.:
3. Weather: dry, wet, cold, cloudy etc.:
4. Thunderstorms:
5. Open air; Fanning:
6. Near the sea and on the mountains:
7. Movement and rest: Fast & Slow motion:
8. Position and Posture:
 - Lying down on the back, sides, abdomen etc.:
 - Sitting, standing, rising, stopping etc.:
 - Looking up, Looking down etc.:
9. Touch, Pressure and Massage:
10. Light, Noise, Smell etc.:
11. Sleep, Nap etc., or Loss of sleep:
12. Eating and Drinking:
 - Before, during and after:
 - Fasting:
 - Particulars of items of food & drink which affect you or make you sick: e.g. Cabbage, Cold drinks, Eggs, Fats, Fish, Fried foods, Fruits, Milk, Onions, Potatoes, Pulses, Sour foods, Sweets etc.
13. Emotion; Anxiety, Grief, Joy etc.:
14. Exertion: Mental and Physical; Reading, Speaking etc.
15. Company, crowds etc.:
16. Ascending and Descending the stairs, in a lift etc.:
17. Bathing & Washing: cold, warm etc.: (Do you like a bath?)
18. Exposure to Sun:
19. Sweating, Passing Urine, Stool etc.:
20. Passing gas up or down:
21. Clothing etc.: woolen, cotton, Tight clothing:
22. In what part of the 24 hours do you feel best or worst?
23. Traveling: in bus, train, plane etc.:
24. Do your troubles occur or become worse periodically:
 - e.g. daily, on alternate days, weekly, fortnightly, monthly, yearly, during new moon, full moon etc.?
25. Do they occur suddenly slowly or disappear suddenly/slowly?
26. Weather and Seasons: Summer, Winter, Cloudy, Rainy etc.:
27. Jarring, Jerking etc.:
28. Music & Dancing:
29. Change of position:
30. How is your health if you are constipated or have diarrhoea?

HAVE YOU NOTICED ANY MARKED CHANGES IN YOUR MENTAL STATE? IF SO, DESCRIBE FULLY.

Have you become:

- Anxious or afraid of anything such as animals, being alone, darkness, death, diseases, robbers, sudden noises, thunder, high places etc.?
- Doubtful? Suspicious?
- Impatient? Hurried? Slow?
- Offended easily?
- Irritable? Quarrelsome? Violent? Abusive, etc.?
- Depressed, Sad, Brooding etc.?
- Diffident? Or Proud?
- Disgusted of anything? Or Suicidal?
- Jealous?
- Changeable? Or Indecisive?
- Shy? Timid? Cowardly?
- Indifferent to anything such as business, relatives etc.?
- Restless?
- Nervous or Excitable? If so, what happens to you when you are nervous?
- Silent or talkative?
- Sexual-minded?

Are you very affectionate?

Do you weep or sigh easily; if so, what makes you weep? How do you feel after weeping?

How do you like and react to sympathy?

How do you like and react to contradiction?

Do you suppress your feelings?

Have you any imaginary feelings or fears?

Do you get started? If so, when?

How is your mental capacity and memory?

Do you make mistakes? If so, of what type?

Do you regret anything?

Are you seriously worried or unhappy over any personal, domestic, economical, social or any other problems? If so, describe the situation in detail:

PREVIOUS HISTORY:

State ALL major illnesses suffered so far (including accidents, food poisonings etc.) such as Malaria, Typhoid, Measles, Small pox, Pneumonia, Pleurisy, etc., with approximate dates and duration. Mention whether you completely recovered your health after each.

(Women should mention abortions, miscarriages etc., if any, and the condition of their health during pregnancy.)

Have you ever suffered from any serious shock, grief, disappointments, fright, mental upset, etc.?

If so, describe in detail:

Is there any abnormality, swelling, numbness, paralysis etc., in any part of the body?

Did you suffer from any skin disorder? If so, how was it cured?

Did you suffer from any venereal disease?

Have you been vaccinated? How often? With what results?

Are you used to alcohol, smoking, tea, coffee, tobacco, or any drug etc. (mention quantity)

Have you ever had any accident? Any injury to the body or head?

Did you ever become unconscious? If so, when and how long?

Are aluminum vessels used for preparing or storing your food?

Did you have any bad habits?

Were you bitten by any animal, or poisonous insects?

For Children:

At what age did teething, walking and talking start?

Were growth and development normal?

Did the mother have any illness during pregnancy?

Was the child born at full term? By normal delivery?

FAMILY HISTORY: State age and condition of health of the following: (If anyone is not alive, state age at and the cause of death)

Father:

Mother:

Brothers & Sisters:

Married or Single:

Partner (Wife or Husband):

Year of Marriage:

Children living (if any children died, state causes):

Any abortions or still births:

Did any relative of yours suffer from anemia, cancer, diabetes, insanity, rheumatism or tuberculosis?

PREVIOUS TREATMENT: State all the medicines and treatments (including operations and their results) taken so far (as far as you know) and the results:

Nutritec Software Symptom Survey

NAME: _____ DATE: _____

Phone: _____ E-mail: _____

Fax: _____ DOB: ___/___/___

Sex : Male Female Tissue Calcium: _____

Height : _____ Weight : _____

Blood Pressure: _____ Pulse: _____

Sitting: _____ Laying: _____ Standing: _____

INSTRCTIONS: Completely black out one of the three circles:

1-mild, 2-moderate, 3-severe

- MILD** symptoms (once or twice last 6 months)
- MODERATE** symptoms (once or twice last month)
- SEVERE** symptoms (Chronic, once or twice last week)
- Leave circles **BLANK** if they do not apply to you!

- 1 2 3 ----- GROUP 1 -----
- 1 Acid foods upset
 - 2 Feel chilled often
 - 3 "Lump" in throat
 - 4 Dry mouth-eyes-nose
 - 5 Pulse speeds after meals
 - 6 Keyed up; unable to feel calm
 - 7 Cuts heal slowly
 - 8 Gag easily
 - 9 Unable to relax; startles easily
 - 10 Extremities cold and/or clammy
 - 11 Strong light irritates
 - 12 Urine amount reduced
 - 13 Heart pounds after retiring
 - 14 "Nervous" stomach
 - 15 Appetite reduced
 - 16 Cold sweats often
 - 17 Body temperature rises easily
 - 18 Skin sensitive to touch
 - 19 Staring, blinks little
 - 20 Frequently has a sour stomach

- GROUP 2 -----
- 21 Joint stiffness after rising
 - 22 Muscle-leg-toe cramps at night
 - 23 "Butterfly" stomach, cramps
 - 24 Eyes or nose watery
 - 25 Eyes blink often
 - 26 Eyelids swollen or puffy
 - 27 Indigestion soon after meals
 - 28 Always seems hungry; "lightheaded" often
 - 29 Food digests rapidly
 - 30 Vomit frequently
 - 31 Frequently hoarse
 - 32 Irregular breathing
 - 33 Pulse slow or feels "irregular"
 - 34 Slow gag reflex
 - 35 Difficulty swallowing
 - 36 Alternating constipation and diarrhea
 - 37 "Slow starter"
 - 38 Not easily chilled
 - 39 Perspire easily
 - 40 Poor circulation or sensitive to cold
 - 41 Subject to colds, asthma, bronchitis

- GROUP 3 -----
- 42 Eat when nervous
 - 43 Excessive appetite

- GROUP 3 continued -----
- 44 Hungry between meals
 - 45 Irritable before meals
 - 46 Get "shaky" if hungry
 - 47 Feeling fatigued, eating relieves
 - 48 "Lightheaded" if meals delayed
 - 49 Heart palpitates if meals missed or delayed
 - 50 Afternoon headaches
 - 51 Upset feeling from excessive eating of sweets
 - 52 Awaken after few hours sleep hard to get back to sleep
 - 53 Crave candy or coffee in afternoons
 - 54 Moods of depression "blues" or melancholy
 - 55 Abnormal craving for sweets or snacks

- GROUP 4 -----
- 56 Hands and feet go to sleep easily, numbness
 - 57 Sigh frequently, "air hunger"
 - 58 Aware of "breathing heavily"
 - 59 Discomfort at high altitude
 - 60 Opens windows in closed room
 - 61 Susceptible to colds and fevers
 - 62 Afternoon yawner
 - 63 Get "drowsy" often
 - 64 Swollen ankles worse at night
 - 65 Muscle cramps, worse during exercise; "charley-horse"
 - 66 Shortness of breath on exertion
 - 67 Dull pain in chest or radiating into left arm, worse on exertion
 - 68 Bruise easily, "black/blue" spots on arms or legs
 - 69 Tendency to anemia
 - 70 Frequently have "nose bleeds"
 - 71 "Ringing in ears" or noises in head
 - 72 Tension under the breast-bone, or feeling of "tightness" in the chest, gets worse on exertion

- GROUP 5 -----
- 73 Dizziness
 - 74 Dry skin
 - 75 Burning feet
 - 76 Blurred vision
 - 77 Itching skin and feet
 - 78 Excessive falling hair
 - 79 Frequent skin rashes
 - 80 Bitter or metallic taste in mouth in the mornings
 - 81 Bowel movements painful or difficult
 - 82 Feelings of worry, dread, or insecurity
 - 83 Feeling queasy; headache over eyes
 - 84 Greasy foods upsets
 - 85 Stools light-colored
 - 86 Skin peels on foot soles
 - 87 Pain between shoulder blades
 - 88 Using laxatives
 - 89 Stools alternate from soft to watery
 - 90 History of gallbladder attacks or gallstones
 - 91 Sneezing attacks
 - 92 Dreaming, nightmares/bad dreams
 - 93 Bad breath (halitosis)
 - 94 Milk products cause distress
 - 95 Sensitive to hot weather
 - 96 Burning or itching anus
 - 97 Crave sweets

- GROUP 6 -----
- 98 Loss of taste for meat
 - 99 Lower bowel gas several hours after eating
 - 100 Burning stomach sensations, eating relieves
 - 101 Coated tongue
 - 102 Pass large amounts of foul smelling gas
 - 103 Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
 - 104 Mucus colitis or "irritable bowel"
 - 105 Gas shortly after eating
 - 106 Stomach "bloating" after eating

1 2 3 ----- GROUP 7A -----

- 107 Insomnia
- 108 Nervousness
- 109 Can't gain weight
- 110 Intolerance to heat
- 111 Highly emotional
- 112 Flush easily
- 113 Night sweats
- 114 Skin is thin and moist
- 115 Inward trembling
- 116 Heart palpitates
- 117 Increased appetite without weight gain
- 118 Pulse races when resting
- 119 Eyelids and face twitch
- 120 Irritable and restless
- 121 Can't work under pressure

----- GROUP 7B -----

- 122 Noticeable weight gain
- 123 Decrease in appetite
- 124 Easily fatigued
- 125 Ringing in ears
- 126 Sleepy during day
- 127 Sensitive to cold
- 128 Dry or scaly skin
- 129 Constipation
- 130 Mental sluggishness
- 131 Hair coarse, falls out
- 132 Headaches upon arising wear off during day
- 133 Pulse slow, below 65
- 134 Frequent urination
- 135 Impaired hearing
- 136 Reduced initiative

----- GROUP 7C -----

- 137 Failing memory
- 138 Low blood pressure
- 139 Increased sex drive
- 140 Headaches, "splitting or rending" type
- 141 Decreased sugar tolerance

----- GROUP 7D -----

- 142 Abnormal thirst
- 143 Bloating of the abdomen
- 144 Weight gain around hips or waist
- 145 Sex drive reduced or lacking
- 146 Tendency toward ulcers and/or colitis
- 147 Increased sugar tolerance
- 148 (FEMALE) Menstrual disorders
- 149 (YOUNG GIRLS) Lack of menstrual function

----- GROUP 7E -----

- 150 Dizziness
- 151 Headaches
- 152 Hot flashes
- 153 Increased blood pressure
- 154 (FEMALE) Hair growth on face or body
- 155 Sugar in urine (not diabetes)
- 156 (FEMALE) Masculine tendencies

----- GROUP 7F -----

- 157 Weakness and/or dizziness
- 158 Chronic fatigue
- 159 Low blood pressure
- 160 Nails weak and/or ridged
- 161 Tendency towards hives
- 162 Arthritic tendencies
- 163 Perspiration increase
- 164 Bowel disorders
- 165 Poor circulation
- 166 Swollen ankles
- 167 Crave salt
- 168 Brown spots or bronzing of skin
- 169 Allergies - tendency to asthma
- 170 Weakness after colds or influenza
- 171 Muscular and nervous exhaustion
- 172 Respiratory disorders

1 2 3 ----- GROUP 8 -----

- 173 Apprehension
- 174 Irritability
- 175 Morbid fears
- 176 Never seems to get well
- 177 Forgetfulness
- 178 Indigestion
- 179 Poor appetite
- 180 Craving for sweets
- 181 Muscular soreness
- 182 Depression; feelings of dread
- 183 Noise sensitivity
- 184 Acoustic hallucinations
- 185 Tendency to cry without reason
- 186 Hair is coarse and/or thinning
- 187 Weakness
- 188 Fatigue
- 189 Skin sensitive to touch
- 190 Tendency towards hives
- 191 Nervousness
- 192 Headache
- 193 Insomnia
- 194 Anxiety
- 195 Anorexia
- 196 Inability to concentrate; confusion
- 197 Frequent stuffy nose; sinus infections
- 198 Allergy to some foods
- 199 Loose joints

----- FEMALE ONLY -----

- 200 Very easily fatigued
- 201 Premenstrual tension
- 202 Painful menses
- 203 Depressed feelings before menstruation
- 204 Excessive and prolonged menstruation
- 205 Painful breasts
- 206 Menstruate too frequently
- 207 Vaginal discharge
- 208 Hysterectomy / ovaries removed
- 209 Menopausal hot flashes
- 210 Menses scanty or missed
- 211 Acne, worse at menses
- 212 Long standing depression

----- MALE ONLY -----

- 213 Prostate trouble
- 214 Urination difficult or dribbling
- 215 Frequent night-time urination
- 216 Depression
- 217 Pain on inside of legs or heels
- 218 Feeling of incomplete bowel evacuation
- 219 Lack of energy
- 220 Migrating aches and pains
- 221 Too easily tired
- 222 Avoids activity
- 223 Leg nervousness at night
- 224 Diminished sex drive

List below your five main physical complaints in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Notes:

10
(TO BE FILLED IN BY A PHYSICIAN)

Physical Examination:

Appearance, Decubitus, Gait, etc:

Digestive System:

Respiratory System:

Circulatory System:

Urogenital:

Locomotor:

Skin:

Weight:

Height:

Temp:

Pulse:

B.P.:

Resp:

Special Findings:

Laboratory Findings:

Blood:

Urine:

Stool:

Sputum:

X-Ray:

ECG:

Diagnosis:

Treatment: