Eastern Healing Centre

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VITAL BODY READINGS AND CONSULTATION

Patient's Name: **Date: ____/____/____**

Phone Number:

1. Head temperature :
2. Hand Condition : (warm, cold; swelling & color)
3. Feet condition : (temperature, swelling & color)
4. Bowel Movement Frequency :
5. Bowel Consistency :
6. Urine Color & Frequency :
7. Appetite :
8. Sleep Pattern :
9. Thirst : Preferred Temperature (cold, warm, hot)
10. Tongue Coating : (dry, wet, yellow, white)
11. Color of Mucus if present :

NOTES ON BODY FUNCTION CHANGES: