PATIENT INTAKE FORM

Name _____ Date of Birth _____ Age _____
(mm/dd/yyyy)

Address _____ Height _____ Weight _____ Sex _____

_____ Occupation _____

_____ Referred by _____

Phone (H) _____ Physician Name _____

(C) _____ (W) _____ Physician Number _____

Email _____ Subscribe to E-Newsletter for promotions, updates, educational info Yes ☐ No ☐

In Emergency Notify _____ Relationship _____ Phone _____

CHIEF COMPLAINT _____

When did the problem begin? _____ Medical Diagnosis _____

What other treatments have you tried? _____

Have you tried Traditional Chinese Medicine before? _____ Acupuncture _____ Herbs _____

Allergies? (drugs, chemicals foods, etc.) _____

Medications/Supplements _____

Are you on a restricted diet or exercise program? _____

Occupational stress (chemical, physical, psychological) _____

Please describe your average diet _____

How many meals do you eat a day? _____ Do you have any cravings? _____

Please circle the products that are used. (cigarettes, alcohol, recreational drugs, coffee, tea, soft drinks)

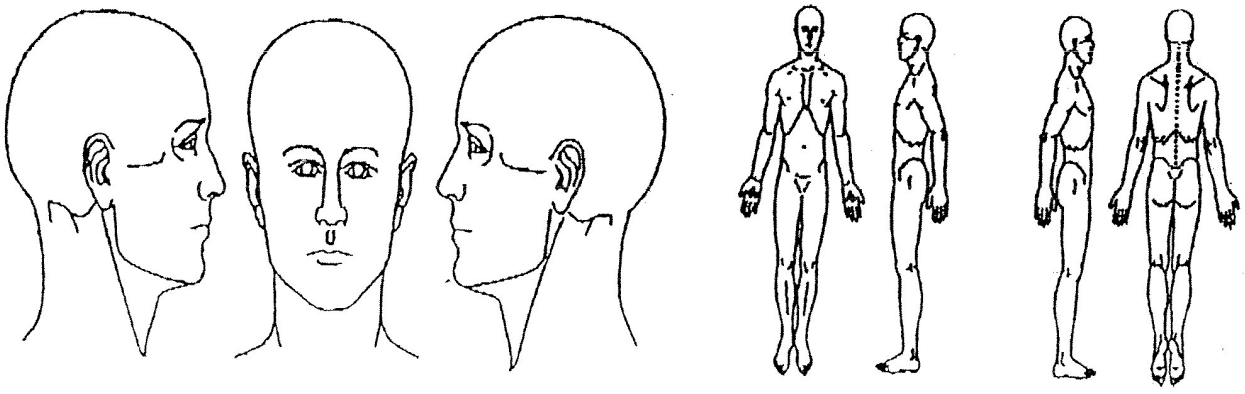
How often are these product(s) used a week? _____

Medical History:

Cancer _____ HIV/AIDS _____ Heart Disease _____ Diabetes _____ Thyroid Disease _____

Hepatitis _____ High/Low Blood Pressure _____ Venereal Disease _____ Bleeding Disorders _____

Indicate areas of pain or distress



GENERAL

- ❑ History of bleeding disorders
- ❑ Bleed or bruise easily
- ❑ Heart palpitations
- ❑ Shortness of breath
- ❑ Strong thirst (hot / cold)
- ❑ Recurrent infections
- ❑ Catches cold easily
- ❑ Sweats easily
- ❑ Night sweats
- ❑ Thirst / No desire to drink
- ❑ Fatigue
- ❑ Sudden drop in energy (Time of day _____)
- ❑ Edema
- ❑ Often feels cold / hot

HEAD/EARS/EYES/NOSE/THROAT

- ❑ Headaches
- ❑ Migraines
- ❑ Dizziness
- ❑ Ringing in ears
- ❑ Earache/Ear discharge
- ❑ Blurry vision
- ❑ Spots in front of eyes
- ❑ Eye dryness/pain
- ❑ Nasal discharge
- ❑ Nose bleeds
- ❑ Grinding/Clenching teeth
- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Sores on lips/mouth/tongue
- ❑ Other _____

DIGESTION

- ❑ Heartburn
- ❑ Bad breath
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal pain/cramps
- ❑ Loose stools/diarrhea
- ❑ Strong smelling stools
- ❑ Bloody stools
- ❑ Belching/Gas
- ❑ Indigestion/Bloating
- ❑ Anorexia
- ❑ Bulimia
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Constipation
- ❑ Feeling of heaviness after eating

GENITO-URINARY

- ❑ History of Bladder/Kidney infections
- ❑ Pain on urination
- ❑ Urgency with urination
- ❑ Frequent urination
- ❑ Blood in urination
- ❑ Unable to hold urine
- ❑ Decrease in urinary flow
- ❑ Kidney Stones
- ❑ Incontinence at night
- ❑ Change in sexual drive
- ❑ Prostate problems
- ❑ Impotency
- ❑ Other _____

Do you wake up to urinate? Yes/No

How many times? _____

SLEEP

- ❑ Hours of sleep per night ____
- ❑ Quality of sleep _____
- ❑ Wake up at night
- ❑ Difficulty falling asleep
- ❑ Easily fall asleep
- ❑ Light sleeper
- ❑ Deep sleeper
- ❑ Wake up rested
- ❑ Nightmares
- ❑ Frequent dreams
- ❑ Other _____

GYNECOLOGICAL

# of pregnancies _____
# of births _____
# of premature births ____
# of abortions _____
# of miscarriages _____

Age of 1st menses _____
days between menses _____
Duration of menses _____
Age of menopause _____

- ❑ Clots
- ❑ Fibroids
- ❑ Infertility
- ❑ PMS _____ _____
- ❑ Breast lumps
- ❑ Vaginal discharge
- ❑ Vaginal pain
- ❑ Endometriosis

❑ Irregular periods ❑ Painful periods ❑ Light periods ❑ Heavy periods

Date of last PAP _____ Other _____

Do you practice birth control? Yes / No How long? _____ Are you pregnant? Yes / No

NEUROLOGICAL / BEHAVIOURAL

- ❑ Stroke
- ❑ Paralysis
- ❑ Panic Attacks
- ❑ Poor balance
- ❑ Poor memory
- ❑ Guilt / Sadness
- ❑ Euphoria
- ❑ Worry
- ❑ Difficulty concentrating
- ❑ Irritability
- ❑ Aggressive / bad temper
- ❑ Impatience
- ❑ Anxiety
- ❑ Depression
- ❑ Mania

Other _____