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, juice)

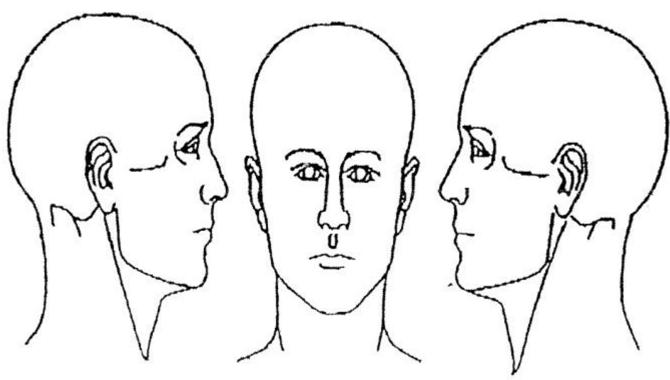
How often are these product(s) used a week? ____

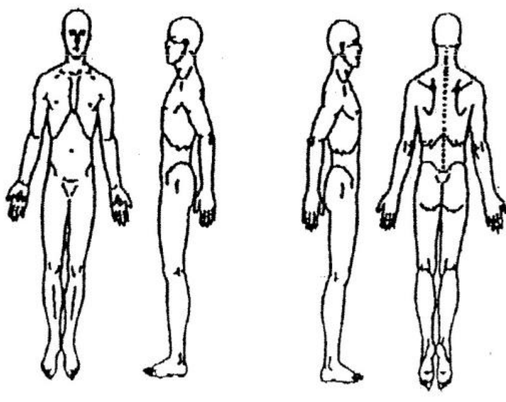
Medical History:

Cancer ______ HIV/AIDS _____ Heart Disease ______ Diabetes _____ Autoimmune 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 (check / circle all that apply)

- ❑ Paralysis / Numbness
- ❑ Stroke
- ❑ Poor balance
- ❑ Panic / Anxiety Attacks
- ❑ Poor memory / concentration
- ❑ Guilt / Sadness / Grief
- ❑ Fear / Dread
- ❑ Worry / Over-thinking
- ❑ Shame / Burden
- ❑ Jealous / Inability to let go
- ❑ Irritability / Impatience
- ❑ Rage / Bad temper
- ❑ Resentment / Helpless
- ❑ Anxiety / Phobias
- ❑ Depression
- ❑ Low motivation

Other _______________