

TCM Intake Form – All Information is Confidential

Today's date: _____ Referred by: _____

Last name: _____ First name: _____

Home address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Sex: M F

Email address: _____

Can we add you to our email list for our newsletter and clinic updates? Y N

Best number to contact you: _____ H W C

Occupation: _____

Marital Status: Single Married Partner Separated Divorced Widowed

Emergency contact: _____ Relationship: _____

Phone number(s): _____

Please answer the following questions by circling Yes or No

| | | | | | | |
|----------------------------------|-----|----|-----------------------------------|-----|----|---|
| Do you have a tendency to faint? | Yes | No | Have you ever had Hepatitis? | Yes | No | |
| Have you eaten today? | Yes | No | If yes, please circle | A | B | C |
| | | | We do not treat active Hepatitis. | | | |
| Do you have a pacemaker? | Yes | No | AIDS/HIV Positive? | Yes | No | |
| Do you bleed for a long time? | Yes | No | Pregnant? | Yes | No | |
| Any trouble breathing right now? | Yes | No | | | | |
| | Yes | No | | | | |

Reason for your visit today: _____

How long have you had this condition? _____

Initial cause or trauma? _____ Is it getting worse? Yes No

On a scale of 1 (no problem) to 10 (emergency room), what is the severity of your complaint? _____

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Does it affect your sleep, work or daily activities? Please explain how.

What makes it better? _____ What makes it worse? _____

Have you or are you currently under any physician’s care for this condition? Yes No

Are you under a physician’s care for any condition? If yes, please explain:

Physician: _____

Chiropractor: _____

OB/GYN: _____

Other Physician: _____

Have you ever had Acupuncture before? Yes No Chinese Herbs? Yes No

Allergies/Reactions? _____

Please list all medications/supplements/herbs/vitamins that you are currently taking:

| Medication/Supplement/Dose | Reason | How Long |
|----------------------------|--------|----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List all surgeries and dates:

Family Medical History

| Family Member | Age | Good/Fair/Poor | Cancer/Major Health Concern | Cause of Death/Age |
|----------------|-----|----------------|-----------------------------|--------------------|
| Father | | | | |
| Mother | | | | |
| Brother/Sister | | | | |
| Brother/Sister | | | | |
| Brother/Sister | | | | |
| Brother/Sister | | | | |
| Husband/Wife | | | | |
| Child – M/F | | | | |
| Child – M/F | | | | |
| Child – M/F | | | | |
| Child – M/F | | | | |

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Is there a family history (blood relatives only)?

| Condition | Relationship | Condition | Relationship | Condition | Relationship |
|--------------------------|--------------|----------------------|--------------|-------------------|--------------|
| Asthma | | Epilepsy | | Stroke | |
| Arthritis | | High blood pressure | | Suicide | |
| Allergies | | Heart disease | | Stomach Disorders | |
| Anemia | | Kidney disease | | Tuberculosis | |
| Auto Immune Disorders | | Leukemia | | | |
| Bleeding | | Mental Health | | | |
| Cancer/type(s) | | Migraine | | | |
| Colitis | | Obesity | | | |
| Congenital Heart disease | | Rheumatoid Arthritis | | | |
| Diabetes | | Rheumatic Fever | | | |
| Drug Abuse/Addiction | | Seizures | | | |

Your Habits:

Do you smoke? Yes No _____ pkgs/day
 Do you drink coffee? Yes No _____ cups/day
 Do you drink alcohol? Yes No _____ oz./day
 Do you use drugs? Yes No
 Do you have a regular sleep schedule? Yes No Bedtime _____ Wake up _____
 Do you exercise regularly? Yes No What activities: Hours per week: _____

General Health:

Secondary health complaints/symptoms:

- _____
- _____
- _____

How does it affect your life/activities of daily living?

Please describe your symptoms (burning, numbing, stinging...) _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Additional questions/comments: _____

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Please answer the following questions if you have PAIN:

On a scale of 1-10 (1=no problem, 10= emergency room) what is the severity your pain currently:

Describe location:

Quality of pain (circle): dull sharp stabbing sore cramping throbbing burning
 constant radiating fixed moves about severe moderate

Pain radiates to:

Describe the onset of the pain:

Helps pain (circle): ice heat rest movement am pm dampness dry
 Increases pain (circle): ice heat rest movement am pm dampness dry

Do any movements increase the pain?

Does exercise affect your pain?

Do you get relief from medications/ if so please list?

Treatments you have had for this pain:

WESTERN MEDICAL HISTORY – Please circle the conditions you have.

- | | | | | |
|------------------|---------------------|---------------------|----------------------|------------------|
| Aids/ HIV | Constipation | Goiter | Lyme Disease | Scarlet Fever |
| Alcoholism | Cough | Gout | Measles | Seizures |
| Allergies | Depression | Headaches | Memory Loss | Sinus Problems |
| Anxiety | Diarrhea | Heart Attack | Menstrual Problems | Sore throat |
| Appendicitis | Diabetes | Heart Disease | Menopause | Stroke |
| Arteriosclerosis | Digestive Issues | Hepatitis: (circle) | Multiple Sclerosis | Stress |
| | | A B C D | | |
| Arthritis | Dizziness | Herpes | Night Sweats | Thyroid Disease |
| Asthma | Emphysema | High Blood Pressure | Osteoporosis | TMJ |
| Back Problems | Epilepsy | High Cholesterol | Pacemaker | Tuberculosis |
| Bladder Disease | Fatigue | Irritable Bowel | Pneumonia | Ulcers |
| Cancer | Frequent Urination | Insomnia | Polio | Venereal Disease |
| Chest Pain | Fibromyalgia | Joint Pain | Rheumatoid Arthritis | Other: |
| Colitis | Gallbladder Disease | Kidney Disease | Rheumatic Fever | |

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Pattern of Symptoms in TCM: *Please circle any symptoms you may have currently*

Emotional State Fatigue Stressed Frustrated Angry Repressed Irritable
 Worried Pensive Manic Joyful Sad Obsessive Grief Determined
 Fearful Happy/Content Shy Unfocused Depressed
 Other _____

How are your energy levels overall? (1 – Poor to 10 – Fantastic) _____

Lungs – *Please circle any symptoms you may have currently*

| | | |
|----------------------|-------------------|------------------------|
| Persistent Cough | Chronic Allergies | Dry/ flaky/ itchy skin |
| Nose Bleeds | Nasal Dryness | Sneezing |
| Difficulty Breathing | Sinus congestion | Sore throats |
| Wheezing | Cigarette Smoking | Allergies |

Have you ever smoked in the past, if so how long and how much/day?

Do you desire to stop smoking?

Kidney - *Please circle any symptoms you may have currently*

| | | | | | |
|--------------|--------------------|---------------------------|--|----------------------------|---------------------------|
| Cold Hands | Hot body temp | No sweating | Low back pain before period | Dizziness | Night time urination |
| Cold Feet | Cold Body temp | Night Sweats | Dark circles around eyes | Ringing in the ears | Hair loss |
| Sweat easily | Afternoon flushing | Lots of thirst day/ night | Feet cold, esp. at night | Low libido | Premature graying of hair |
| Sweaty palms | Hot flashes | Cold hips/ buttocks | Cold menstrual cramps | Loose stool in the morning | |
| Sweaty feet | Excessive sweating | Low back weakness/pain | Do you think you are colder than others? | Incontinence | |

Blood - *Please circle any symptoms you may have currently*

| | | | |
|---------------------------|--------------------------|-----------------------|-------------------|
| Menstruation: Early/ Late | Blurry vision | Fainting | Hair dry/ brittle |
| Dry Skin | Poor night vision | Weak or brittle nails | |
| Chapped Lips | Difficulty concentrating | Hair loss (head) | |

Heart - *Please circle any symptoms you may have currently*

| | | | |
|---------------------|---------------------|--------------------|--------------------|
| Palpitations | Extreme Shyness | Speech impediment | Restless dream |
| Anxiety | Forgetfulness | Hoarseness | Awaking from sleep |
| Mental Restlessness | Depression | Low Blood Pressure | Insomnia |
| Chest Pain | High Blood Pressure | Hot Hands | Arrhythmia |

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| | | | |
|-------------|---------------|------------------|-----------------------|
| Hemophilia | Heart Murmur | Hot Feet | Wake early in morning |
| Manic Moods | Tongue Ulcers | Rapid Heart Beat | |

Spleen - Please circle any symptoms you may have currently

| | | | |
|-----------------------|-----------------------|---------------------------------------|------------------------------|
| Poor Appetite | Indigestion | Tired around menstruation & ovulation | Bruise Easily |
| Heaviness in the Head | Sick more than others | Nausea | Spotting before menstruation |
| Crave Sweets | Feel heavy/ sluggish | Hypoglycemia | Cold Nose |
| Loose Stool | Bloated after eating | Energy lower after eating | Flatulence |
| Abdominal Pain | Varicose Veins | Poor circulation | |

Stomach - Please circle any symptoms you may have currently

| | | | |
|--------------------------------|---------------|--------------|---------------|
| Stomach ache | Stomach Ulcer | Acid Reflux | Vomit |
| Belching | Hiccups | Mouth Ulcers | Heartburn |
| Always Hungry, Never Satisfied | Bad Breath | Nausea | Bleeding Gums |

Liver and Gallbladder - Please circle any symptoms you may have currently

| | | | | |
|--------------------|---------------------------------------|------------------------|---------------------------|---------------------|
| Chest Pain | Breast Tenderness | Red Eyes | Depression | Pain in the Ribcage |
| Chest Tightness | Bitter Taste in Mouth in the Morning | Chronic Neck Tightness | Headaches | Migraines |
| All Over Body Pain | Alternating Diarrhea and Constipation | Shoulder Tension | Gallstones | Ringing in the ears |
| Convulsions | Irritability | Seizures | Painful periods | Skin Rashes |
| Numbness/ Tingling | Easy to Anger | Nipple Pain | Difficulty falling asleep | Muscle Spasms |
| Eye Dryness | Easily Frustrated | PMS | Easily overwhelmed | Acne |
| Muscle Cramps | Feeling of a Lump in the Throat | | | |

Digestion - Please circle any symptoms you may have currently

| | | | |
|--------------------|---------------------------|-----------------|------------------------|
| Loose Stool | IBS | Colitis | Small, Hard, Dry Stool |
| Mucus in the Stool | Constipation | Diarrhea | Crohn's Disease |
| Less than 1BM/day | Difficulty Passing Stools | Blood in Stools | Incomplete Stools |
| Eating Disorder | Painful BM | Burning of Anus | Hemorrhoids |

Urination - Please circle any symptoms you may have currently

| | | | |
|----------------------|--------------------|--------------|-------------------|
| Normal Color | Reddish | Small Amount | Dribbling |
| Dark Yellow | Cloudy | Large Amount | UTI's |
| Clear | Strong smell | Frequent | Pain &/or Burning |
| Night Time Urination | Day Time Urination | | |

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Dampness - Please circle any symptoms you may have currently

| | | | |
|-------------------------------------|--|-----------------------|----------------------------------|
| Mental Cloudiness/ Forgetfulness | Low Mental Focus | Swollen Feet | Edema: Upper Lower Abdomen |
| Mental Sluggishness | Heaviness in the Head, Limbs and Body | Joint Stiffness/ Pain | Chest Congestion |
| Mental Disorder | Swollen Hands | | |

Libido - Please circle any symptoms you may have currently

| | | |
|--------|---------|-----------|
| Normal | High | No Desire |
| Other | Explain | |

Women's Health

Are you pregnant or possibly pregnant? Yes or No

(Please notify acupuncturist if this status changes at any time during your care at the clinic)

Please circle any symptoms you may have currently

| | | |
|--------------------|------------------------|---------------|
| Polycystic Ovaries | Uterine Fibroids | Endometriosis |
| Hysterectomy | Irregular Menstruation | |

Age at menarche: _____ Age of menopause (if applicable) _____

The first day of your last period? _____

Do you take Birth Control? Yes No If so, which one? _____

Number of days between Periods? _____ How long do you menstruate? _____

Do you have a regular flow? Yes No How heavy? Light Medium Heavy

What color? Light red Dark red Bright red other

Do you have clots? Yes No Do you have spotting? Yes No

Do you have pain with menstruation? Yes No (if yes) Dull Sharp Where?

Do you have leucorrhea? Yes No Do you have nipple discharge? Yes No

Do you have a change in bowel movements around menstruation? Yes No

Do you see a Gynecologist on a regular basis? Yes No

How many children do you have? _____

How many pregnancies have you had? _____

Any premature births? _____

Any miscarriages? _____

Any cesarean operations? _____

Any complications during pregnancy? _____

