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Patient Intake Form

Please complete this form as thoroughly as possible; all answers are confidential.

GENERAL INFORMATION

Name _____ Gender M F Date _____

Address _____ City _____ State _____ Zip _____

Email _____

Phone: Home _____ Work _____ Cell _____
(please indicate preferred contact number)

Occupation _____ Employer _____

Date of Birth _____ Age _____ Height _____ Weight _____

Single Married Partnered Widowed Separated/Divorced

Emergency contact _____ Relation _____

Emergency contact number: Home _____ Cell _____

Name of physician _____ Phone number _____
(No contact will be made without your permission)

Your signature _____

GOALS — What health concerns would you like to address through treatment

LIFESTYLE HABITS

Alcohol (drinks per week) _____ Coffee/Tea (cups per day) _____ Soda (regular or diet) _____

Cigarettes (packs per day) _____ Drug use (recreational) _____

Exercise Yes No How often? _____

What kind of exercise? _____

FAMILY HISTORY — Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse/partner	children
Adopted						
Good health						
Alcohol or other drug use						
Depression or mental illness						
Allergies						
High blood pressure/heart disease/stroke						
Cancer or tumors						
Diabetes						
Seizures						
Hepatitis/other liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Blood or bleeding disorders/anemia						
Thyroid disorders						
Kidney disorders						
Deceased (age)	N/A					

MEDICAL If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

Year	Operation/Illness	Hospital or Treatment Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICINES Please list all medications, vitamins and/or food supplements you are currently taking:

Medications	Dosage	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins & Supplements	Dosage	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

CONDITIONS/SYMPTOMS — Please mark any condition you have experienced in the past or currently.

Temperature (Kidney)

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cold hands |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold fingers |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold toes |
| <input type="checkbox"/> | <input type="checkbox"/> | Sweaty hands |
| <input type="checkbox"/> | <input type="checkbox"/> | Sweaty feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot overall |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold overall |
| <input type="checkbox"/> | <input type="checkbox"/> | Afternoon flushes |
| <input type="checkbox"/> | <input type="checkbox"/> | Night sweats |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat in the hands, feet, and chest |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Thirsty |
| <input type="checkbox"/> | <input type="checkbox"/> | Perspire easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of perspiration |
| <input type="checkbox"/> | <input type="checkbox"/> | Take water to bed |

Energy (Lung/Kidney)

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty keeping eyes open during day |
| <input type="checkbox"/> | <input type="checkbox"/> | General weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily catch colds |
| <input type="checkbox"/> | <input type="checkbox"/> | Low energy |
| <input type="checkbox"/> | <input type="checkbox"/> | Feel worse after exercise |

Blood (Liver/Spleen/Heart)

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | See floating black spots |

Heart Function

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Palpitations |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Sores on the tip of the tongue |
| <input type="checkbox"/> | <input type="checkbox"/> | Restlessness |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental confusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain traveling to shoulder |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent dreams |
| <input type="checkbox"/> | <input type="checkbox"/> | Wake unrefreshed |

Lung Function

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Nasal discharge, color: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose bleeds |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Congestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry mouth |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry nose |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory allergies, to what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Alternating chills & fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Sneezing |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache, location: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Overall achy feeling |
| <input type="checkbox"/> | <input type="checkbox"/> | Stiff neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Stiff shoulders |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Sadness |
| <input type="checkbox"/> | <input type="checkbox"/> | Melancholy |

Spleen Function

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Low appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Abrupt weight gain |
| <input type="checkbox"/> | <input type="checkbox"/> | Abrupt weight loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal bloating |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal gas |
| <input type="checkbox"/> | <input type="checkbox"/> | Gurgling In stomach |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue after eating |
| <input type="checkbox"/> | <input type="checkbox"/> | Prolapsed organs (diagnosed): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily bruised |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> | Pensive |
| <input type="checkbox"/> | <input type="checkbox"/> | Over-thinking |
| <input type="checkbox"/> | <input type="checkbox"/> | Worry |

Spleen, Stomach, Large Intestine Function

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Loose stool |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipated |
| <input type="checkbox"/> | <input type="checkbox"/> | Incomplete evacuation |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood In stools |
| <input type="checkbox"/> | <input type="checkbox"/> | Mucous In stools |
| <input type="checkbox"/> | <input type="checkbox"/> | Undigested food in stools |

Dampness

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | General sensation of heaviness |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental heaviness |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental sluggishness |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental fogginess |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen hands |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest congestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Snoring |

Stomach Function

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Burning sensation after eating |
| <input type="checkbox"/> | <input type="checkbox"/> | Large appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Bad breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth (canker) sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding, swollen or painful gums |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | Acid regurgitation |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer (diagnosed) |
| <input type="checkbox"/> | <input type="checkbox"/> | Belching |
| <input type="checkbox"/> | <input type="checkbox"/> | Hiccups |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |

Eyes (Liver Function)

- | <i>past</i> | <i>current</i> | |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Itchy |
| <input type="checkbox"/> | <input type="checkbox"/> | Bloodshot |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry |
| <input type="checkbox"/> | <input type="checkbox"/> | Watery |
| <input type="checkbox"/> | <input type="checkbox"/> | Gritty |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurry vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased night vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Near-sighted |
| <input type="checkbox"/> | <input type="checkbox"/> | Far-sighted |

Liver/Gall Bladder Function

past current

- Alternation diarrhea & constipation
- Chest pain
- Tight sensation in chest
- Bitter taste In mouth
- Anger easily
- Frustration
- Depression
- Irritability
- Frequently unable to adapt to stress; cause of stress: _____
- Skin rashes
- Headache: at top of head
- Tingling sensation
- Numbness
- Muscle spasms
- Muscle twitching
- Muscle cramping
- Seizures
- Convulsions
- Lump in throat
- Neck tension
- Neck: limited range-of-motion
- Depression
- Shoulder tension
- Shoulder: limited range-of-motion
- High-pitched ringing in ears
- Gall stones
- Sexually transmitted disease (s); specify: _____

Kidney/Urinary Bladder Function

past current

- Frequent cavities
- Easily broken bones
- Sore knees
- Weak knees
- Cold sensation in knees
- Low back pain
- Memory problems
- Wake frequently to urinate
- Low-pitched ringing in ears
- Kidney stones
- Bladder infections
- Lack of bladder control
- Fear
- Easily startled
- Excessive hair loss

Urination

past current

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Blood
- Painful
- Discharge
- Difficult
- Urgent
- Frequent

Male — Genital

past current

- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles
- Increased libido
- Decreased libido
- Other (describe) _____

Women — Gynecology

past current

- Menopause
- Irregular periods
- Menstrual cramps
- Excessive blood flow
- Menstrual blood clots
- Abnormal pap smear
- Vaginal infections
- Vaginal pain/itching
- Uterine fibroids
- Endometriosis
- Breast tenderness
- Breast lumps, cysts
- Increased libido
- Decreased libido
- Other (describe) _____

Currently pregnant: trimester _____

Past pregnancies:

of live births: _____

of miscarriages _____

of abortions _____

Other Information

Patient Signature _____

Date _____