Traditional Chinese Medicine

Intake Form

All information is Strictly Confidential

Health Record

Name: _____ Age: _____ Date of Birth: ____(M)/____(D)/____(Y)

Address: _____ City: _____ Height: _____ Weight: _____

Occupation: _____ Prov: _____ Postal Code: _____

Tel. (Cell): _____ Email: _____

Emergency Contact: _____ Tel. (Work): _____

Referred By: _____ Family Physician: _____

Have you received acupuncture or Chinese herbs before? Y ☐ N ☐

Main reason(s) you are seeking treatment: _____

When did this condition begin? _____

Have you been given a diagnosis by a Doctor? If so, what? _____

Health History

- ☐ Cancer, Type: _____
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Allergies / Asthma
- ☐ AIDS / HIV+
- ☐ Arthritis
- ☐ Herpes
- ☐ Anemia
- ☐ Mental Illness
- ☐ Other Illness: _____ _____

Surgeries (Year): _____

Significant traumas (accidents, falls, etc.) or illness (year): _____

Allergies: _____

Medications - Please list all supplements, prescription and non-prescription drugs you are currently taking. Please include type (pills, tablets, liquids, sprays, suppositories, etc.,) and specify dosage:

_____

_____

_____

Occupational Stresses (Chemical, Physical, Psychological): _____

Do you exercise regularly?: Y ☐ N ☐ Describe: _____

Habits/Frequency

_____ Cigarettes/Day _____ Recreational Drugs/Week

_____ Alcohol/Week _____ Glasses Water/Day

_____ Caffeine/Day _____ Other(s)

What relieves the pain (heat, cold, massage, rest, exercise, etc.)?

_____

What aggravates the pain (weather, heat, cold, etc.)?

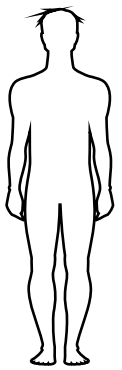
_____

Are you pain free?

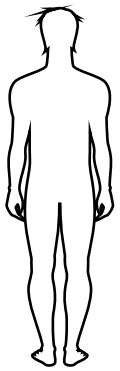
(no pain) (severe pain)

1 2 3 4 5

On the figures, please mark the areas of pain/concern:



FRONT



BACK

Sensations/Pain:

- ☐ Sharp
- ☐ Tingling
- ☐ Burning
- ☐ Dull
- ☐ Moves
- ☐ Severe
- ☐ Shooting
- ☐ Numbness

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Currently Seeing the Following Professional:

- ☐ Chiropractor
- ☐ Naturopath
- ☐ Physiotherapist
- ☐ Massage Therapist
- ☐ Other: _____

Cardiovascular:

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Palpitations
- ☐ Low Blood Pressure
- ☐ Fainting
- ☐ Neck Stiffness
- ☐ Chest Pain or Tightness
- ☐ Cold Hands/Feet
- ☐ Difficulty Breathing
- ☐ Irregular Heartbeat
- ☐ Swelling in hands/ankles/feet
- ☐ Poor Circulation
- ☐ Other: _____

Respiratory:

- ☐ Chronic Cough
- ☐ Pneumonia
- ☐ Production of Phlegm What colour?: _____
- ☐ Coughing Blood
- ☐ Hay Fever/Allergies
- ☐ Asthma
- ☐ Sinus Problems
- ☐ Bronchitis
- ☐ Tight Chest
- ☐ Difficulty Breathing When Lying Down
- ☐ Other: _____

Gastrointestinal:

- ☐ Nausea
- ☐ Gas
- ☐ Vomiting
- ☐ Pain or Cramps
- ☐ Belching
- ☐ Hiccups
- ☐ Sensitive Abdomen
- ☐ Bad Breath
- ☐ Hemorrhoids
- ☐ Rectal Pain
- ☐ Itchy Anus
- ☐ Black Stool
- ☐ Bloody Stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Alternating Loose/Constipation
- ☐ Laxative use: _____ /Week Type: _____
- ☐ Other: _____

Bowel Movements:
Frequency: _____
Colour: _____
Odor: _____
Texture/Form: _____

Muscle and Joints:

- ☐ Neck Pain
- ☐ Spinal Curvature
- ☐ Weakness
- ☐ Muscle Pain
- ☐ Difficulty Walking
- ☐ Body Heaviness
- ☐ Body Aches/Stiffness
- ☐ Joint Pains (Where): _____
- ☐ Back Pain (Where): _____
- ☐ Other: _____

Neuropsychological/Emotions:

- ☐ Seizures
- ☐ Easily Stressed
- ☐ Anxious
- ☐ Relaxed/Calm
- ☐ Sadness
- ☐ Grief
- ☐ Fearful
- ☐ Anxiety
- ☐ Depression
- ☐ Angry/Frustrated
- ☐ Irritability Often/Easily
- ☐ Poor Memory
- ☐ Bad Temper
- ☐ Over Thinking
- ☐ Manic
- ☐ Impatient
- ☐ Concussion
- ☐ Areas of Numbness
- ☐ Considered/Attempted Suicide
- ☐ Treated for Emotional Problems
- ☐ Other: _____

Genito-Urinary:

- ☐ Pain on Urination
- ☐ Unable to Hold Urine
- ☐ Urgency to Urinate
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Excessive or Scanty Urination
- ☐ Bedwetting
- ☐ Kidney Stones
- ☐ Venereal Disease
- ☐ Pain/Itching Genitalia
- ☐ Genital Lesions/Discharge
- ☐ Impotency
- ☐ Decreased Libido
- ☐ Wake up to Urinate _____ /Night; Time: _____
- ☐ Other: _____

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Ears:

- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Earaches
- ☐ Other: _____

Eyes:

- ☐ Eyestrain
- ☐ Eye Pain
- ☐ Poor Vision
- ☐ Night Blindness
- ☐ Colour Blindness
- ☐ Cataracts
- ☐ Blurry Vision
- ☐ Spots/Floaters
- ☐ Glasses
- ☐ Red/Burning Itchy Eyes
- ☐ Other: _____

Nose, Throat, Mouth, Head:

- ☐ Teeth Problems
- ☐ Dizziness
- ☐ Enlarged Lymph Glands
- ☐ Mucus
- ☐ Gum Problems
- ☐ Nose Bleeds
- ☐ Migraines
- ☐ Dry Mouth/Thirsty
- ☐ Swollen Glands
- ☐ Dry Mouth
- ☐ Sinus Problems
- ☐ Recurrent Sore Throats
- ☐ Copious Saliva
- ☐ Grinding Teeth
- ☐ Dry Throat
- _____ /Month
- ☐ Sores on Lips or Tongue
- ☐ Facial Pain
- ☐ Bitter Taste in Mouth
- ☐ Other: _____

Skin and Hair:

- ☐ Itching/Dryness
- ☐ Hives
- ☐ Hot Flashes
- ☐ Dandruff
- ☐ Eczema/Psoriasis
- ☐ Rashes
- ☐ Night Sweats
- ☐ Nails Break Easily
- ☐ Acne
- ☐ Changes in Hair/Skin Texture
- ☐ Loss of Hair
- ☐ Bruise Easily
- ☐ Ulcerations
- ☐ Easily/Spontaneous Sweating
- ☐ Other: _____

How Well Do You Sleep?:

- ☐ Sound/Restful
- ☐ Dream Disturbed
- ☐ Difficulty Falling Asleep
- ☐ Wake Up Easily/Early
- ☐ Insomnia
- ☐ Heavy Sleep
- ☐ Vivid Dreams/Nightmares
- ☐ Light Sleep
- ☐ Hours of Sleep/Night: _____

Are you stressed or relaxed?: (relaxed) 1 2 3 4 5 (stressed)

What is your energy level?: (relaxed) 1 2 3 4 5 (stressed)

Appetite?:

- ☐ Normal/Healthy
- ☐ Ravishing Hunger
- ☐ Need to eat several meals
- ☐ Hungry, but no appetite
- ☐ Poor Appetite
- ☐ Any taste in mouth? _____

Preferred Flavour: ☐ Bitter ☐ Sweet ☐ Spicy ☐ Salty ☐ Sour Preferred Drinks: ☐ Warm ☐ Cold ☐ Other: _____

For Women - Pregnancy and Gynecology:

- ☐ Clots
- ☐ Irregular Periods
- ☐ Birth Control Type: _____
- ☐ Number of Pregnancies: _____
- ☐ Vaginal Sores
- ☐ Age at First Menses: _____
- ☐ Birth Control Duration: _____
- ☐ Number of births: _____
- ☐ Vaginal Discharged
- ☐ Flow (Describe): _____
- ☐ Last Pap Smear: _____
- ☐ Miscarriages: _____
- ☐ Breast Lumps
- ☐ Last Menses: _____
- ☐ Currently Pregnant
- Premature Births: _____
- ☐ Menopause
- ☐ Menses Duration: _____
- ☐ Currently Nursing