Detailed Intake Form

Family Medical History

Please check all that apply and list which family members have/had those.

- ☐ Alcoholism
- ☐ Allergies
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune Disease
  What kind? ______________________________
  ____
- ☐ Cancer/Tumor (What Kind?)
  ____
  ____
  ____
  ____
- ☐ Diabetes: Type I or II
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Obesity
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other

Your Past Medical History

Please check all that apply and write the age when you had that symptoms/disease.

- ☐ Acne
- ☐ Acid Reflux
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune Disease
  What kind?
- ☐ Birth Trauma
- ☐ Blood Disorder
- ☐ Cancer/Tumor
  What kind?
- ☐ Chicken Pox
- ☐ Chronic Bronchitis
- ☐ Chronic Fatigue Syndrome
- ☐ Depression
- ☐ Diabetes Type I or II
- ☐ Digestive Disorder
- ☐ Ear/Sinus Infections
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infection
  What kind?
- ☐ Insomnia
- ☐ Intestinal Disorder
- ☐ Lupus
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Parasites
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Skin Disorder
- ☐ Strep Throat
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Varicose Vein
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other (Specify)
  ____

Please list any major physical or emotional traumas (accidents, falls, abuse, etc.), hospitalizations or severe illnesses (include year): ______________________________

____

____

Please list any past surgeries (include dates): ______________________________

____

Please list pharmaceutical drugs taken within the last year: ______________________________

____

Please list Chinese herbal formula taken before: ______________________________

____

Please list vitamins, herbs, supplements taken within the last year: ______________________________

____

Diet & Lifestyle

Appetite ☐ Low ☐ Moderate ☐ High

Thirst ☐ Low ☐ Moderate ☐ High

How many glasses of water/liquid do you drink per day? __________

I prefer ☐ Hot ☐ Cold foods and drinks

I tend to crave ☐ Sour ☐ Bitter ☐ Sweets ☐ Spicy/Pungent ☐ Salty

I regularly consume ☐ Coffee ☐ Soft Drinks ☐ Artificial Sweetners ☐ Sugars ☐ Cand/frozen Food ☐ Fast Food ☐ Dairy ☐ White Flour

How often do you eat out? ______________________________

Average Daily Menu

Breakfast	Lunch	Dinner	Snacks

Do you smoke tobacco/cigar? ☐ No ☐ Yes: Frequency __________

Do you drink alcohol? ☐ No ☐ Yes: Frequency __________

Do you smoke marijuana? ☐ No ☐ Yes: Frequency __________

Do you use other recreational drugs? ☐ No ☐ Yes: Frequency __________

Do you watch television? ☐ No ☐ Yes: Frequency __________

Exercise & relaxation/meditation techniques practiced:

Type ______________________________ Frequency __________

Type ______________________________ Frequency __________

Please check all that apply (Past 3 months to present)

Jin/Metal – Fei/LU

- ◻ Allergies
- ◻ Catch cold/flue easily
- ◻ Chronic Cough
- ◻ Excessive Phlegm/Mucus
- ◻ Difficulty Exhaling
- ◻ Shortness of Breath
- ◻ Sinus infection
- ◻ Weak or Hoarse voice
- ◻ History of Asthma/Bronchitis
- ◻ Spontaneous Sweating
- ◻ Lack of Sweating
- ◻ Excessive sadness
- ◻ History of dry skin, itching, acne, or other skin condition ______________________________

Huo/Fire – Xin/HT

- ◻ Anxiety
- ◻ Chest Pain
- ◻ Easily startled
- ◻ Mouth/tongue ulcers
- ◻ Dream-disturbed sleep
- ◻ Insomnia
- ◻ Restless sleep
- ◻ Wake up easily
- ◻ Empty feeling/Lack of feeling
- ◻ Heart palpitations
- ◻ Irregular/rapid heartbeat
- ◻ Manic/Depressive Disorder

Tu/Earth – Pi/SP

- ◻ Acid regurgitation
- ◻ Abdominal distention
- ◻ Bad breath
- ◻ Belching
- ◻ Bloating after eating
- ◻ Tired after eating
- ◻ Constipation
- ◻ Blood/mucus in stools
- ◻ Fatigue, what time of the day? ______________________________
- ◻ Frequent Hiccup
- ◻ Flatulence/Gas fullness
- ◻ Intestinal pain/cramping
- ◻ Lack of appetite or taste
- ◻ Nausea or Vomiting
- ◻ Diarrhea or loose stool
- ◻ Hemorrhoids
- ◻ Lack of muscle strength
- ◻ Bodily Heaviness
- ◻ Stomach pain
- ◻ Bruise/bleed easily
- ◻ Worry or Over thinking
- ◻ Incomplete feeling after defecation
- ◻ Burning/itchy anus

Bowel movements: ________ times/day Loose Normal Hard Irregular shape ________________

Mu/Wood – Gan/LV

- ◻ Easy to get angry
- ◻ Easily get stressed
- ◻ Depression
- ◻ Moody
- ◻ Irritability
- ◻ Rib pain
- ◻ Joint pain or weakness
- Eye: ◻ red ◻ dry ◻ itchy
- ◻ Blurred vision
- ◻ Nearsightedness or Farsightedness
- ◻ Corrective lenses
- ◻ Seeing spots in eyes
- ◻ Swollen glands
- ◻ Red face & ears
- ◻ Grinding teeth
- ◻ TMJ Problem
- ◻ Vertigo/dizziness
- ◻ Neck or Should tension
- ◻ Alternating constipation/diarrhea
- ◻ Brittle nails
- ◻ Migraine

Stress level ◻ Low ◻ Moderate ◻ High

Headaches: How often ________________ Location ______________________________

Pain quality ______________________________ Pain severity (1-10) ____________

Shui/Water – Shen/KD

- ◻ Afternoon fever
- ◻ Cold hands/feet
- ◻ Chronic sore throat
- ◻ Difficulty inhaling
- ◻ Fearful
- ◻ Frequent urination
- ◻ History of Kidney stones
- ◻ Heal pain
- ◻ Hip pain
- ◻ Knee pain or weakness
- ◻ Low back pain
- ◻ Poor memory or concentration
- ◻ Burning or painful urination
- ◻ History of urinary tract infections
- ◻ Poor hearing
- ◻ Premature hair loss or graying of hair
- ◻ Dry or thin hair
- ◻ Night sweating
- Ear ringing: ◻ high pitch ◻ low pitch ◻ high volume ◻ low volume
- ◻ Night time urination

Sex drive: ◻ Normal ◻ Moderate ◻ High

Gynecology

Age menses began ________________ Date last period began ________________

Length of menses ___________ days Length of menstrual cycle ___________ days

Day(s) of heavy menstrual flow ________ day(s) Days of light menstrual flow _________ days

Blood color ☐ Pink ☐ Red ☐ Dark red ☐ Purple Low back pain ☐ Yes ☐ No

Blood clotting ☐ Yes ☐ No Size ______________ Amount _________________

Cramping ☐ Yes ☐ No Location __________________ Irregular menstrual cycle ☐ Yes ☐ No

PMS ☐ Yes ☐ No If yes, pleas describe ____

Vaginal sores ☐ Yes ☐ No Breast lumps ☐ Yes ☐ No

Vaginal discharge: Color ________________ Quantity _______________ Odor _______________

Number of pregnancies ______ Age ___________ Number of live birth _____ Age __________

Number of miscarriages/abortions _____________ Age ____________________

Date of last gynecological exam _________________

Oral contraceptives	☐	No	☐	Yes	______________
Sexually transmitted diseases	☐	No	☐	Yes	______________
Endometriosis	☐	No	☐	Yes	______________
Ovarian cysts	☐	No	☐	Yes	______________
Fibroids	☐	No	☐	Yes	______________
Vaginal infections	☐	No	☐	Yes	______________
Yeast infections	☐	No	☐	Yes	______________
Hysterectomy	☐	No	☐	Yes	______________
Other	☐	No	☐	Yes	______________

Male Health

Enlarged prostate/BPH	☐	No	☐	Yes	______________
Frequent/Difficult/Painful urination	☐	No	☐	Yes	______________
Erectile dysfunction/Impotence	☐	No	☐	Yes	______________
Pain in testicles or penis	☐	No	☐	Yes	______________
Sexually transmitted disease	☐	No	☐	Yes	______________
Other	☐	No	☐	Yes	______________