

ORIENTAL MEDICINE INTAKE FORM

Name: _____ Date: _____

Address: _____ Phone: _____

Email: _____ Referred by: _____

PRESENT HEALTH CONCERNS: Please list your most important health concerns in order of their significance.

1. _____ Approx. Date of Onset: _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other _____

2. _____ Approx. Date of Onset: _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other _____

3. _____ Approx. Date of Onset: _____

Does it interfere with your: Work Sleep Daily Routine Recreation

Other therapies tried: Medications Surgery Chiropractic Phys. Therapy Other _____

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Please list **allergies** that you have to any of the following:

Drugs: _____ Foods: _____

Other (i.e. pollen, paint, etc.): _____

HEALTH HISTORY

Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations, with approx. dates.

Personal Habits:

Tobacco packs/day _____
 Alcohol drinks/wk _____
 Coffee/tea/cola cups/day _____
 Recreational drugs times/wk _____

High Stress Level Reason _____

Do you follow any diet regimens/restrictions?

Yes No

If Yes, describe: _____

Work Activity:

Sitting % of time _____
 Standing % of time _____
 Light labor % of time _____
 Heavy labor % of time _____

Exercise:

Do you exercise regularly? Yes No

If Yes, describe & tell how

often: _____

FAMILY INFORMATION

Do you have children? Yes No If Yes, how many? _____ Ages _____

Are you, or could you be currently pregnant? Yes No Due date _____

Please check if you have had (in the **last three months**)

GENERAL

- | | | |
|--|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Fevers/Chills | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Poor sleeping |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Heavy sleeping |
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Bleed / bruise easily | <input type="checkbox"/> Dream disturbed sleep |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Peculiar tastes | (time?) | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Fatigue | |

SKIN AND HAIR

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Rashes/Hives | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Fungal infections |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Change in hair or skin texture |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Pimples/Acne | |

Other hair or skin concerns:

HEAD, EYES, EARS, NOSE, AND THROAT

- | | | |
|---|---|---|
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Earaches/Infections | <input type="checkbox"/> Sores on lips/tongue |
| <input type="checkbox"/> Eye strain/pain | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Excessive saliva |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> Excessive tearing | <input type="checkbox"/> Excessive phlegm – color _____ | <input type="checkbox"/> TMJ disorder |
| <input type="checkbox"/> Poor/blurry vision | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Recurrent sore throats | |
| <input type="checkbox"/> Cataracts/Glaucoma | | |
| <input type="checkbox"/> Headaches (location, triggers, severity)? | | |

Other head & neck concerns:

CARDIOVASCULAR

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands | |

Other heart or blood vessel concerns:

RESPIRATORY

- | | |
|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pain with deep breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of breath |

Tight chest

Production of phlegm - color? _____
Is it thick or thin

Other lung related concerns:

GASTROINTESTINAL

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Belching | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Itchy anus |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Burning anus |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Black stools | <input type="checkbox"/> Hemorrhoids/fissures |
| <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Mucus in stools | |
| <input type="checkbox"/> Hiccups | <input type="checkbox"/> Acid Regurgitation | |

History of chronic laxative use?

Other concerns with your general digestion:

GENTIO-URINARY

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Nocturnal emissions |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Impotency | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Frequent urinary tract infections |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Chronic yeast infection |
| <input type="checkbox"/> Decrease in flow | | |

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

- | | | |
|---|---|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Cramps/spasms | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Lower back pain | <input type="checkbox"/> General joint pain/stiffness | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Hand/wrist pains | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Joint with limited range of motion_____ |
| <input type="checkbox"/> Muscle pains | | |

Other muscle, joint or bone concerns:

NEUROPSYCHOLOGICAL

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Easily susceptible to stress |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Concussion | <input type="checkbox"/> History of emotional/physical abuse |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Irritability | |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

GYNECOLOGY

Age of first menses_____ If no longer menstruating, approximate date ceased_____

First day of last menses_____ Length between menses:_____days Duration of period:_____days

- | | | |
|---|---|--|
| <input type="checkbox"/> Unusual flow (<input type="checkbox"/> heavy or <input type="checkbox"/> light) | <input type="checkbox"/> Clots in flow | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal discharge – color_____ | <input type="checkbox"/> Vaginal sores |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal odor | <input type="checkbox"/> Hot flashes |
| | | <input type="checkbox"/> Breast lumps/soreness |

GYNECOLOGY (continued)

Changes in body or psyche prior to menstruation ("PMS"):

Date of last PAP: _____ Results were: normal abnormal unsure
If you use birth control, what type & for how long?

Have you ever used hormonal methods for contraception or period regulation?
(i.e. the pill, Depo-Provera, etc.)

Other gynecological concerns:

PREGNANCY HISTORY

Number of pregnancies _____ Births _____ Miscarriages _____ Abortions _____
Were your births relatively normal? Explain:

Other related concerns:

COMMENTS

Please let us know of any other concerns you would like to address:

Family History: Please fill in the boxes for each condition that applies to one of your family members.

	Yes	Who	Comments
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc)			
Skin disorders (eczema, psoriasis, etc.)			
Seizure disorders			