Patient Intake Form

Patient Name:______________________________Age:_____Date of Birth:___/___/___

Height:________Weight now:_______one year ago:_____ Do you smoke? Y/N

Main problem(s): You would like treated____

When did this problem begin?____

What are the possible causes of current issue(s)?____________________________________

Have you been given a diagnosis for this problem? If so, what?______________________

To what extent does this problem interfere with your daily activities (work, sleep, etc.)?

____

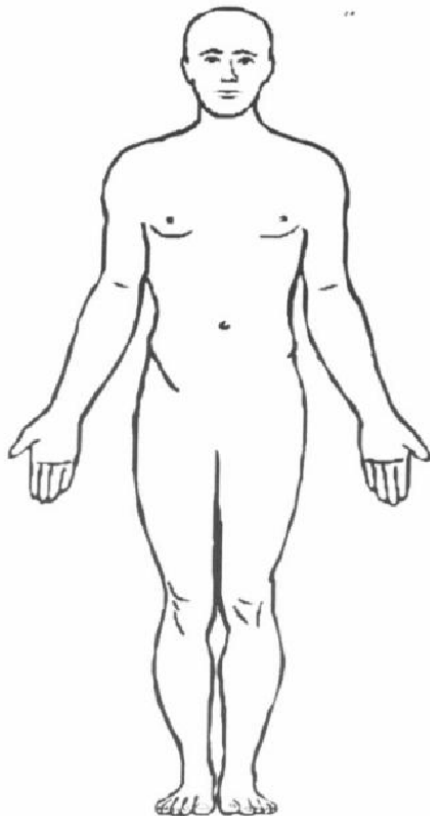
What kind of treatment(s) have you tried?____

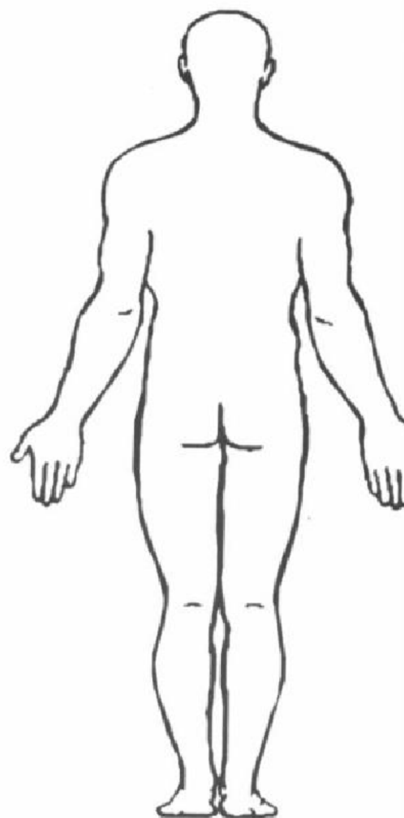
What makes this problem worse?____

What makes it better?____

Is there anybody in your family with the same/similar problem?_____________________

Indicate painful or distressed area:





Please check if you have any of the following diseases or conditions.

□Poor appetite(胃口差) □Poor sleeping(睡眠差) □Fatigue(乏力) □Fevers(发热)

□Chills(发冷) □Night sweats(盗汗) □Sweat easily(自汗) □Tremors(震颤，发抖)

□Desire for spicy food(嗜食辛辣食物) □Desire cold foods(嗜食冷饮)

□Strong thirst (cold or hot drinks) (烦渴)

□Cold hands/feet(手足冷) □Swelling of hands/feet(手足肿胀) □Numbness(麻木)

□Tingling(刺痛)

□Fainting(头晕) □Blurry vision(视力模糊) □High/Low blood pressure(高/低血压)

□Palpitation(心慌) □Chest pain(胸痛) □Bleed or bruise easily(容易出血或瘀青)

□Earaches(耳痛) □Ringing in ears(耳鸣) □Poor hearing(耳聋) □Bad breath(口臭)

□Persistent cough(持续性咳嗽) □Coughing blood(咯血)

□Production of phlegm (痰) – What color?_________________

□Bloating(腹胀) □Abdominal pain/cramps(腹痛/抽筋) □Indigestion(消化不良)

□Acid Reflux(胃酸反流) □Nausea(恶心) □Vomiting(呕吐) □Belching(嗳气)

□Diarrhea(腹泻) □Constipation(便秘) □Gas(放屁) □Black stools(黑便)

□Blood in stools(便血) □Hemorrhoids(痔疮)

Frequency of bowel movements (大便次数)_______

□Frequent urination(尿频) □Urgent to urinate(尿急) □Pain on urination(尿痛)

□Blood in urine(血尿) □Unable to hold urine(遗尿) □Dribbling(尿淋漓不尽)

□Pause of flow(尿中断)

Female

First day of last period (末次月经的第一天)______ Age of first menses(初潮年龄)___

Duration of periods(经期) ____days, cycle (周期)____days

□Clots(血块) □Hot flashes(崩漏) □Irregular periods (月经不调) □Pain/cramps prior/during periods(经期/经间期疼痛、痉挛) □Vaginal/genital discharge (分泌物异常) □Breast tenderness (乳房触痛) □Breast lumps (乳房肿块)

□Endometriosis(子宫内膜异位症) □Fibroids(纤维瘤) □Ovarian cysts (卵巢囊肿)

□Fertility problems (生育障碍)

Male

□Prostate problems (前列腺问题) □Discharge(分泌物异常) □Impotence(性无能)

□Frequent seminal emission(频繁遗精) □Fertility problems(生育问题)

□Ejaculation problems (射精问题) □Painful/swollen testicles(睾丸疼痛/肿胀)

□Other(其它) ____

Recent Medical Tests or Procedures (please indicate test results and dates below)

____

____

Past Medical History: (Please include month/year when the diagnose was established)

□Cancer(癌症) □Diabetes(糖尿病) □Hepatitis(肝炎) □Thyroid Dz(甲状腺疾病)

□Seizures(癫痫) □Fibromyalgia(纤维肌痛) □Arthritis(关节炎) □TB(结核病)

□Anemia(贫血) □Hypertension(高血压) □Asthma (哮喘)

□Heart Dz(心脏病) □Digestive Disorder(消化障碍) □HIV/AIDS Positive(艾滋病)

□Venereal Dz(性病) □Other(其它) (please specify):______________________________

Surgeries (手术)______________________**Hospitalization** (住院)___________________

Significant trauma(严重外伤)____

Allergies(过敏) to: ____

Family Medical History (Please specify family member) __________________________

□Hypertension(高血压) □Heart Dz(心脏病) □Stroke(中风) □Asthma(哮喘)

□Alcoholism(酗酒) □Cancer(癌症) □Miscarriage(流产)

□Diabetes(糖尿病) □Other(其它) ____

Medicines: Taken within the last two months (Including vitamins, over the counter drugs, herbs, etc.)

1. Name:_______________________ Dosage:__________ Purpose:____________________
2. Name:_______________________ Dosage:__________ Purpose:____________________
3. Name:_______________________ Dosage:__________ Purpose:____________________

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature: _________________________ **Date:**____/____/____

□Adult Patient □Parent or Guardian □Spouse