ORIENTAL MEDICAL ARTS

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PATIENT INTAKE FORM

Name_____Date of Birth_____

Address_____City_____State_____Zip_____

Day Phone_____Evening Phone_____Cell_____

e-mail address_____

In case of emergency contact_____

Address (if different from above)_____

Phone_____ Relationship_____

Please describe the reason for your visit today (Chief Complaint, including date of onset)_____

_____

Please list any secondary complaints: _____

_____

Is it getting better, worse, or staying the same?_____

_____

Are you, or have you been, treated for this problem with any other health professionals?

_____

Has it been effective?_____

What was your diagnosis?_____

What is your age? _____ Birthdate: _____

Are you ☐ Female or ☐ Male

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CURRENT HEALTH STATUS

Current stress level: ☐ Low ☐ Medium ☐ High Current weight _____

Any recent use of antibiotics? ☐ Yes ☐ No Current height _____

Your last Cholesterol Level was: _____ Your Last Blood Pressure Reading: _____

List any medication, supplements &/or herbs you are currently taking and why:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

☐ If you need more room please check this box and continue on the pack of the page.

Do you have a pacemaker or other medical device? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

Do you have any of the following:

- ☐ A change in bowel or bladder habits
- ☐ A sore that doesn't heal
- ☐ Any unusual bleeding or discharge
- ☐ Thickening or lump in breast or elsewhere
- ☐ Indigestion or difficulty swallowing
- ☐ Obvious change in mole or wart
- ☐ Prolonged cough or hoarseness

PAST MEDICAL HISTORY

List any accidents, surgeries or hospitalizations, including approximate dates:

1. _____ 2. _____

3. _____ 4. _____

Indicate any significant illness you have now or have had in the past: ☐ Arthritis ☐ Asthma ☐ Anemia

☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Stroke ☐ Kidney or bladder trouble ☐ Gallstones ☐ Ulcers

☐ High blood pressure ☐ Chronic fatigue ☐ Hepatitis ☐ Jaundice ☐ sudden weight gain or loss

☐ Emotional Disorders ☐ HIV

Other: _____

Please indicate the use and frequency of the following substances:

Tobacco: _____ Marijauana: _____ Coffee/Black Tea: _____

Alcohol: _____ Recreational Drugs: _____

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GENERAL HEALTH QUESTIONNAIRE

BODY TEMPERATURE: In general your body temperature is:

☐ cold all over ☐ cold hands & feet ☐ feel hot most of time ☐ hot flashes ☐ normal

PERSPIRATION: Do you: ☐ sweat too easily ☐ sweat only on exertion ☐ rarely sweat ☐ night sweat

SKIN: Is you skin: ☐ dry ☐ itchy ☐ moist/clammy ☐ burning ☐ bruise easily (black & blue spots)

Do you have: ☐ skin rashes ☐ acne ☐ dry scalp ☐ hair loss/thinning ☐ hives

HEADACHES/DIZZINESS: Do you get headaches ☐ Yes ☐ No

If you answered yes, how often do you get them? ☐ daily ☐ weekly ☐ monthly ☐ rarely

Where do you feel the pain? ☐ frontal/sinus ☐ temples ☐ back of head ☐ top of head ☐ all over

Do you have dizziness? ☐ Yes ☐ No

PAIN:

Are you currently having pain? ☐ Yes ☐ No

Is you pain best described as: ☐ dull/achy ☐ Sharp/stabbing ☐ heavy sensation ☐ moves around

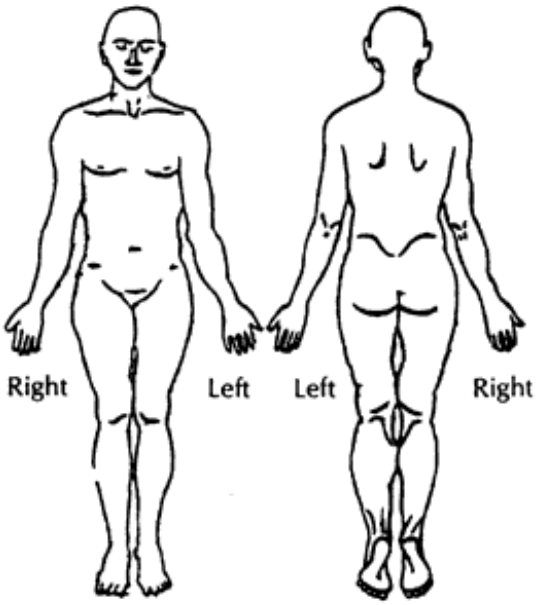
Your pain is better with: ☐ heat ☐ cold ☐ moving around ☐ no change

The type of weather that makes your pain worse is: ☐ hot ☐ cold ☐ damp ☐ no change

On a scale of 1-10, your pain is <u>usually</u>: (where 1 is mild and 10 is the worst pain you can imagine)

please circle answer 1 2 3 4 5 6 7 9 10

Today your pain is: 1 2 3 4 5 6 7 9 10



Please mark with an “X” any places that you experience pain.

Please mark with an “O” any places that you experience numbness, tingling &/or “needles & pins” sensation.

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APPETITE/THIRST

How many times per day do your eat including snacks? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ more

Your appetite is: ☐ low ☐ medium ☐ excessive

Do you crave foods that are: ☐ sweet ☐ salty ☐ oily ☐ other _____

The amount of thirst you experience is: ☐ low ☐ medium ☐ excessive

To quench your thirst you usually drink: ☐ water ☐ tea ☐ soda ☐ coffee ☐ other

You like your drinks to be: ☐ hot ☐ room temperature ☐ cold

SLEEP

Do you have difficulty sleeping? ☐ yes ☐ no Do you usually wake up feeling rested? ☐ yes ☐ no

How many hours do you usually sleep? ☐ 5-6 ☐ 7-8 ☐ 9-10 ☐ other _____

Do you have difficulty with: ☐ falling asleep ☐ staying asleep ☐ nightmares

EYES: ☐ eye pain ☐ dry eyes ☐ blurred vision ☐ darkness under eyes ☐ Other_____

EARS: ☐ poor hearing ☐ earaches ☐ ringing/buzzing in the ear ☐ ear discharge

NOSE: ☐ frequent colds ☐ sinus trouble ☐ frequent nose bleeds ☐ other _____

THROAT: ☐ sore throat ☐ hoarseness ☐ difficulty swallowing ☐ jaw problems

☐ Teeth/gum problems ☐ swollen tongue ☐ other _____

CHEST: ☐ hard to breath ☐ wheezing ☐ shortness of breath (circle: all the time or upon exertion)

☐ trouble breathing at night ☐ mucus rattles when breathing ☐ pain/pressure in chest ☐ palpitations

☐ persistent cough ☐ coughing blood ☐ coughing phlegm (if so; phlegm color: _____)

ELIMINATION: How many times do you usually moves your bowels in a day? ☐ 0 ☐ 1 ☐ 2 ☐ 2+

The consistency of the stool is: ☐ diarrhea ☐ loose ☐ formed/normal ☐ over dry/compacted

Do you experience: ☐ lower bowel gas ☐ abdominal bloating ☐ stools with very foul oder

EMOTIONAL/MENTAL: Do you frequently experience any of the following:

☐ depression ☐ irritability ☐ worry ☐ fear ☐ anxiety ☐ anger ☐ other _____

NEUROLOGICAL: ☐ numbness/tingling in limbs ☐ poor coordination ☐ muscle weakness

☐ feeling weak & shaky ☐ seizures ☐ nerve pain (neuralgia) ☐ difficulty with memory &/or confusion

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WOMEN ONLY: Pregnant? ☐yes ☐no. Age started menstrual cycle _____. Age stopped _____☐

How long between your cycles? _____ days. How long does your cycle last? _____ days.

Do you experience any of the following in regards to your cycles: ☐worry/anxiety ☐mood swings

☐ missed periods ☐bleeding in-between periods ☐clotting ☐heavy bleeding

☐ light/scanty bleeding ☐ low or now sex drive ☐painful breasts ☐ hot flashes

Last PAP test? _____ result _____ Last mammogram _____ result _____

Are you using birth control? ☐ none ☐pill ☐Other _____

Discharges: ☐ none ☐ yellow ☐thick ☐white ☐ colorless ☐ odor ☐ itching ☐ other _____

# of pregnancies _____ # of births _____ # of miscarriages _____ # of abortions _____

MALES ONLY: ☐ low sex drive ☐ no sex drive ☐ sexual dysfunction ☐ discharge other than ejaculation

☐ pain with ejaculation ☐pain or burning while urinating ☐ prostrate trouble ☐ other _____

MISCELLANEOUS: Is there anything else pertinent to your health that you would like to share?

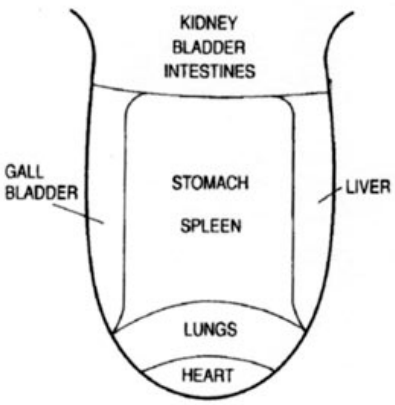
_____

_____

THANK YOU FOR YOUR VALUABLE TIME AND EFFORT IN FILLING OUT THIS FORM

To be filled out by therapist:

Tongue Diagnosis



Pulse Diagnosis:

Palpation:

Body color
Body size
Coat color
Coat thickness
Cracks
Spots