Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
~All information is strictly confidential

General Patient Information:
Date:____/____/_____
Last Name:_____ First Name _____
Address:_____
City, State, Zip Code:_____
Home phone____/____/_____ Work ____/____/_____ Cell____/____/_____
E-mail_____
Age____ Date of Birth____/____/_____ Gender_____ Marital Status _____
Occupation_____ Employer_____
Guardian (if under 18)_____
Guardian phone number____/____/_____
At what phone number would you like to receive calls about appointments or other health care information
_____
May we leave phone messages here with detailed information (please circle) Yes No

Please list persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):
Name_____ Phone # ____/____/_____
Name_____ Phone # ____/____/_____

Emergency Contact Information: (please check box □ if same as above)
Name_____ Phone #____/____/_____

How were you referred to this clinic? _____

Patient Intake Evaluation:
Major health complaint(s) in order of significance to you:
1. _____
2. _____
3. _____

How do these conditions interfere with your daily activities?
_____
_____
_____

Please list any medications or nutritional supplements you are currently taking:
1. _____ 2. _____ 3. _____
4._____ 5._____ 6._____
7._____ 8._____ 9._____

Please list any surgeries you have had and approximate dates:
1._____ 2._____ 3._____

Patient Medical History:
Currently I am, or have the following:
□ *Pregnant* □ *Using Recreational Drugs* □ *Pacemaker* □ *Hepatitis* □ *HIV/AIDS*

How was your childhood health? _____
Habits or excessive usage: □ alcohol □ chocolate □ coffee □ drugs □ exercise □ food □ salt □ sugar □ sex

Recent Tests- (please indicate test results and date below)
□ *Physical* □ *Blood* □ *Mammography* □ *Thermography* □ *Pap Smear* □ *Prostate* □ *Cholesterol* □ *HIV* □*STD* □ *Hepatitis* □ *Others*_____ *Test results and date:* _____

Check any you currently have, or have had in the past:

□Allergies	□Asthma	□Alcoholism	□Auto-immune disease	□CVA(stroke)
□Cancer	□Diabetes	□Drug abuse/use	□Epilepsy	□Heart Illness
□Hepatitis	□Hernia	□High Blood psi.	□Kidney Illness	□Lung Illness
□Liver Illness	□Mononucleosis	□Meningitis	□Organ transplant	□Paralysis
□Rheumatic Fever	□Seizure	□STD	□Thyroid illness	□Tuberculosis
□Whooping cough	□Jaundice			

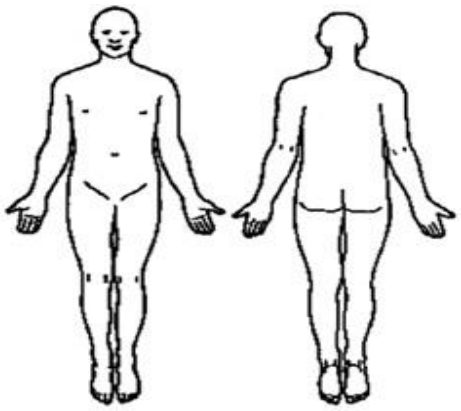
Immunizations:_____
Any Adverse Reactions:_____

Patient Profile:
Please clearly mark any areas of pain and any scars with X's. Indicate which of these areas are scars in the margin next to the picture.
Is your pain?
□*sharp* □*stabbing* □*burning* □ *dull* □ *cramping* □ *aching* □ *moving* □ *fixed* □ *other*_____

Do the following lessen the pain?
□ *pressure* □ *heat* □ *cold* □ *movement* □ *rest*
□ *other*_____

Do the following worsen the pain?
□ *pressure* □ *heat* □ *cold* □ *movement* □ *rest*
□ *other*_____

Does your pain limit your movement or flexibility?
□ *yes* □ *no*



Please check the following that currently pertain to you. If you have symptoms in the following categories it *may* indicate that you have an imbalance in that organ's function *as it is seen in Traditional Chinese Medicine*.

Overall Temperature- Kidney/Lung Function

- ☐ Cold hands or feet
- ☐ Sweaty hands or feet
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Hot flashes any time of the day
- ☐ Heat in the hands, feet, or chest
- ☐ Take water to bed
- ☐ Hot body temperature (sensation)
- ☐ Cold body temperature (sensation)
- ☐ Thirsty
- ☐ Lack of thirst
- ☐ Craves ice cold drink
- ☐ Craves warm or hot drink
- ☐ Craves room temperature drink

Lung & Large Intestine Organ and Meridian system

- ☐ Shortness of breath or difficult breathing
- ☐ Cough
- ☐ Sinus problems
- ☐ frequent sneezing
- ☐ frequent colds
- ☐ Sore throat or scratchy throat
- ☐ nasal congestion or discharge
- ☐ Dry mouth, nose, throat or skin

- [ ] Lack of perspiration
- [ ] Perspire easily
- [ ] Asthma
- [ ] Overall achy feeling in Body
- [ ] Frequent Yawning
- [ ] Smoke Cigarettes: # per day-_____
- [ ] Hives, rashes, or itchy skin
- [ ] Loss of smell
- [ ] Pimples or acne
- [ ] Allergies: to what_____
- [ ] Diverticulitis
- [ ] Frequent nose Bleeds
- [ ] Constipation
- [ ] Incomplete Bowel movements
- [ ] Difficult Bowel movements
- [ ] Blood in stool or black stool
- [ ] Bowel movement has strong odor
- [ ] Mucous in stool
- [ ] Gas/ Flatulence
- [ ] Burning sensation with bowel movement
- [ ] Grieving
- [ ] Sadness

Stomach & Spleen Organ and Meridian system

- [ ] Indigestion
- [ ] Burping/ belching
- [ ] Heartburn
- [ ] Hiccups
- [ ] Acid reflux
- [ ] Stomach ulcer- diagnosed
- [ ] Burning sensation in Stomach
- [ ] Abdominal bloating
- [ ] Diabetes
- [ ] Lower abdominal pain
- [ ] Poor appetite
- [ ] Upper abdominal pain
- [ ] Hungry, but don't want to eat
- [ ] Unable to stay focused
- [ ] Large appetite
- [ ] Poor long-term memory
- [ ] Bruises easily or varicose veins
- [ ] Low energy
- [ ] Gurgling noise in stomach
- [ ] fatigue & lassitude
- [ ] Nausea or vomiting
- [ ] Fatigue after eating
- [ ] Sensation of heaviness in the body or head
- [ ] Headaches on the forehead
- [ ] General weakness of limbs or muscles
- [ ] Bad Breath
- [ ] Mouth (Canker) Sores
- [ ] Bleeding, swollen or painful gums
- [ ] Prolapsed organ- diagnosed:_____
- [ ] Undigested food in stool
- [ ] Over-thinker, pensive
- [ ] Loose stool or diarrhea
- [ ] Worry
- [ ] Hemorrhoids

Heart & Small Intestine Organ and Meridian system

- [ ] palpitations
- [ ] insomnia
- [ ] irregular heart beat
- [ ] trouble falling asleep
- [ ] heart problems
- [ ] trouble staying asleep

- [ ] chest pain/discomfort
- [ ] chest fullness, tightness or pressure
- [ ] arm numbness or tingling
- [ ] tongue or speech problems
- [ ] sores on tongue
- [ ] lack of joy/ humor
- [ ] fidgety
- [ ] talkative
- [ ] wake un-refreshed
- [ ] dreams disturb sleeping
- [ ] vivid dreams
- [ ] anxiety/dread
- [ ] mental restlessness
- [ ] mental confusion, “foggy”, or unclear thinking
- [ ] poor short term memory
- [ ] intestinal hernia

Kidney & Urinary Bladder Organ and Meridian system

- [ ] Frequent Cavities
- [ ] Arthritis
- [ ] Bone problems
- [ ] Bones break easy
- [ ] Sore or weak Knees
- [ ] Cold sensation in Knees
- [ ] Decreased libido
- [ ] Excessive libido
- [ ] Memory Problems, forgetfulness
- [ ] Water Retention/ Edema
- [ ] Wake During Night to Urinate
- [ ] Infertility/Sterility
- [ ] Low-Pitched Ringing in Ears
- [ ] Hearing loss
- [ ] Ear problems
- [ ] Kidney Stones
- [ ] Bladder Infections
- [ ] Bladder control weakness
- [ ] Low back pain
- [ ] Headaches at base of skull or back of head
- [ ] Premature gray hair
- [ ] Hair Loss
- [ ] Fear or easily startled
- [ ] Lack of Willpower

Urination

- [ ] Yellow or Pale Yellow
- [ ] Dark Yellow
- [ ] Clear
- [ ] Reddish
- [ ] Visible blood
- [ ] Cloudy
- [ ] Dribbling or weak stream
- [ ] fluids consumed are less than urine output
- [ ] fluids consumed are more than urine output
- [ ] Discharge
- [ ] Painful
- [ ] Difficult
- [ ] Frequency
- [ ] Urgency
- [ ] Scanty
- [ ] Profuse
- [ ] Strong Odor

Liver & Gallbladder Organ and Meridian system

- [ ] Tenderness on sides of ribcage
- [ ] Muscle Twitching, cramping or spasms

- ☐ Headaches on top of head, sides of head or behind the eyes
- ☐ Dizziness
- ☐ Alternating constipation and diarrhea
- ☐ High pitched ringing in the ears
- ☐ Bitter Taste in the Mouth
- ☐ Anger/Frustration
- ☐ Resentment
- ☐ Depression/ "feel down"
- ☐ Irritable
- ☐ Stressed
- ☐ Indecisive
- ☐ Brittle/coarse nails or hair
- ☐ Tendon problems
- ☐ Frequent sighing
- ☐ Anemia (of any type)
- ☐ Seizures or convulsions
- ☐ Gall stones
- ☐ sensation of a Lump in the throat
- ☐ Itchy, gritty, or red eyes
- ☐ blurry vision
- ☐ decreased night vision
- ☐ seeing spots/floaters
- ☐ other eye problems
- ☐ High blood pressure

For Women Only:

No. of pregnancies____

No. of live births____

No. of premature births____

No. of miscarriages___

No. of abortions____

Age at 1st menses_____

Average length of period _____ Days of heavy flow_____

☐ early cycle (less than 21 days) ☐ late cycle (more than 35 days)

Number of days between cycles _____

Menstrual Color: ☐ bright red ☐ scarlet ☐ dk. red ☐ dk. purple ☐ brown

Menses clot size: ☐ dime size ☐ quarter size ☐ larger ☐ no clots

In General Menses Is: ☐ light ☐ mod. ☐ heavy ☐ very heavy

Menstrual Pain/Cramps: ☐ before ☐ during ☐ after menses ☐ No cramping

☐ Fertility concerns

☐ body change w/period ☐ mood swing w/period

☐ Ovarian cysts

Are you in Menopause? _____ Age at menopause (if applicable)____

☐ Fibroids

Vaginal Discharge: ☐ clear ☐ wt. ☐ yellow ☐ green

☐ pink/red

☐ Endometriosis how often_____

Breast

☐ Tenderness with Menses ☐ General tenderness or pain ☐ Lumps/masses ☐ discharge

☐ History of breast cancer (self) ☐ Family history of breast cancer