(KLoi@LoiAcupuncture.com)

TCM Medical Intake Form

Important: Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition though they may play a major role in diagnosis and treatment.

… All information is strictly confidential

General Patient Information

Date: _____ / _____ / _____ Name: ______________________________

Address: ______________________________ City: ______________________________

State: ______________________________ Zip: ______________________________

E-mail Address: ______________________________

Home Phone: ______________________________ Work Phone: ______________________________

Age: ________ Date of Birth: _____ / _____ / _____ Place of Birth: ______________________________

Guardian (if under 18): ______________________________

Gender: ☐ Male ☐ Female Height:____ ' _____ '' Weight:________lbs

Social Security Number: ________ - ________ - ________

Driver's License Number: ______________________________

Occupation: ______________________________ Employer: ______________________________

Employer Address: ______________________________ City: ______________________________

State: ______________________________ Zip: ______________________________

Does anything limit you from care? ☐ Yes ☐ No If yes, explain: ______________________________

How did you hear about our office? ______________________________

Other physicians/therapists seen for this condition: ______________________________

Medications (if any): ______________________________

Prescribed by: ______________________________

Treatment: ______________________________

____

____

____

____

Results: ______________________________

____

____

____

____

Supplements (if any vitamins, herbs, minerals, etc.): ______________________________

____

____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	Complaints
1.	☐	☐	☐	☐	
2.	☐	☐	☐	☐	
3.	☐	☐	☐	☐	
4.	☐	☐	☐	☐	
5.	☐	☐	☐	☐	
6.	☐	☐	☐	☐	
7.	☐	☐	☐	☐	
8.	☐	☐	☐	☐	
9.	☐	☐	☐	☐	
10.	☐	☐	☐	☐	

How do these conditions impair your daily activities? ______________________________

____

Patient Medical History

How was your childhood health? ______________________________

Hospital Visits/Stays: ______________________________

Recent tests: (please indicate test results and date below)

☐ Physical ☐ Cholesterol ☐ Prostate ☐ Blood (which?) ______________

☐ HIV/STD ☐ Pap Smear ☐ Mammography

☐ Other: ______________________________

Test Results and Date: ______________________________

____

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Check any you have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic Fever
☐ Heart Disease	☐ CVA (stroke)	☐ Vein Condition	☐ Thyroid Disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Jaundice	☐ Gonorrhea	☐ Mumps	☐ Bleeding Tendency
☐ Syphilis	☐ Measles	☐ Chicken Pox	☐ Nervous Disorder
☐ Meningitis	☐ HIV	☐ Polio	☐ Mononucleosis
☐ Epilepsy	☐ High Fever	☐ Hepatitis	☐ Multiple Sclerosis
☐ Paralysis	☐ Cancer	☐ Migraines	☐ High Blood Pressure
☐ Other Lung Illnesses	☐ Other Liver Illnesses	☐ Other Heart Illnesses	☐ Other Kidney Illnesses
☐ Other Spleen Illnesses		☐ Other Stomach Illnesses	

☐ Other: ______________________________

Immunizations: ______________________________

Surgeries: ______________________________

Family History

Family Member	Alive	Deceased	Present Health or Cause of Death
Father	☐	☐	
Mother	☐	☐	
Spouse	☐	☐	
Children	☐	☐	
Brother	☐	☐	
Brother	☐	☐	
Sister	☐	☐	
Sister	☐	☐	

Where are you in the birth order? ☐ First ☐ Last ☐ Middle ☐ Only

Check the following that have occurred in your blood relatives:

☐ Diabetes	☐ Cancer	☐ Heart Disease	☐ High Blood Pressure
☐ Allergies	☐ Tuberculosis	☐ Obesity	☐ Bleeding Tendency
☐ Kidney Disease	☐ Alcoholism	☐ Nervous Illness	☐ Mental Illness
☐ Stroke	☐ Other: ________________		

Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which areas are scars):

Is the pain:

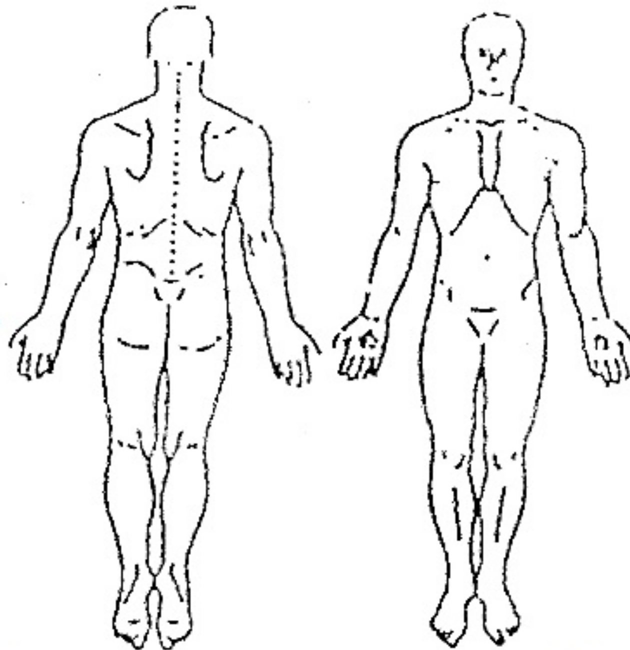
☐ Sharp ☐ Burning ☐ Aching
☐ Cramping ☐ Dull ☐ Moving
☐ Fixed ☐ Other: ____________

Do the following lessen the pain?

☐ Pressure ☐ Cold ☐ Heat
☐ Exercise ☐ Other: ____________

Do the following worsen the pain?

☐ Pressure ☐ Cold ☐ Heat
☐ Other: ____________________



<u>Please check symptoms pertaining to you</u>:

<u>Overall Energy</u>

☐ Shortness of breath
☐ Difficulty keeping eyes open in the daytime
☐ General weakness
☐ Easily catch colds
☐ Low energy
☐ Feel worse after exercise

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Overall Temperature (Kidney Function):

- [ ] Cold hands
- [ ] Cold feet
- [ ] Sweaty hands
- [ ] Sweaty feet
- [ ] Hot body temperature (sensation)
- [ ] Cold body temperature (sensation)
- [ ] Afternoon flushes
- [ ] Night sweats
- [ ] Heat in the hands, feet, and chest
- [ ] Hot flashes any time of the day
- [ ] Thirsty
- [ ] Perspire easily
- [ ] Lack of perspiration
- [ ] Take water to bed
- [ ] Difficulty keeping eyes open in the daytime

Lung Function:

- [ ] Nasal discharge (Color): ____________________
- [ ] Cough
- [ ] Nose bleeds
- [ ] Sinus congestion
- [ ] Dry mouth
- [ ] Dry throat
- [ ] Dry nose
- [ ] Dry skin
- [ ] Allergies (To What)? ____________________
- [ ] Alternating fever and chills
- [ ] Sneezing
- [ ] Headache (Location): ____________________
- [ ] Swollen hands
- [ ] Swollen feet
- [ ] Swollen joints
- [ ] Chest congestion
- [ ] Nausea
- [ ] Snoring
- [ ] Overall achy feeling in the body
- [ ] Stiff neck
- [ ] Stiff shoulders
- [ ] Sore throat
- [ ] Difficulty breathing
- [ ] Smoke cigarettes (# of cigarettes per day): ________
- [ ] Sadness
- [ ] Melancholy

Blood (Liver, Spleen, Heart Function):

- [ ] Dizziness
- [ ] See floating black spots

Spleen Function:

- [ ] Low appetite
- [ ] Abrupt weight gain
- [ ] Abrupt weight loss
- [ ] Abdominal bloating
- [ ] Abdominal gas
- [ ] Gurgling noise in the stomach
- [ ] Fatigue after eating
- [ ] Prolapsed organs (previously diagnosed)
  Which organ? ____________________
- [ ] Easily bruised
- [ ] Hemorrhoids
- [ ] Pensive
- [ ] Over-thinking
- [ ] Worry

Spleen, Stomach, Large Intestine, Small Intestine Function:

- [ ] Loose
- [ ] Constipated
- [ ] Incomplete
- [ ] Diarrhea
- [ ] Blood in stools
- [ ] Mucous in stools
- [ ] Undigested food in stools

Dampness trapped in the body:

- [ ] General sensation of heaviness in the body
- [ ] Mental heaviness
- [ ] Mental sluggishness
- [ ] Mental fogginess
- [ ] Convulsions
- [ ] Lump in the throat
- [ ] Neck tension
- [ ] Limited Range-of-Motion in neck
- [ ] Shoulder tension
- [ ] Limited Range-of-Motion in shoulder
- [ ] Drink alcohol
- [ ] Recreational drugs
- [ ] (Which)? ____________________
- [ ] (How much per week)? ____________________
- [ ] High-pitched ringing in the ears
- [ ] Gall stones (history or current)
- [ ] Sexually transmitted disease
- [ ] (Which)? ____________________

Stomach Function:

- [ ] Burning sensation after eating
- [ ] Large appetite
- [ ] Bad breath
- [ ] Mouth (canker) sores
- [ ] Bleeding, swollen or painful gums
- [ ] Heartburn
- [ ] Acid regurgitation
- [ ] Ulcer (diagnosed)
- [ ] Belching
- [ ] Hiccoughs
- [ ] Stomach pain
- [ ] Vomiting

Liver, Gall Bladder Function:

- [ ] Alternating diarrhea and constipation
- [ ] Chest pain
- [ ] Tight sensation in the chest
- [ ] Bitter taste in the mouth
- [ ] Anger easily
- [ ] Frustration
- [ ] Depression
- [ ] Irritability
- [ ] Frequently unable to adapt to stress
- [ ] (What causes the stress?) ______________________
- [ ] Skin rashes
- [ ] Headache at the top of the head
- [ ] Tingling sensation
- [ ] Numbness
- [ ] Muscle spasms
- [ ] Muscle cramping
- [ ] Seizures
- [ ] Lack of bladder control
- [ ] Fear
- [ ] Easily startled

Urination:

- [ ] Normal color
- [ ] Dark yellow
- [ ] Clear
- [ ] Reddish
- [ ] Cloudy
- [ ] Scanty
- [ ] Profuse
- [ ] Strong odor
- [ ] Burning
- [ ] Painful

Heart Function:

- [ ] Palpitations
- [ ] Anxiety
- [ ] Sores on the tip of the tongue
- [ ] Restlessness
- [ ] Mental confusion
- [ ] Chest pain traveling to shoulder
- [ ] Frequent dreams
- [ ] Wake un-refreshed
- [ ] Drink coffee (# of cups per week): ______________________

Eyes (Liver Function):

- [ ] Itchy
- [ ] Bloodshot
- [ ] Hot
- [ ] Dry
- [ ] Watery
- [ ] Gritty
- [ ] Blurry vision
- [ ] Decreased night vision
- [ ] Near-sighted
- [ ] Far-sighted

Kidney, Urinary Bladder Function:

- [ ] Frequent cavities
- [ ] Easily broken bones
- [ ] Sore knees
- [ ] Weak knees
- [ ] Cold sensation in the knees
- [ ] Low back pain
- [ ] Memory problems
- [ ] Excessive hair loss
- [ ] Low-pitched ringing in the ear
- [ ] Kidney stones
- [ ] Bladder infections
- [ ] Wake during the night twice or more to urinate
- [ ] Discharge
- [ ] Difficult
- [ ] Painful
- [ ] Urgent
- [ ] Frequent

Libido:

- [ ] Normal
- [ ] High
- [ ] Low

Other Symptoms: ______________________

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Female:

Regular menstrual cycle? ☐ Y ☐ N
Pregnant? ☐ Y ☐ N
Number of children: ____________
Number of pregnancies: ____________
Age of first menstruation: ____________
Age of menopause (if applicable): ____________
Average number of days of flow: ____________
Average number of days entire Cycle: ____________

	Severe	Moderate	Slight	Normal
Vaginal discharge:	☐	☐	☐	☐
Bleeding between periods:	☐	☐	☐	☐

Do you experience any of the following pre-menstrual syndromes?

☐ Nausea
☐ Headaches
☐ Anxiety
☐ Other emotions: ____________
☐ Sharp pain, where? ____________
☐ Other: ____________
☐ Food cravings
☐ Irritability
☐ Breast swelling
☐ Depression
☐ Water retention
☐ Breast tenderness
☐ Dull pain, where? ____________
☐ Vomiting
☐ Migraines

Please fill in the following menstrual chart:
(Put in a number and what color it is)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other:							

For fertility patients, please attach your Basal Body Temperature (BBT) Chart

Male:

Symptom	Severe	Moderate	Slight	Normal
☐ Swollen testes	☐	☐	☐	☐
☐ Testicular pain	☐	☐	☐	☐
☐ Impotence	☐	☐	☐	☐
☐ Premature ejaculation	☐	☐	☐	☐
☐ Feeling of coldness or numbness in external genitalia	☐	☐	☐	☐

☐ Other: ______________________________

Other Comments: ______________________________

____

____

____

____

____

____

____

Patient Signature: ______________________________ **Date:** ____________

Acupuncturist Signature: ______________________________ **Date:** ____________