TRADITIONAL CHINESE MEDICINE & ACUPUNCTURE INTAKE FORM

Patient Name: _____ Date: _____

Date of Birth (MM/DD/YYYY): _____

Sex at birth: □ Female □ Male Preferred Pronoun: _____

Gender Identity: _____ □ Prefer not to answer

Address: _____ Apt/unit #:_____

City: _____ Province: _____ Postal Code: _____

Preferred form of contact for reminder/follow-up calls: oHome oWork oCell oEmail

E-mail Address: _____

Emergency Contact Name: _____ Relation: _____

Phone Number(s): _____ or _____

How did you hear about us? _____

Name of the friend or professional who referred you_____

Extended Health Insurance Company Name: _____

Insured Member: _____ Birth Date (MM/DD/YYYY): _____

Policy # _____ Member ID#_____

Coverage per year: _____

Health Care Providers

Medical Doctor _____ Location_____

Date of last physical exam: _____ Blood tests included? YES NO

Specialist(s) _____ Location_____

Other _____ Location_____

Other _____ Location_____

Main Health Concerns

What are your health concerns, in order of importance to you**?**

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **6.** _____

How would you describe your general state of health? Excellent Good Fair Poor

Medical Information

Are you currently pregnant? Yes No

Are you currently lactating? Yes No

Please list any known allergies (prescription or over-the-counter medicines, environmental, natural medicines, food) and any previous drug reactions:

_____

_____

_____

Please indicate any *serious conditions* (**broken bones, surgeries, imaging, accidents…**), *traumatic events* (**divorce, loss of employment, death of loved one, abuse, addiction…**) and any *hospitalizations:*

_____

_____

_____

Please list prescribed and over the counter medications you are currently using or have used in the last 5 years. Include dose, frequency and duration of use.

Medication _____ Dose _____ Frequency _____ Duration_____

Medication _____ Dose _____ Frequency _____ Duration_____

Medication _____ Dose _____ Frequency _____ Duration_____

Medication _____ Dose _____ Frequency _____ Duration_____

Medication _____ Dose _____ Frequency _____ Duration_____

Please list names and brands of all current vitamins, minerals, botanicals and other natural health products you are currently using. Include dose, frequency and duration of use.

Name _____ Dose _____ Frequency _____ Duration_____

Name _____ Dose _____ Frequency _____ Duration_____

Name _____ Dose _____ Frequency _____ Duration_____

Name _____ Dose _____ Frequency _____ Duration_____

Name _____ Dose _____ Frequency _____ Duration_____

How many times have you been treated with antibiotics in the last 5 years? _____

Where you ever on antibiotics for an extended period of time? Y N Reason:_____

Dr. Melyssa Hoitink
Naturopathic Doctor

Family Medical History

Please indicate if any of your family members have experienced the following:

Condition	Relative	Condition	Relative
Alcoholism/Addiction		High Blood Pressure	
Alzheimer's Disease/Dementia		Insomnia	
Allergies (Food/Hayfever)		Kidney Problems	
Arthritis (osteo/rheumatoid)		Liver Disease	
Asthma/Emphysema		Mental Health Problems	
Autoimmune disease (MS, RA…)		Migraines/Headaches	
Cancer (please specify type)		Osteoporosis	
Diabetes		Skin conditions	
Digestive Problems		Thyroid problems	
Heart Disease		Other	

Traditional Chinese Medicine History

Have you ever been treated with Traditional Chinese Medicine? Yes No

If yes, please circle any treatments you have received:

Acupuncture Herbal Medicine Moxibustion Cupping Other

Temperature

Please check all that apply:

- □ Generally More Hot
- □ Generally More Cold
- □ Cold Hands
- □ Cold Feet
- □ Cold Knees
- □ Cold Lower Back
- □ Other Cold Areas
- □ Hot Hands
- □ Hot Feet
- □ Heat in the Palms, Soles, and Chest
- □ Other Hot Areas
- □ Fever
- □ Night fever
- □ Afternoon fever
- □ Chills
- □ Hot flashes
- □ Alternating Fever and Chills
- □ Aversion to Cold
- □ Aversion to Hot
- □ Aversion to wind
- □ Prefer hot drinks
- □ Prefer cold drinks

Skin & Sweat

Please check all that apply:

- □ Sweat Easily
- □ Profuse Sweat
- □ Sweat at night
- □ Sweaty hands and feet
- □ Spontaneous sweating
- □ Sweat has a strong odour

If sweat has a strong odour, please describe:

_____

_____

Please check all that apply:

- □ Dry skin
- □ Rashes
- □ Eczema
- □ Brittle nails
- □ Itchy skin
- □ Acne or boils
- □ Edema
- □ Dry hair
- □ Moist skin
- □ Easily bruised
- □ Varicose veins
- □ Other: _____

Head

Please check all that apply:

- □ Vertigo
- □ Indecisiveness
- □ Heaviness in the head
- □ Dizziness
- □ Poor memory
- □ Edema or swelling of the face
- □ Mental restlessness
- □ Fainting
- □ Mental exhaustion
- □ Headaches

If you experience headaches, please indicate where you experience them:

- □ Frontal
- □ Temples (both sides)
- □ Occipital (back of the head)
- □ Temple (one side)
- □ Vertex (top of the head)
- □ No headache

If you experience headaches, please indicate the quality of the sensation:

- □ Dull
- □ Stabbing
- □ Oppressing
- □ Sharp
- □ Fixed
- □ Pressure
- □ Moving
- □ Burning
- □ Heavy

Eyes

Please check all that apply:

- □ Blurred Vision
- □ Floaters in your visual field
- □ Poor Night Vision
- □ Flashes in your visual field
- □ Dry Eyes
- □ Swelling of your eyes
- □ Red Eyes
- □ Other: _____

Ears

Please check all that apply:

- □ Ringing in the ears
- □ Ear aches
- □ Deafness
- □ Popping
- □ Diminished hearing
- □ Other: _____

Nose

Please check all that apply:

- □ Nasal discharge
- □ Sinusitis
- □ Clear/white nasal discharge
- □ Sneezing
- □ Yellow sticky nasal discharge
- □ Other: _____
- □ Nasal congestion

Mouth

Please check all that apply:

- □ Dry mouth
- □ Dry lips
- □ Ulcers in mouth
- □ Dry throat
- □ Sore throat
- □ Difficulty swallowing
- □ Frequent throat clearing
- □ Feel something in the throat

Please indicate if you experience any of the following taste sensations in your mouth:

- □ None
- □ Bitter
- □ Metallic
- □ Sweet
- □ Sour
- □ Salty
- □ Sticky sensation
- □ Lack of taste

Chest & Breathing

Please check all that apply:

- □ Cough
- □ Cough up Blood
- □ Dry Cough
- □ Wet Cough
- □ Shortness of Breath
- □ Difficulty Breathing
- □ Asthma
- □ Wheezing
- □ Phlegm
- □ Phlegm difficult to cough up
- □ Phlegm easy to cough up
- □ Easily catch colds
- □ Palpitations
- □ Chest Pain
- □ Chest Discomfort
- □ Dull Chest Ache
- □ Chest Tightness
- □ Sighing

Diet

Please check all that apply:

- □ Irregular eating habits
- □ Regular eating habits
- □ Vegetarian
- □ Crave spicy foods
- □ Crave sweet foods
- □ Crave greasy foods
- □ Crave salty foods
- □ Crave sour foods
- □ Crave bitter foods
- □ No cravings

Thirst

Please check all that apply:

- □ No thirst
- □ Thirst with desire to drink
- □ Thirst without desire to drink

Appetite

Please check all that apply:

- □ Poor
- □ Excessive
- □ Reduced recently
- □ Increased recently
- □ No hunger
- □ Hunger without desire to eat
- □ Hunger even after overeating
- □ Normal

Digestion

Please check all that apply:

- □ Abdominal Pain
- □ Belching
- □ Regurgitation of food
- □ Nausea
- □ Bad breath
- □ Bloating
- □ Vomiting
- □ Vomiting after eating
- □ Gas
- □ Hiccups
- □ Acid regurgitation/ Heartburn

Bowel Movements

How many bowel movements you have per day or per week? _____

Quality: *Please check all that apply:*

- □ Well-formed
- □ Watery Diarrhea
- □ Alternating Constipation/Diarrhea
- □ Shapeless
- □ Foul-smelling Diarrhea
- □ Hard initial stools followed by loose stools
- □ Thin stools
- □ Diarrhea at dawn
- □ Normal
- □ Diarrhea
- □ Constipation

Form: *Please check all that apply:*

- □ Dry stools
- □ Mucus in stools
- □ Hard stools
- □ Blood in stools
- □ Loose Stools
- □ Foul-smelling stools
- □ Undigested food in stools
- □ Normal

Do you experience any of the following?

- □ Urgent defecation
- □ Try to pass stool with no success
- □ Fecal incontinence
- □ Burning sensation around the anus
- □ Straining
- □ Itchy anus
- □ Difficult but successfully pass stool

Colour: *Please check all that apply:*

- □ Brown
- □ Green
- □ Light yellow
- □ Greyish/white
- □ Dark Yellow
- □ Other
- □ Black/tar-like

Abdomen

Please check all that apply:

- □ Abdominal pain
- □ Abdominal pain better with warmth
- □ Abdominal pain worse with pressure
- □ Fullness in the abdomen
- □ Abdominal pain worse with warmth
- □ Distension in the abdomen
- □ Abdominal pain better with pressure
- □ Gurgling in the stomach (borborygmus)

Back

Please check all that apply:

- □ Upper back pain
- □ Lower back pain
- □ Soreness
- □ Cold lower back
- □ Other

Limbs

Please check all that apply:

- □ Cold limbs
- □ Pain
- □ Numbness
- □ Edema
- □ Tingling
- □ Joint pain
- □ Spasm
- □ Tremor

Joint Pain

Please list which joints are affected:

_____

_____

Please check all that apply:

- □ Knee joint affected
- □ Fixed pain with heavy sensation
- □ Pain alleviated by cold
- □ Moving pain
- □ Hot burning pain
- □ Pain due to injury
- □ Fixed pain
- □ Pain alleviated by warmth
- □ Swelling of the affected joint(s)

Urination

Please check all that apply:

- □ Frequent Urination
- □ Scanty Urine
- □ Painful Urination
- □ Urgent Urination
- □ Stones
- □ Hesitant Urination
- □ Interrupted Flow
- □ Dribbling
- □ Burning Sensation on Urination
- □ Waking during the night to urinate
- □ Profuse Urine
- □ Difficulty Urinating
- □ Incontinence
- □ Bloody Urination

Colour: *Please check all that apply:*

- □ Clear
- □ Milky
- □ Yellow
- □ Turbid
- □ Dark Yellow
- □ Tea-coloured (brown)

Emotions

How would you describe your outlook on life lately?

_____

_____

Is there an emotion that is more difficult for you to feel?

_____

_____

Do any of the following feels occur more frequently?

- □ Anger
- □ Irritability
- □ Frustration
- □ Sadness
- □ Joy
- □ Worry/Anxiety
- □ Fear
- □ Depression

Do you experience any of the following?

- □ Mood swings
- □ Manic tendencies
- □ Crying easily
- □ Over-thinking
- □ Easily startled

Energy

Do you feel you have enough energy in the day? Yes No

Please rate your energy on a scale of 1 to 10, with 10 being the most energy: _____

What time of day do you have the most energy? _____

What time of day do you have the least energy? _____

Sleep

Please check all that apply:

- □ Insomnia
- □ Difficulty falling asleep
- □ Difficulty staying asleep
- □ Waking during the night
- □ Feel refreshed in the morning
- □ Dreaming
- □ Nightmares
- □ Napping

What time do you go to bed? _____

How long does it take you to fall asleep? _____

What time do you wake up? _____

How many times do you wake during the night? _____

What wakes you? _____

Men's Health

Please check all that apply:

- □ Swollen Testes
- □ Testicular Pain
- □ Impotence
- □ Premature Ejaculation
- □ Feeling of Coldness or Numbness in external genitalia
- □ No sexual desire
- □ Excessive sexual desire

Women's Health

Age of First Period: _____ Number of Pregnancies: _____ Number of Children: _____

Is your menstrual cycle regular? Yes No Are you menopausal? Yes No

How long is your average cycle (beginning of menses to first day of next menses)? _____

How many days does your flow last? _____

What was the date of your last period? _____

Please check all that apply:

- □ Heavy Flow
- □ Light Flow
- □ Normal Flow
- □ Bright Red Colour
- □ Pale Red Colour
- □ Dark Red Colour
- □ Purple Colour
- □ Brown Colour
- □ Clots
- □ Vaginal Discharge
- □ Vaginal Dryness
- □ Vaginal Pain
- □ Vaginal Irritation
- □ Vaginal Itch
- □ Bleeding Between Periods

PMS Symptoms: *Please check all that apply:*

- □ Breast Distension
- □ Breast Tenderness
- □ Food Cravings
- □ Water Retention
- □ Headaches
- □ Migraines
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Alternating Diarrhea/ Constipation
- □ Depression
- □ Irritability
- □ Anxiety
- □ Other Emotions
- □ Abdominal cramps

If you experience cramping, please circle all that apply:

- □ Stabbing
- □ Aching
- □ Better with Pressure
- □ Worse with Pressure
- □ Better with Heat
- □ Worse with Heat
- □ Better with Exercise
- □ Worse with Exercise