PATIENT DATA:

Date:_____

Name:_____

Address (Street, City, Zip):_____

Phone: (h)_____ (w)_____ (cell) _____

Date of Birth:_____ Age: _____ Email: _____

Gender: _____ Preferred Pronouns: _____

Circle One: single partnered married polyamorous separated divorced widowed

Occupation: _____Name of Spouse/Partner or Parent (if child) _____

Emergency contact: (name) _____ (phone) _____

How did you learn about our office? _____

Current Physician _____Diagnosis by MD_____

Which of the following types of treatment have you experienced before? **Circle all that apply:**

Acupuncture Herbal Medicine Chiropractic Massage Functional Medicine Dietary Consultation Homeopathy

PRIMARY COMPLAINTS:

1.
2.
3.

MEDICAL HISTORY:

MEDICATIONS: Please list all prescribed (allopathic) drugs, non-prescribed medications, vitamins, herbs etc., you are taking, stating what they are used for.

1.
2.
3.
4.

Please check: Do you use or do any of the following on a regular basis?

Alcohol	Tobacco	Drugs	Coffee or Tea	Exercise	Soft drinks	Sugar	Soy Products	Wheat/ Gluten	Vegetarian diet	Vegan diet

Please list any hospitalizations, accidents, and past illnesses. Include dates and ages.

1.
2.
3.
4.

Please list any serious diseases in your family history such as Cancer, Diabetes, Hypertension, Heart disease etc.

Mother: Father:

Grandparents: Siblings:

Identity

Asian Medicine seeks to understand you as a whole person, in order to provide treatment most tailored to you. Your identity - both from your own perspective and how that affects your experience in society - may be an important component of your health picture. Some aspects of your identity may be fairly obvious to others, while some aspects would be known only to you. We are interested in learning about all the aspects of your identity that you feel may contribute (positively, negatively, or neutrally) to your health and well-being. We welcome discussion about identity in the context of providing you the best healthcare possible, using the tools of Asian Medicine. Please circle areas that apply to you.

Age Sex Gender Sexual Orientation Race Ethnicity Religion Disability Other _____

Please check or circle current complaints

General

Spontaneous Sweating	Sleep Apnea	Braces/orthodontia
Excessive Sweating	Nightmares	Grinding Teeth / TMJ
Night Sweats	Average # of Hours of Sleep @ Night? _____	Loss of Smell or Taste
Lack of Sweating	Wake Up Tired	Swollen Glands
Hot or Cold Intolerance	Wake up too Early	Lymphedema
Cold Hands or Feet or All Over	Fatigue	Vertigo / Dizziness
Freezing Hands or Feet or All Over	Weakness	Bleed or Bruise Easily
Hot Hands or Feet or All Over	Sudden Energy Drop: time? _____	Hair loss
Fevers / Chills	Palpitations / Awareness of Heart Beat	Weight Gain/Loss
Aversion to Hot Weather or Summer	Dry Ears	Cravings
Aversion to Cold Weather or Winter	Dry Eyes	Premature birth
Aversion to Humidity/Damp Weather	Dry Nose	Forceps delivery
Aversion to Wind or Air Conditioning	Dry Throat	Held in an incubator
Sleep Too Much	Dry Mouth	Life threatening event
Light Sleep	Bitter Taste in Mouth	Auto-Immune disease
Difficulty Falling Asleep	Metallic Taste in Mouth	Immune issues like high ANA titer
Difficulty Staying Asleep	Sweet Taste in Mouth	Infections e.g. HIV+, Lyme, EBV
Sleep Interrupted due to Pain?	Salty Taste in Mouth	Cancer
Sleep Interrupted due to Thoughts?	Sticky Taste in Mouth	Diagnosis of Hemophilia? Y N
Sleep Interrupted due to Urination?	Dental amalgam fillings	Other?
Sleep Interrupted due to Other?	Removal of teeth	

Musculoskeletal

Neck Pain	**Type of pain:** Sharp	Convulsions
Jaw Pain	Fixed / Static	Reduced range of motion of joint
Shoulder Pain	Oppressive	Cracking / Crepitus of Joint(s)
Arm Pain	Dull	Deformities of Bones
Elbow Pain	Movable	Brittle Bones
Hand/Wrist Pain	Soreness	Leg Cramps
Back Pain	Stiffness	Muscle Atrophy
Rib Pain	Pricking	Muscle Pains
Hernia Pain	Radiating	Muscle Spasms Location?
Hip Pain	Tightness	Muscle Weakness

Leg Pain	Hypermobile	Other:
Knee Pain	Joint Swelling	
Foot/Ankle Pains		

Neurological

Traumatic Head Injury – Lost Consciousness? Yes No	Weakness of Limb, Loss of Grip Strength	Recent Aversion to Loud Noise or Crowds
Severe Emotional Trauma - PTSD	Paralysis	Slow Speech
Areas of Numbness, Tingling, Electric	Uncontrolled, Excessive Movement	Inappropriate Speech
Tremors / Tics	Poor Memory / Concentration	Poor Word Recall
Seizures	Confusion / Brain fog	Social Isolation
Convulsions	Cognitive Impairment	Increased Need for Sleep
Restless Legs	Poor Brain Endurance	Fatigue Easily with Common Tasks
Lack of Coordination / Balance	Deteriorations with Handwriting	
Frequent Falls	Stroke or TIA (Transient Ischemic Attack)	Other:

Dermatological

Eczema	Pus or boils	Cracking or Flaking
Rosacea	Ulcerations	Scaling
Psoriasis	Sores; location _____ ?	Oily
Rash	**Quality of skin:**	Dryness
Acne	Itching	Burning
Fungal Infections	Redness	Other:

Cardiovascular

High Blood Pressure	Swelling of Feet/Hands	High Triglyceride Levels
Low Blood Pressure	Shortness of Breath	Varicose Veins
Irregular Heartbeat	Fainting	Blood Clots
Rapid Heartbeat	Atherosclerosis	Chest Pain
Slow Heartbeat	High Cholesterol Levels	Other:

Respiratory

Allergies	Cough with Scanty Phlegm	Difficulty Breathing
Catch Colds Frequently/Easily	Dry Cough	Difficulty Laying Down
Asthma	Phlegm Hard to Expectorate	Coughing up blood
Bronchitis	Phlegm Easy to Expectorate	Snoring
Pneumonia	White Phlegm	Excessive Salivation
Cough with Profuse Phlegm	Yellow Phlegm	Other:

Gastrointestinal

Increased Appetite	Bad Breath	Dry Stools
Decreased Appetite	Mouth Sores	Mucus in Stool
Bloating after Eating	Painful / bleeding gums	Itchy Anus
Gas after Eating	Burning Tongue	Anal Fissures
Pain after Eating	Problems Swallowing	Hemorrhoids
Epigastric Fullness after Eating	Nausea	Diabetes Type 1 or 2
Food Sits in Stomach	Belching	Insulin Resistance
Upper Epigastric pain	Hiccups	Gallstones
Heartburn / Reflux / Indigestion	Hiatal Hernia	Hepatitis
Lower Abdominal Pain	Vomiting	Pancreatitis

Rectal Pain	Gas	Parasites
Tense-Type Pain	Constipation	Eat Three Meals / day
Stabbing Pain	Frequency of Bowel Movement?	Eat Two Meals / day
Distending Pain	Forceless Bowel Movement	Eat One Meal / day
Dull Pain	Incomplete Bowel Movement	More than Three Meals a Day
Not Thirsty	Stool Incontinence	Big Meals
Thirst for Cold Liquids	Difficult Bowel Movement	Small Meals
Thirst for Warm or Hot Liquids	Painful Bowel Movement	Snacks Only
Drinking causes Bloating	Formed Stools	Smoothie
Thirst at Night	Loose Stools	Food Allergies – Which?
Thirsty but Drinking causes immediate Fullness	Liquid Stools or Diarrhea	Desire for Hot, Cooked / Cold, Raw Foods
Drinking causes Nausea	Sticky Stools	Current Weight_____lbs
Drinking doesn't Quench Thirst	Bloody Stools	Current Height_____' _____"

Genito-Urinary

Urination: Less than 4 x Day	Interrupted Urination	Red / Pink Urine
4-6 x Day	Hesitant Urination	Cloudy Urine
Over 6 x Day	No Force to Urinate	Odorous Urine
Night Time Urination Frequency? _____	Bedwetting	Genital Sores
Painful Urination	Incontinence	Interstitial Cystitis
Difficult Urination	Dark Yellow Urine	Urinary Tract Infection
Urgent Urination	Light Yellow Urine	Edema: where? _____
Profuse Urination	Clear Urine	Other:

Head, Eyes, Ears, Nose & Throat

Headaches	Earache	Runny Nose
Migraines	Tinnitus / Ringing in Ears	Peculiar Smells
Eye Pain	Poor Hearing	Nose Bleeding
Blurry Vision	Deafness	Sore Throat
Poor Vision	Fainting	Lump in Throat
Poor Night Vision	Blocked Sinuses	Laryngitis
Light Sensitivity	Post-nasal Drip	Tonsillitis
Spots in Front of Eyes / Floaters	Sneezing	Other:
Pressure in Eyes / Ears	Nasal Polyps	

Emotional

Happy	Emotional / Weepy	Worry, Over-thinking
Content	Disconnected	Fearful
Numb or Flat	Easy Irritable	Mood Swings
Sensitive	Easily Angered	Suicidal
Sad	Aggressive / Bad Temper	Mental Illness
Discontent	Low Stress Tolerance	Depressed

Women

Age Menses began _____	Menstrual Cramps Radiating into Legs	Thin Endometrium
Cycle Length: _____ Days	PMS	Endometriosis
Days of bleeding: _____ Days	Increased Libido	Fibroids Adhesions Cysts
Regular Menstrual Cycle	Decreased Libido	Facial Hair Growth

Irregular Menstrual Cycle	Sexually Transmitted Disease	Polycystic Ovarian Disease (PCOS)
Early Menses	HPV positive? Yes No	Vaginal Discharge
Late Menses	Tested positive for Chlamydia? Yes No	Scanty Discharge
Menses Every _____ Months	Pelvic Inflammatory Disease	Profuse Discharge
No Periods / Amenorrhea	Pelvic Pain	Strong Odor
Menstrual Blood Color: _____	Date of last PAP? _____	Vaginal Pain
Color of Blood: Red	Method of Birth Control	Vaginal Sores
Color of Blood: Pale or Light	Number of Pregnancies _____	Vaginal Dryness
Color of Blood: Brown	Number of Children _____	Breast Soreness
Color of Blood: Dark Red	Number of Abortions _____	Fibrocystic Breasts
Clots	Number of Miscarriages _____	Breast Cancer
Scanty Menstrual Bleeding	Are you pregnant? Yes No	Ovarian / Uterine Cancer
Heavy Menstrual Bleeding	Difficult Birth / Caesareans	Hot Flashes
Menstrual Cramps	Thick Endometrium	Age at Menopause _____
Female Fertility issues	Infertility	
Used birth control pills or Depo-Provera	Luteal Phase Problems	# of IUI cycles? _____ # of IVF cycles? _____
Day 3 FSH level _____	AMH level _____	Low Progesterone
Other:		

Men

Benign Prostate Enlargement	Testicular Cancer	Increased Libido
Prostate Cancer	Undescended Testicle	Discharge
Scrotal Itching	Erectile Dysfunction	Premature Ejaculation
Scrotal Dampness	Impotence	Sexually Transmitted Disease
Scrotal Pain	Soft Erections	Perianal Soreness
Painful / Swollen Testicles	Decreased Libido	Morning Erections?
Male Fertility issues	Infertility	Varicocele
Undescended testicles	Sperm Analysis normal? Yes No	Low Sperm Count
Low Sperm Motility	Immune issues like Antisperm Antibodies	Other:

Anything else you would like us know:

_____

_____

_____

Health Questionnaire

Please circle appropriate number: 0=never/least, 1=occasionally, 2=frequent, 3=all the time

SECTION - A	0	1	2	3	How often do you feel you lack artistic appreciation?	0	1	2	3
Is your memory noticeably declining?	0	1	2	3	How often do you feel depressed in overcast weather?	0	1	2	3
Are you having a hard time remembering names and phone numbers?	0	1	2	3	How much are you losing your enthusiasm for your favorite activities?	0	1	2	3
Is your ability to focus noticeably declining?	0	1	2	3	How much are you losing enjoyment for your favorite foods?	0	1	2	3
Has it become harder for you to learn things?	0	1	2	3	How much are you losing enjoyment of friendships and relationships?	0	1	2	3
How often do you have a hard time remembering your appointments?	0	1	2	3	How often do you have difficulty falling into deep restful sleep?	0	1	2	3
Is your temperament getting worse in general?	0	1	2	3	How often do you have feelings of dependency on others?	0	1	2	3
Are you losing your attention span endurance?	0	1	2	3	How often do you feel more susceptible to pain?	0	1	2	3
How often do you find yourself down or sad?	0	1	2	3	How often do you have feelings of unprovoked anger?	0	1	2	3
How often do you fatigue when driving compared to the past?	0	1	2	3	How much are you losing interest in life?	0	1	2	3
How often do you fatigue when reading compared to the past?	0	1	2	3	**SECTION 2 - D**	0	1	2	3
How often do you walk into rooms and forget why?	0	1	2	3	How often do you have feelings of hopelessness?	0	1	2	3
How often do you pick up your cell phone and forget why?	0	1	2	3	How often do you have self-destructive thoughts?	0	1	2	3
SECTION - B	0	1	2	3	How often do you have an inability to handle stress?	0	1	2	3
How high is your stress level?	0	1	2	3	How often do you have anger and aggression while under stress?	0	1	2	3
How often do you feel that you have something that must be done?	0	1	2	3	How often do you feel you are not rested even after long hours of sleep?	0	1	2	3
Do you feel you never have time for yourself?	0	1	2	3	How often do you prefer to isolate yourself from others?	0	1	2	3
How often do you feel you are not getting enough sleep or rest?	0	1	2	3	How often do you have unexplained lack of concern for family and friends?	0	1	2	3
Do you find it difficult to get regular exercise?	0	1	2	3	How easily are you distracted from your tasks?	0	1	2	3
Do you feel uncared for by the people in your life?	0	1	2	3	How often do you have an inability to finish tasks?	0	1	2	3
Do you feel you are not accomplishing your life's purpose?	0	1	2	3	How often do you feel the need to consume caffeine to stay alert?	0	1	2	3
Is sharing your problems with someone difficult for you?	0	1	2	3	How often do you feel your libido has been decreased?	0	1	2	3
SECTION C1	0	1	2	3	How often do you lose your temper for minor reasons?	0	1	2	3
How often do you get irritable, shaky, or have lightheadedness between meals?	0	1	2	3	How often do you have feelings of worthlessness?	0	1	2	3
How often do you feel energized after eating?	0	1	2	3	**SECTION 3 – G**	0	1	2	3
How often do you have difficulty eating large meals in the morning?	0	1	2	3	How often do you feel anxious of panic for no reason?	0	1	2	3
How often does your energy level drop in the afternoon?	0	1	2	3	How often do you have feelings of dread or impending doom?	0	1	2	3
How often do you crave sugar and sweets in the afternoon?	0	1	2	3	How often do you feel knots in your stomach?	0	1	2	3
How often do you wake up in the middle of the night?	0	1	2	3	How often do you have feelings of being overwhelmed for no reason?	0	1	2	3
How often do you have difficulty concentrating before eating?	0	1	2	3	How often do you have feelings of guilt about everyday decisions?	0	1	2	3
How often do you depend on coffee to keep yourself going?	0	1	2	3	How often does your mind feel restless?	0	1	2	3
How often do you feel agitated, easily upset, and nervous between meals?	0	1	2	3	How difficult is it to turn you mind off when you want to relax?	0	1	2	3
SECTION - C2	0	1	2	3	How often do you have disorganized attention?	0	1	2	3
Do you get fatigued after meals?	0	1	2	3	How often do you worry about things you were not worried about before?	0	1	2	3
Do you crave sugar and sweets after meals?	0	1	2	3	How often do you have feelings of inner tension and inner excitability?	0	1	2	3
Do you feel you need stimulants such as coffee after meals?	0	1	2	3	**SECTION 4 - ACH**	0	1	2	3
Do you have difficulty losing weight?	0	1	2	3	Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
How much larger is your waist girth compared to your hip girth?	0	1	2	3	Do you feel your verbal memory is decreased?	0	1	2	3
Do you suffer from frequent urination?	0	1	2	3	Do you have memory lapses?	0	1	2	3
Have your thirst and appetite been increased?	0	1	2	3	Has your creativity been decreased?	0	1	2	3
Do you experience weight gain when under stress?	0	1	2	3	Has your comprehension been diminished?	0	1	2	3
Do you have difficulty falling asleep?	0	1	2	3	Do you have difficulty calculating numbers?	0	1	2	3
SECTION 1 – S	0	1	2	3	Do you have difficulty recognizing objects & faces?	0	1	2	3
Are you losing your pleasure in hobbies and interests?	0	1	2	3	Do you feel like your opinion about yourself has changed?	0	1	2	3
How often do you feel overwhelmed with ideas to manage?	0	1	2	3	Are you experiencing excessive urination?	0	1	2	3
How often do you have feelings of inner rage (anger)?	0	1	2	3	Are you experiencing slower mental response?	0	1	2	3
How often do you have feelings of paranoia?	0	1	2	3					
How often do you feel sad or down for no reason?	0	1	2	3					
How often do you feel like you are **not** enjoying life?	0	1	2	3					