# Intake Form

Name: ________________________________________ Date: _________________________
Address: ____________________________ Telephone #: _________________________
DOB: ___________________________ Occupation: __________________________
Email: _______________________________ Family Doctor: _______________________
Emergency Contact/tel: _____________________________________________________________

## Chief Complaint

What is the chief complaint? ___________________________________________________

The onset/duration: ___________________________________________________________

Concurrent treatments/therapies/: ______________________________________________

______________________________________________________________________________

### Family Medical History

☐ Allergy ☐ Cancer
☐ Seizure ☐ Diabetes
☐ Alcoholism ☐ Asthma
☐ Hypertension
☐ Stroke/Heart Disease
☐ Other

Comments:
______________________
______________________
______________________
______________________
______________________

### Past Medical History

☐ Allergy ☐ Cancer
☐ Seizure ☐ Diabetes
☐ Alcoholism ☐ Surgeries
☐ Venereal Disease
☐ Liver Disease
☐ Accidents/Trauma
☐ Stroke/Heart Disease
☐ Birth Trauma
☐ Childhood Illness
☐ Other

Comments:
______________________
______________________
______________________

### Social History

☐ Exercise ☐ Diet
☐ Smoking ☐ Alcohol
☐ Street Drugs
☐ Medications
☐ Cannabis ☐ CBD oil
☐ Vitamins
☐ Caffeine
☐ Herbs/Homeopathic
☐ Occupational Stress
☐ Other

Comments:
____________________
____________________

Surgeries/ Accidents:_________________________________________________________
______________________________________________________________________________

### Chills/Fever

Do you experience any chills or fever?
☐ Yes ☐ No
☐ Alternating chills/fever
☐ Day ☐ Night
☐ Spontaneously
☐ Low grade fever
☐ Chronic low-grade fever
☐ Other

Comments:_______________
_______________________
_______________________
_______________________

### Abnormal Perspiration

Any abnormal sweating?
☐ Yes ☐ No
☐ Day ☐ Night
☐ Spontaneously
☐ Color
☐ With exertion
☐ Odor
☐ Without exertion
☐ Hot flashes
☐ Night sweating
☐ Other

Comments:____________
____________________

### Sleep

Do you sleep well?
☐ Yes ☐ No
# of hours per night: ___
Bedtime ____ Rise ___
☐ Trouble falling asleep
☐ Trouble staying asleep
☐ Recurrent dreams
☐ Nightmares
☐ Trouble getting out of bed
☐ Sleep walk ☐ Sleep Talk
☐ Shift work
☐ Other

Comments:_____________
______________________

| Appetite | Pain |
|---|---|
| ☐ Good ☐ Poor<br><br>☐ Recent Changes ☐ Thirst<br>☐ Food cravings ☐ Wt gain/loss<br>☐ Prefer hot/cold drink ☐ Fullness<br>☐ Prefer hot/cold food ☐ Fullness after eating<br>☐ Eat regular meals ☐ Lack of appetite<br>☐ Insatiable appetite<br>☐ Unusual Tastes (sweet, sour, salty, pungent, metallic)<br>☐ Other<br><br>Comments:______________________________<br>_________________________________________<br>_________________________________________ | Do you have pain?<br>☐ Yes ☐ No<br><br>☐ Fixed ☐ Migrates ☐ Constant<br>☐ Intermittent ☐ Dull ☐ Sharp/stabbing<br>☐ Acute ☐ Chronic<br>☐ Worse w/ pressure ☐ Worse w/ damp weather<br>☐ Better w/ pressure ☐ Better w/ hot/cold<br>☐ Headache<br>☐ Time of day worse/better<br>☐ Other<br>Comments:__________________________<br>_____________________________________<br>_____________________________________ |

## Neurological

☐ Seizures ☐ Lack of coordination ☐ Weakness/paralysis
☐ Numbness face/limbs ☐ Numbness fingers/toes ☐ Loss of balance
☐ Dizziness: ☐ w/ loss of balance, ☐ w/ heavy/foggy head, ☐ worse w/ fatigue, ☐ sudden onset,
☐ gradual onset ☐ Other ☐ Migraine, How often_________, Last migraine ____
☐ Headache (H/A), How often ______________________, Last H/A ______________________

Comments:_________________________________________________________________________
__________________________________________________________________________________

## Sensory

☐ Ringing in ears: ☐high pitch, ☐low pitch, ☐sudden onset, ☐gradual onset
☐ Hearing impairment: ☐sudden onset, ☐gradual onset ☐ Earaches, ☐ History ear infection
☐ Vision impairments ☐ Eye pain/strain, ☐redness ☐ Dry eyes ☐ Floaters/spots
☐ Sore throat ☐ Jaw/facial pain/TMJ ☐ Teeth/gum problem
☐ Sinus problems ☐ Nose bleeds ☐ Other

Comments:_________________________________________________________________________
__________________________________________________________________________________

## Cardiovascular

☐ Murmur/ irregular heartbeat ☐ Chest pain ☐ Chest pain w/ cough
☐ Cold hands/feet ☐ Hypertension/hypotension ☐ Swelling hands/feet
☐ Other
Comments:_________________________________________________________________________
__________________________________________________________________________________

## Respiratory

☐ Cough ☐ Sputum (mucous) ☐ Phlegm ☐ Shortness of breath
☐ Dyspnea (difficult breathing) ☐ Hemoptysis (cough blood) ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Chest oppression ☐ Other

__________________________________________________________________________________
__________________________________________________________________________________

## Gastrointestional

How often do you have a bowel movement ___________

☐ Nausea/Vomiting ☐ Heartburn/indigestion/ulcer ☐ Abd pain/cramps
☐Constipation ☐Diarrhea ☐ Hemafecia (blood in the stool) ☐ Gas ☐Bloating
☐ Hemorrhoids/rectal pain ☐ Bowel incontinence ☐ Other
☐ Unusual color/odor ☐ Undigested food/mucous ☐Greasy
☐Texture (formed, small pieces, turds, pellets, thin, watery, explosive) _____________________
Comments:_____________________________________________________________________
_______________________________________________________________________________

## Genitourinary

Frequency of urination ____________ Color of urine _________________

☐ Dysuria (pain/ difficult) ☐ Frequency/urgency ☐ Nocturia (waking at night to urinate)
☐ Urinary incontinence ☐ Hematuria (blood) ☐ Scanty/profuse
☐ Kidney stones ☐ Impotence ☐ Other
Comments:_____________________________________________________________________

## Gynecological

Age of menopause _____ ☐ Instant menopause (from surgery) ☐ Peri-menopausal ______
☐ Hot flashes ☐ Night sweats

Gravida (# of pregnancies)_______ Para (# of births)_______ Are you pregnant? ________

Menstruation
Age of menarche (onset of 1st period) ______ Length of menses ______ Days in cycle _______

Colour of blood (brown, burgundy, Red: dark, bright, pale, orangey) ______________________

☐Headaches: ☐ Before ☐ During ☐ After period
☐ Menstrual clots ☐ Painful ☐ PMS Flow: ☐ Heavy ☐ Scanty ☐ Watery
☐ Irregular menses ☐ Early periods ☐ Late periods ☐ Vaginal discharge/odor/color☐
☐ Breast swelling/lumps ☐ Birth control ___________ ☐ Other
☐ Libido (low, medium, high) ☐ Libido function (pain, vaginal dryness, overthinking, illness…)
Comments:_____________________________________________________________________
_______________________________________________________________________________

## Integumentary

☐ Rashes/hives ☐ Eczema/psoriasis ☐ Itchiness
☐ Ulcerations ☐ Recent moles/changes ☐ Pimples
☐ Dandruff ☐ Changes in hair/skin texture ☐ Other

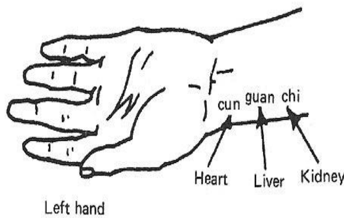
Comments:_____________________________________________________________________
_______________________________________________________________________________

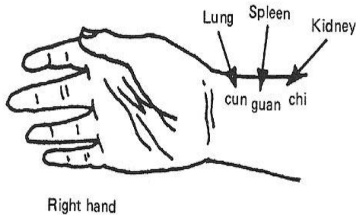
## Psychosocial

☐ Temper/anger problems ☐ Depression/anxiety/stress ☐ Emotional disorder
☐ Insomnia ☐ Poor Memory ☐ Other
Comments:_____________________________________________________________________
_______________________________________________________________________________

# PRACTITIONER'S USE

## Pulse Diagnosis




Description:
Rate/Quality___________________________________________________

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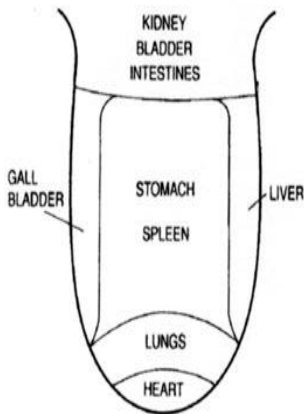
## Tongue Diagnosis




Qualities:
☐ Dry ☐ Rough ☐ Rigid ☐Hard ☐ Greasy
☐ Peeled ☐ Papillae XS ________ ☐ Papillae DEF __________
☐ Sides ulcerated ☐ Curled ☐ Moist
☐ Ulcerated ☐ Scalloped ☐ Swollen ☐ Wet ☐ Wind
Cracking: ☐ vertical ______ ☐ horizontal _____________
Body Colour ____________ Body Shape ________________
☐ Coating ____________, ☐Thick, ☐ Thin, ☐ Rooted ☐ Geographic

Comments:_____________________________________________

___________________________________________________

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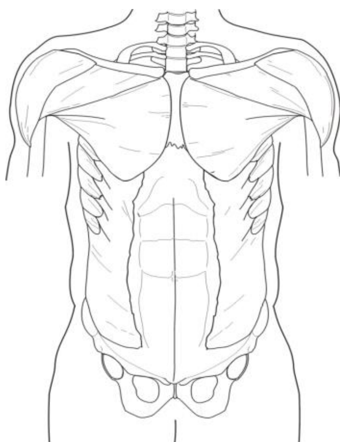
___________________________________________________

## Hara Diagnosis



Pain palpated at MU points:
☐ LU- LU 1 ☐ PC- CV 17 ☐ LV- LV 14 (6th)
☐ HT- CV14 ☐ GB- GB 24 (7th) ☐ ST- CV 12
☐ KI- GB 25 (12th) ☐ SP- LV 13 (11th) ☐ LI – ST 25
☐ SJ- CV 5 ☐ SI- CV 4 ☐ UB- CV 3
Comments_____________________________________________

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# Practitioner's Notes