

Intake Form

Client Name: _____ Date: _____
 Address: _____ Telephone #: _____
 DOB: _____ Occupation: _____
 Email: _____ Family Doctor: _____
 Emergency Contact/tel: _____
 Receive Victoria's Wellness News/Updates: Yes No

Chief Complaint

What is the chief complaint? _____

The onset/duration: _____

Concurrent treatments/therapies/: _____

<u>Family Medical History</u>	<u>Past Medical History</u>	<u>Social History</u>
<input type="checkbox"/> Allergy <input type="checkbox"/> Cancer <input type="checkbox"/> Seizure <input type="checkbox"/> Diabetes <input type="checkbox"/> Alcoholism <input type="checkbox"/> Asthma <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke/Heart Disease <input type="checkbox"/> Other Comments: _____ _____ _____ _____ _____	<input type="checkbox"/> Allergy <input type="checkbox"/> Cancer <input type="checkbox"/> Seizure <input type="checkbox"/> Diabetes <input type="checkbox"/> Alcoholism <input type="checkbox"/> Surgeries <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Accidents/Trauma <input type="checkbox"/> Stroke/Heart Disease <input type="checkbox"/> Birth Trauma <input type="checkbox"/> Childhood Illness <input type="checkbox"/> Other Comments: _____ _____	<input type="checkbox"/> Exercise <input type="checkbox"/> Diet <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Street Drugs <input type="checkbox"/> Medications <input type="checkbox"/> Vitamins <input type="checkbox"/> Caffeine <input type="checkbox"/> Herbs/Homeopathic <input type="checkbox"/> Occupational Stress <input type="checkbox"/> Other Comments: _____ _____ _____

<p style="text-align: center;"><u>Chills/Fever</u></p> <p>Do you experience any chills or fever?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Spontaneously <input type="checkbox"/> Other Comments: _____ _____ _____ _____	<p style="text-align: center;"><u>Perspiration</u></p> <p>Do you sweat?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Spontaneously <input type="checkbox"/> Color <input type="checkbox"/> With exertion <input type="checkbox"/> Odor <input type="checkbox"/> Without exertion <input type="checkbox"/> Other Comments: _____ _____ _____	<p style="text-align: center;"><u>Sleep</u></p> <p>Do you sleep well?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No # of hours per night: ____ <input type="checkbox"/> Trouble falling asleep <input type="checkbox"/> Trouble staying asleep <input type="checkbox"/> Recurrent dreams <input type="checkbox"/> Trouble getting out of bed <input type="checkbox"/> Other Comments: _____ _____ _____
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<u>Appetite</u>	<u>Pain</u>
<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Recent Changes <input type="checkbox"/> Thirst <input type="checkbox"/> Food cravings <input type="checkbox"/> Wt gain/loss <input type="checkbox"/> Prefer hot/cold <input type="checkbox"/> Fullness <input type="checkbox"/> Unusual Tastes <input type="checkbox"/> Other Comments: _____ _____ _____ _____ _____ _____	Do you have pain? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Fixed <input type="checkbox"/> Migrates <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Worse w/ pressure <input type="checkbox"/> Relieved w/ pressure <input type="checkbox"/> Better w/ hot/cold <input type="checkbox"/> Headache <input type="checkbox"/> Time of day worse/better <input type="checkbox"/> Other Comments: _____ _____ _____

Neurological

- | | | |
|---|--|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Weakness/paralysis | <input type="checkbox"/> Numbness face/limbs | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Other | |

Comments: _____

Sensory

- | | | |
|---|---|--|
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Vision impairments | <input type="checkbox"/> Eye pain/strain | <input type="checkbox"/> Floaters/spots |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Jaw/facial pain | <input type="checkbox"/> Teeth/gum problem |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Other |

Comments: _____

Cardiovascular

- | | | |
|---|--|--|
| <input type="checkbox"/> Murmur/ irr heart beat | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Hypertension/hypotension | <input type="checkbox"/> Swelling hands/feet | <input type="checkbox"/> Other |

Comments: _____

Respiratory

- | | | |
|------------------------------------|---|---------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Sputum | <input type="checkbox"/> SOB |
| <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Hemoptysis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chest oppression | <input type="checkbox"/> Other |

Gastrointestinal

Frequency of BM (bowel movement) _____ Last BM _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Heartburn/indigestion/ulcer | <input type="checkbox"/> Abd pain/cramps |
| <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Hemafecia | <input type="checkbox"/> Gas/bloating |
| <input type="checkbox"/> Hemorrhoids/rectal pain | <input type="checkbox"/> Bowel incontinence | <input type="checkbox"/> Other |
| <input type="checkbox"/> Unusual color/odor | <input type="checkbox"/> Undigested food/mucous | |

Comments: _____

Genitourinary

Frequency of urination _____ Color of urine _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Dysuria | <input type="checkbox"/> Frequency/urgency | <input type="checkbox"/> Nocturia |
| <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Hematuria | <input type="checkbox"/> Scanty/profuse |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Impotence | <input type="checkbox"/> Other |

Comments: _____

Reproductive

Age of menarche _____ Age of menopause _____ Length of menses _____

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

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Menstrual clots | <input type="checkbox"/> Painful/irregular menses | <input type="checkbox"/> Heavy flow |
| <input type="checkbox"/> Irregular menses | <input type="checkbox"/> Vaginal discharge/odor/color | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Breast swelling/lumps | <input type="checkbox"/> Birth control | <input type="checkbox"/> Other |

Comments: _____

Integumentary

- | | | |
|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Rashes/hives | <input type="checkbox"/> Eczema/psoriasis | <input type="checkbox"/> Itchiness |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Recent moles/changes | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Changes in hair/skin texture | <input type="checkbox"/> Other |

Comments: _____

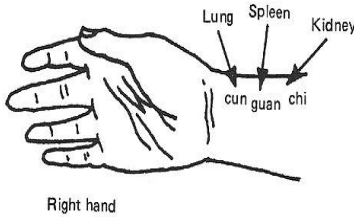
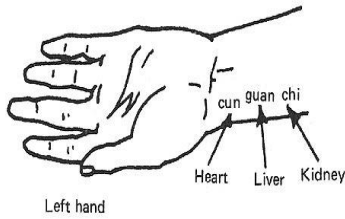
Psychosocial

- | | | |
|--|--|---|
| <input type="checkbox"/> Temper/anger problems | <input type="checkbox"/> Depression/anxiety/stress | <input type="checkbox"/> Emotional disorder |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Other |

Comments: _____

PRACTITIONER'S USE

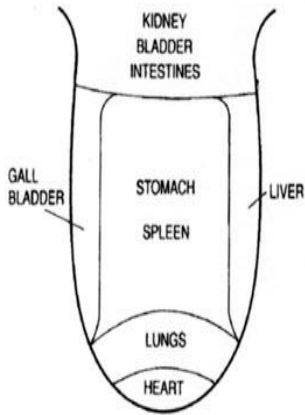
Pulse Diagnosis



Description:

Rate/Quality _____

Tongue Diagnosis

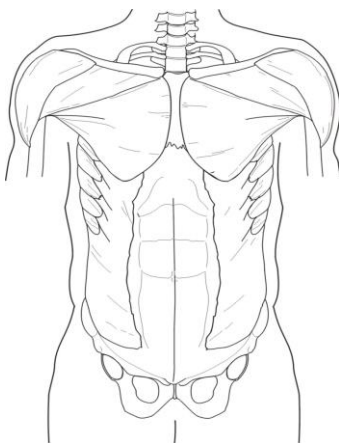


Qualities:

- | | | | |
|--|------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Dry | <input type="checkbox"/> Moist | <input type="checkbox"/> Wet | <input type="checkbox"/> Greasy |
| <input type="checkbox"/> Peeled | <input type="checkbox"/> Lolling | <input type="checkbox"/> Prickles | <input type="checkbox"/> Hard |
| <input type="checkbox"/> Loose | <input type="checkbox"/> Curled | <input type="checkbox"/> Rough | <input type="checkbox"/> Swollen |
| <input type="checkbox"/> Ulcerated | <input type="checkbox"/> Scalloped | <input type="checkbox"/> Wet | <input type="checkbox"/> Rigid |
| <input type="checkbox"/> Coating _____ | | | |

Comments: _____

Hara Diagnosis



Pain palpated at MU points:

- | | | |
|------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> LU- LU 1 | <input type="checkbox"/> PC- CV 17 | <input type="checkbox"/> LV- LV 14 |
| <input type="checkbox"/> HT- CV14 | <input type="checkbox"/> GB- GB 24 | <input type="checkbox"/> ST- CV 12 |
| <input type="checkbox"/> KI- GB 25 | <input type="checkbox"/> SP- LV 13 | <input type="checkbox"/> LI - ST 25 |
| <input type="checkbox"/> SJ- CV 5 | <input type="checkbox"/> SI- CV 4 | <input type="checkbox"/> UB- CV 3 |

Comments _____
