Intake Form

Client 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
- ☐ Vitamins
- ☐ Caffeine
- ☐ Herbs/Homeopathic
- ☐ Occupational Stress
- ☐ Other

Comments:
_____
_____
_____

Chills/Fever

Do you experience any chills or fever?

- ☐ Yes
- ☐ No

- ☐ Day
- ☐ Night
- ☐ Spontaneously
- ☐ Other

Comments:_____
_____
_____
_____
_____
_____

Perspiration

Do you sweat?

- ☐ Yes
- ☐ No

- ☐ Day
- ☐ Night
- ☐ Spontaneously
- ☐ Color
- ☐ With exertion
- ☐ Odor
- ☐ Without exertion
- ☐ Other

Comments:_____
_____
_____

Sleep

Do you sleep well?

- ☐ Yes
- ☐ No

# of hours per night: ___

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Recurrent dreams
- ☐ Trouble getting out of bed
- ☐ Other

Comments:_____
_____
_____

Appetite

□ Good □ Poor

□ Recent Changes □ Thirst
□ Food cravings □ Wt gain/loss
□ Prefer hot/cold □ Fullness
□ Unusual Tastes □ Other

Comments:_____
_____
_____
_____
_____
_____
_____

Pain

Do you have pain?
□ Yes □ No

□ Fixed □ Migrates
□ Constant □ Intermittent
□ Worse w/ pressure
□ Relieved w/ pressure
□ Better w/ hot/cold
□ Headache
□ Time of day worse/better
□ Other

Comments:_____
_____
_____

Neurological

□ Seizures □ Headaches □ Dizziness
□ Weakness/paralysis □ Numbness face/limbs □ Loss of balance
□ Lack of coordination □ Other

Comments:_____
_____

Sensory

□ Ringing in ears □ Hearing impairment □ Earaches
□ Vision impairments □ Eye pain/strain □ Floaters/spots
□ Sore throat □ Jaw/facial pain □ Teeth/gum problem
□ Sinus problems □ Nose bleeds □ Other

Comments:_____
_____

Cardiovascular

□ Murmur/ irr heart beat □ Chest pain □ Cold hands/feet
□ Hypertension/hypotension □ Swelling hands/feet □ Other

Comments:_____
_____

Respiratory

□ Cough □ Sputum □ SOB
□ Dyspnea □ Hemoptysis □ Asthma
□ Pneumonia □ Chest oppression □ Other

_____

Gastrointestional

Frequency of BM (bowel movement) _____ Last BM _____

□ Nausea/Vomiting	□ Heartburn/indigestion/ulcer	□ Abd pain/cramps
□Constipation/diarrhea	□ Hemafecia	□ Gas/bloating
□ Hemorrhoids/rectal pain	□ Bowel incontinence	□ Other
□ Unusual color/odor	□ Undigested food/mucous	

Comments:_____
_____

Genitourinary

Frequency of urination _____ Color of urine _____

□ Dysuria	□ Frequency/urgency	□ Nocturia
□ Urinary incontinence	□ Hematuria	□ Scanty/profuse
□ Kidney stones	□ Impotence	□ Other

Comments:_____
_____

Reproductive

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

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

□ Menstrual clots	□ Painful/irregular menses	□ Heavy flow
□ Irregular menses	□ Vaginal discharge/odor/color	□ PMS
□ Breast swelling/lumps	□ Birth control	□ Other

Comments:_____
_____

Integumentary

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

Comments:_____
_____

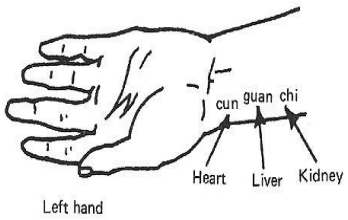
Psychosocial

□ Temper/anger problems	□ Depression/anxiety/stress	□ Emotional disorder
□ Insomnia	□ Poor Memory	□ Other

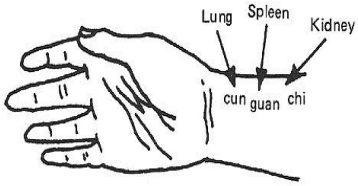
Comments:_____
_____

PRACTITIONER'S USE

Pulse Diagnosis



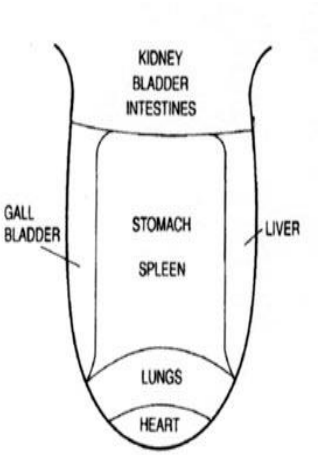
Left hand



Right hand

Description:
Rate/Quality_____
_____
_____
_____
_____
_____
_____

Tongue Diagnosis



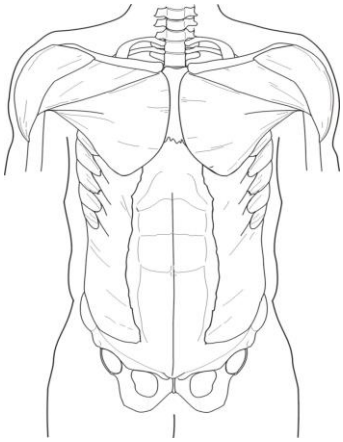
Qualities:

□ Dry	□ Moist	□ Wet	□ Greasy
□ Peeled	□ Lolling	□ Prickles	□ Hard
□ Loose	□ Curled	□ Rough	□ Swollen
□ Ulcerated	□ Scalloped	□ Wet	□ Rigid

□ Coating _____

Comments:_____
_____
_____
_____

Hara Diagnosis



Pain palpated at MU points:

□ LU- LU 1	□ PC- CV 17	□ LV- LV 14
□ HT- CV14	□ GB- GB 24	□ ST- CV 12
□ KI- GB 25	□ SP- LV 13	□ LI – ST 25
□ SJ- CV 5	□ SI- CV 4	□ UB- CV 3

Comments_____
_____

Practitioner's Notes