



Traditional Chinese Medicine Patient Intake Form

Last Name: _____ First Name: _____ Date: _____		
Address: _____ Apt # _____ City/Province _____ Postal Code _____		
Date of Birth: _____ Occupation: _____		
Home Phone: _____ Cel #: _____ Work#: _____		
E-mail: _____ Would you like to be on our seasonal e-mailing list? Yes / NO		
Have you ever been treated with traditional Chinese medicine? YES / NO		
<i>*If so, please circle any treatments you have received</i>		
Acupuncture Tuina Massage Moxibustion Herbal Medicine Cupping Other: _____		
Physicians		Emergency Contact
Current Medication		
Chief complaint for treatment		
Family Medical History <input type="checkbox"/> Allergies <input type="checkbox"/> Cancer <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke, Heart Attack <input type="checkbox"/> Alcoholism <input type="checkbox"/> Asthma <input type="checkbox"/> High blood pressure <input type="checkbox"/> Other _____	Your Past Medical History (with dates) <input type="checkbox"/> Allergies <input type="checkbox"/> Cancer <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke, Heart Attack <input type="checkbox"/> Alcoholism <input type="checkbox"/> Asthma <input type="checkbox"/> High blood pressure <input type="checkbox"/> Surgeries	<input type="checkbox"/> Venereal disease <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Birth trauma <input type="checkbox"/> Childhood illness <input type="checkbox"/> Accidents or significant trauma _____ _____

Please note that acupuncture and tuina massage are very safe. Occasional bruising, and post needling sensation may happen. Fainting may occur for new patients due to nervousness, hunger or extreme tiredness. Chinese herbs are also very safe and effective when recommended by qualified TCM practitioner. Occasional abdominal upset, diarrhea, insomnia and sweating may happen although this can be the response of the body to the treatment. If you have any concerns please do not hesitate to ask.

Acupuncture/Chinese medicine and other TCM remedies are safe and effective for the prevention and treatment of a wide range of health problems, and for the promotion of general well being. Although Acupuncture/TCM are helpful for many health conditions, it is not intended to replace any tests or treatments recommended by your physicians. Please continue your medication prescribed by your physician while you receive TCM services at this clinic.

Exemption of Liability clause:

I _____ hereby request and consent to receive traditional Chinese medical treatments including acupuncture, herbal medicine, and tuina massage from a TCM Practitioner of Living Waters Therapies. I testify that the above treatments and all its ramifications have been fully explained to me.

Name of Patient

Signature of Patient

Date

Your Lifestyle

- | | | | |
|----------------------------------|------------------------------------|---|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stress | <input type="checkbox"/> Regular Exercise |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs | <input type="checkbox"/> Occupational Hazards | |

General Symptoms

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Not rested in the morning | <input type="checkbox"/> Chills | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Heavy Appetite | <input type="checkbox"/> Heavy Sleep | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Bleed or Bruises easily |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Cold hands & feet | <input type="checkbox"/> Sweats easily | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Strongly like hot drinks | <input type="checkbox"/> Restless sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Lack of strength |
| <input type="checkbox"/> Recent weight Gain | <input type="checkbox"/> Dream disturbed sleep | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Dizziness/Vertigo | |

Head, Eyes, Ears, Nose, Throat

- | | | | | |
|--|--|---|---|--------------------------------------|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Jaw tension | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Canker sores (lips/tongue) | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Enlarged thyroid | Other head/neck problems:
_____ |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Nose bleeds | _____ |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Grinds teeth | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Ringing in ears | _____ |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> TMJ | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Poor hearing | |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Facial pain | Phlegm Colour: _____ | <input type="checkbox"/> Earaches | |
| <input type="checkbox"/> Poor/blurred vision | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Headaches | |

Respiratory and Cardiovascular

- | | | | | |
|---------------------------------------|---|---|--|--|
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Cough
Dry or Wet?

Thick or thin
fluid? _____
Colour of
Phlegm: _____ | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Tight chest | | <input type="checkbox"/> Fast heart rate | <input type="checkbox"/> Difficulty breathing when
lying down | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Chest Pain | | <input type="checkbox"/> Irregular heart beat | | <input type="checkbox"/> Blood Clots |

Gastrointestinal

- | | | | | |
|--------------------------------------|---|---|---------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Undigested food in Stool | <input type="checkbox"/> Bloating | <input type="checkbox"/> Itchy anua |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Laxative use | Bowel Movements:
Frequency _____ | <input type="checkbox"/> Gas | <input type="checkbox"/> Burning anus |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Black stools | Color:
Brown/Black/Green/Yellow | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Bloody stools | | Bowels:
Texture: Soft/Firm/Pellets | <input type="checkbox"/> Intestinal pain/cramping |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Mucus in stool | | | <input type="checkbox"/> Strong Smell of Stool |

Musculoskeletal

- | | | | |
|--|---|-------------------------------------|--|
| <input type="checkbox"/> Neck tension/pain | <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Limited use |
| <input type="checkbox"/> Shoulder tension/pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Limited range of motion |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Carpal Tunnel/Wrist pain | <input type="checkbox"/> Joint pain | Other (describe)
_____ |

Skin and Hair

- | | | | | |
|--------------------------------------|------------------------------------|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Change in hair texture | Other hair or skin problems
_____ |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Scalp Tension | _____ |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne | <input type="checkbox"/> Dry Scalp | <input type="checkbox"/> Itchy Scalp | _____ |

Neuropsychological

- | | | | | |
|-----------------------------------|--------------------------------------|--|---|-----------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered/attempted suicide | Other:
_____ |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Seeing a therapist | _____ |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abuse survivor | | _____ |

Genito-urinary

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Noturnal emission |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wakes to urinate | <input type="checkbox"/> Kidney stones | |

Gynecology

- | | | | | |
|-------------------------------|--|--|---------------------------------------|---|
| Age of Menses _____ | Length of cycle _____ days | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Vaginal Odor | # of pregnancies _____ |
| Length of Period _____ days | <input type="checkbox"/> Irregular periods | Color of discharge:
_____ | <input type="checkbox"/> Clots | # of live births _____ |
| Date of last period:
_____ | <input type="checkbox"/> Painful periods | | <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Premature births _____ |
| | <input type="checkbox"/> PMS | <input type="checkbox"/> Vaginal sores | | Age of menopause: _____ |

