Ping Traditional Chinese Medicine Clinic Patient Intake Form

Name ___________________________ Date _______________ Dates of Birth _______________ Gender: __Male __Female

Currently: ___pregnant __pacemaker __HIV disease __hepatitis __blood transfusion

Your Major Doctor’s Name ___________________________ Phone ___________________________

Chief Complaint / Reason For Your Visit: ________________________________________________

How and when did this condition begin? _________________________________________________

Please list your main health concerns you would like to be free of, in order of importance:
1. __________________________________________ 2. __________________________________________
3. __________________________________________ 4. __________________________________________

General Current situation (please check A to K that apply to you within the last 3 months)

A. 1. Fever (___yes ___no) (if yes.) It is ___constantly ___intermittently at specific times ___________

   2. Any hot feeling in/on your body (If yes, please write down which part) ___________________________
   Is it ___constant___ intermittent, at specific times ___________________________________________

   3. Do you feel cold or chill (___yes ___no) (if yes.) Is it ___constant ___intermittent, at specific times__

   4. What makes your cold/chill feel better? _________________________________________________

   5. Is your fever/hot feeling combined with cold/chill (___yes ___no) which one is more prominent____

   6. Does the fever/hot feeling occur simultaneously or separately follow the cold/chill feeling_________

   7. ___ hot flashes ___aversion to cold ___aversion to wind ___Intolerance of heat

B. Please check it out if you have any issues as follow:

   1. ___Do you have abnormal sweat?  2. ___ adiapneustia(no sweat)  3. ___ Do you sweat easily?

   4. What makes your sweating worse? _________________________________________________

   5. Does the sweating occur on the whole body or only on the part of the body? _________________

   6. ___Do you have night sweats?

   7. Do you have other symptoms occurring at the time of your sweating? _______________________

C. 1. Please mark where you have pain or stiffness: ___Head ___Chest ___ hypochondrium pain ___flank

   ___Upper abdomen ___lower abdomen ___upper back ___middle back ___lower back ___Sacrum area ___Neck

   ___Shoulder ___upper arm ___Elbow ___Fore arm ___Wrist ___Palm ___Finger ___Hip ___Thigh ___Knee

   ___Crus(Lower leg) ___Ankle ___Sole ___Heel ___Toes  If you have pain on some place which are not show on the
   above please write here ________________________________________________________________

   2. Character of your pain: ___distending pain ___stabbing pain ___moving pain ___fixed pain ___cold pain
   (crymodynia) ___burning pain ___colic pain ___dull pain ___heaviness ___pulling pain ___empty pain
3. How long have you had this pain ___________________________________________________________

4. What makes your pain better? ____________________________________________________________

What makes your pain worse? ____________________________________________________________

5. Is the pain __ constant __ intermittent or at specific time___________________________________

D. Please check if you have any symptoms as following: 1. ___ dizziness ___ vertigo ___ choking sensation
in the chest ___ Palpitation ___ fainting ___ high blood pressure ___ low blood pressure ___ irregular heart
beat ___ heart pounding ___ tightness in the chest ___ chest pain ___ loss of consciousness

2. ___ heaviness ___ numbness ___ fatigue ___ cold hands ___ cold feet ___ swelling of hands
___ swelling of feet ___ change color on your hands or feet ___ bleeds easily ___ bruises easily ___ edema
___ tremors ___ Poor coordination ___ convulsions ___ coma ___ paralysis ___ seizures ___ birth trauma
___ vaginal delivery ___ cesarean

3. ___ history of mental illness ___ considered/attempted suicide ___ unable to focus ___ phobia
___ seeing therapist ___ mental fog ___ mental exhaustion ___ sinking feeling ___ upset ___ timidity ___ lethargy
___ poor memory ___ mania ___ depression ___ anxiety ___ easily stressed ___ confusion/foggy ___ lack of
___ clarity ___ moody ___ fear/fright ___ feeling hyper ___ sadness ___ frustration ___ melancholy ___ grief
___ anger ___ easily irritability ___ restlessness ___ emotional ___ tics ___ frequent sighing ___ over-worried
___ bad-tempered ___ hopelessness ___ joyful ___ giddy ___ over-thinking ___ talkative ___ silent
___ extrovert ___ introvert ___ panic ___ feeling stuck

4. ___ skin itching ___ rashes ___ eczema ___ dry skin ___ moist skin ___ sores ___ ulcers ___ herpes
___ psoriasis ___ eruptions ___ discharge ___ acne ___ bruises ___ hives ___ yeast/fungal infection
___ change in skin texture ___ dandruff ___ loss of hair ___ balding ___ thinning of hair ___ change in hair

5. ___ Sudden drop in energy ______ How would you rate your energy level from 1 to 10

6. Are you taking (__ aspirin __ blood thinners __ vitamins __ herbs __ supplements) if so, please writing
down names_________________________________________________________________________________
____________________________________________________________________________________________

E. Respiratory system: cough: how long? _____________; ___ cough worse during day time ___ cough
worse at night ___ cough with blood ___ dry cough ___ thin phlegm ___ thick phlegm ___ clear phlegm
___ white phlegm ___ yellow phlegm ___ green phlegm ___ phlegm with bad smell ___ tightness in chest
___ heaviness in chest ___ pain in chest ___ shortness of breath ___ fullness in chest ___ difficulty breathing
with sitting ___ difficulty breath with lying down ___ difficulty inhaling ___ difficulty exhaling ___ frequent
sighing ___ pneumonia ___ bronchitis ___ asthma ___ wheezing ___ frequent cold ___ chronic cough; other
chest discomfort_______ ______________________________________________________________________

F. ENT: 1.__ ear pain __ ear discharge ___ tinnitus with high pitch ___ tinnitus with low pitch
___ hearing loss ___ deafness what makes your tinnitus worse ______________________________________
what makes your tinnitus better ______________________________________________________________
when you feel your tinnitus better_____________________________________________________________
when you feel your tinnitus worse __________________________________________________________

2. ___ itching eye ___ eye pain ___ dry eyes ___ blurred vision ___ night blindness ___ cataract
___ glaucoma ___ twitching ___ floaters ___ poor vision ___ red eye and other__________________________
____________________________________________________________________________________________

3. ___ migraine (__ frontal __ temporal __ vortex __ occipital) ___ head injury ___ facial pain ___ facial
paralysis ___ heaviness in head
4. ___teeth grinding   ___drooling   ___excess saliva   ___dry mouth   ___dry lips   ___gum disease
   ___gum bleeding   ___gum swelling   ___ulcers in mouth   ___sores in mouth   ___bad breath;   taste and feeling
   in mouth (_-_Bland   _-_Bitter   _-_Sweet   _-_Sour   _-_Astringent   _-_Salty   _-_oily   _-_Numbness   _-_Pain)

5. ___dry throat   ___hoarseness   ___recurrent sore throat   ___loss of voice   ___difficulty swallowing
   ___lump in throat   ___frequent tonsillitis   ___frequent throat clearing

6. ___loss of smell   ___good sense of smell   ___nose bleeds   ___allergies   ___sinus infection   ___post
   nasal drip   ___sinus congestion   ___running nose with thin discharge   ___running nose with thick discharge
   ___running nose with clear discharge   ___running nose with yellow discharge   ___running nose with green
   discharge   ___pain in the nasal cavity

G. Sleep: ___Insomnia   ___ hours of sleep per night   ___Trouble falling asleep   ___easy falling asleep
   ___Light sleeper   ___Heavy sleeper   ___waking up early   ___disturbing dreams   ___trouble staying asleep
   ___sleep apnea   ___somnolence   ___sleep walking

H. Digestive system: 1. Do you follow a special diet: ___yes   ___no, if so please explain__________
   ______________________________________________________________________________________________
   2. ___not thirsty and not wanting to drink water   ___thirsty and wanting to drink water   ___thirsty and
drinking lots of water   ___thirsty but just wanting to drink a little of water   ___thirsty and wanting to drink warm
   water   ___thirsty and wanting to drink cold water   ___thirsty just wanting water in the mouth and not wanting
to swallow the water   ___vomiting or nausea after drinking water

   3. ___food allergies   ___lost appetite   ___anorexia   ___easily hungry with large appetite   ___easily
   hungry with poor appetite   ___cravings   ___cramping   ___gas after meals   ___abdomen/pain   ___overeating
   ___fatigue after eating   ___bad breath   ___hiccup   ___mouth sores   ___heart burn   ___nausea   ___vomiting
   ___bulimia   ___ulcers   ___increased appetite   ___heartburn   ___hemorrhoids   ___nervous stomach   ___gall stones
   ___tenderness in abdomen   ___fullness in abdomen   ___burning in abdomen   ___difficulty swallowing
   ___weight gain   ___weight loss   ___diff loosing/gaining weight   ___feel distending in the epigestrium
   ___feeling obstruction in stomach   ___flatulency; strong preference for particular food?__________
   ______________________________________________________________________________________________

I. Lower GI and urinary:  1. How often do you have a bowel movement?__________; check
   symptoms which apply to you: ___dry stools   ___watery stools   ___sticky stools   ___loose stools   ___stools
   alternate between dry and diarrhea or loose stool   ___dry stool come first then becomes loose   ___blood in
   stool   ___pus in stool   ___mucus in stools   ___undigested food in stool   ___black stool (tarry stool)
   ___burning sensation   ___cramping   ___gas after meals   ___abdominal pain   ___overeating
   ___fatigue after eating   ___bad breath   ___hiccup   ___mouth sores   ___heartburn   ___nausea   ___vomiting
   ___bulimia   ___ulcers   ___increased appetite   ___hernia   ___hemorrhoids   ___nervous stomach   ___gall stones
   ___tenderness in abdomen   ___fullness in abdomen   ___burning in abdomen   ___difficulty swallowing
   ___weight gain   ___weight loss   ___diff loosing/gaining weight   ___feel distending in the epigestrium
   ___feeling obstruction in stomach   ___flatulency; strong preference for particular food?__________
   ______________________________________________________________________________________________

2. how many times do you urinate in 24hrs?________; how many times during the day time?________;
   how many times during the night time?________; how much do you urinate per day________; ___difficulty
   urinating   ___burning sensation   ___pain when you urinate   ___cloudy urine   ___poor stream/scanty urine ;
   what is the smells of your urine?________; ___dripping   ___unable to hold urine   ___urgency to urinate
   ___genital itching   ___genital sore/pain   ___discharge   ___aconuresis (urinary incontinence)   ___enuresis;
   color of your urine (__dk yellow  __pale  __pink/red)

J. OB/GYN : 1. ___age of first menses   ___length of your menstrual cycle?   ___length of period   ___date of
   last menstrual period   ___days of heavy flow   ___date of last PAP   ___bleeding after intercourse   ___very heavy
   bleeding   ___normal bleeding   ___scanty bleeding   ___absent menstruation;   menstrual flow(__thin __thick)
   ___metrorrhagia(heavy bleeding)   ___amenorrhea   ___dysmenorrhea   ___clots   color of blood(__pale red
   __red  _-_light red  _-_dark red  _-_purple  _-_dark purple  _-_brown)   ___odor of blood   ___fullness in the
   abdomen   ___pain before period   ___pain during period   ___pain after period   ___mood change before period
spotting between period   irregular menstrual cycle; any other physical changes/symptoms

2. watery leucorrhea   thick leucorrhea   lack of lubricant   white leucorrhea   Yellowish leucorrhea   bloody Leucorrhea   vaginal itching   vaginal burning   vaginal pain   genital eruptions   fibroids; smell of your discharge

3. currently pregnant   number of pregnancies   number of live births   number of miscarriages   number of abortions   number of premature births   infertility   pain during intercourse   uterine prolapse   pre menopause   post menopause   endometriosis

4. birth control pills(type   How long   ); hormone replacement   age at menopause   history of ovarian cysts   history of uterine problems   decreased libido

K. breast lump   breast cancer   breast tenderness   breast fullness   breast swelling   breast pain; breast discharge(   clear   white   yellow   green   black   blood   watery   thin   thick)

other:

L. Infertility (please explain with as much detail as possible)

1. How long have you been trying to get pregnant?

2. Have you tried any method of assisted reproduction?

3. Any long term exposure to chemicals?

4. Do you keep track of your menstrual cycle?

5. Do you keep your BBT(basal body temperature)?

6. Do you test yourself for ovulation?

7. Has your partner been evaluated for infertility?

8. Anything else you would like to tell us?

Family History:

Your past medical history:
Surgeries: (please include dates and if any complications)
1. ____________________________________________  2. ____________________________________________  
3. ____________________________________________  4. ____________________________________________  

Traumatic injury: (please include dates and if any complications)
Car accident: ____________________________________________  
Falls: ____________________________________________  
Other ____________________________________________  

Allergies:
Drugs/Medication: ____________________________________________  
Chemicals: ____________________________________________  
Food: ____________________________________________  

Current Medications: 
____________________________________________________________________________  
____________________________________________________________________________  
____________________________________________________________________________  

Occupational/Environmental Exposures or Hazards:
Chemical: ____________________________________________  Acid/Alkalines: ____________________________  
Heavy Metals: ____________________________________________  Physical Labor: ____________________________  
Electrical: ____________________________________________  Psychological: ____________________________  

Habits/Excessive Usage: (Please tell us how often & how much)
Alcohol: ____________________________  Artificial sweetener: ____________________________  
Chocolate: ____________________________  Cigarettes: ____________________________  
Coffee: ____________________________  Cola: ____________________________  
Drugs: ____________________________  Exercise: ____________________________  
Food: ____________________________  Salt: ____________________________  
Sugar: ____________________________  Tea: ____________________________  
Water: ____________________________  How often do you have sexual intercourse: ____________________________  
Other: ____________________________  

Do you make time for relaxation/meditation/prayer?  ___ Yes  ___ No  

I understand the every information it is related to give me the correct diagnosis in Traditional Chinese Medicine, 
I written down all the information on the above are true. I understand I should update all my new medical 
information to the practitioner in the timely manner.  

Patient signature: ____________________________________________  Date: ____________________________  