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 ___abd/stomach pain ___overeating ___fatigue after eating ___bad breath ___hiccup ___mouth sores ___heart burn ___nausea ___vomiting ___bulimia ___ulcers ___increased appetite ___hernia ___hemorroides ___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 ___sticky feeling in anus ___difficult to move out the stool ___tenesmus(feeling on urge but no BM) ___slippery purging incontinence ___pulling down sensation on the anus ___anus pain ___rectum pain ___anus Itching

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: __abuse __AIDS __alcoholism __allergies __asthma __cancer __chemical dependency __diabetes __heart disease __high blood pressure __mental illness __respiratory disease __seizures __stroke others_____
_____

Your past medical history: __Aids/HIV __alcoholism __allergies __anemia __arthritis __asthma __auto immune disease __bleeding disease __breast cysts __bi polar disorder __bronchitis __cancer __candida(yeast) __chemical dependency __chronic fatigue syndrome __chronic lung disease __colitis __diabetes __eating disorder __fracture __glaucoma __gall stone __gout __headaches __heart disease __hepatitis __hernia __herniated disc __high blood pressure __high cholesterol __kidney disease __liver disease __low blood pressure __migraine __mononucleosis __multiple sclerosis __mental illness __osteoporosis __organ transplant __parkinson's disease __pneumonia __prostate problems __rheumatic fever __seizures/epilepsy __sexually transmitted diseases(STD) __stroke __substance abuse/addiction __suicide attempt __thyroid disease __tuberculosis __ulcers __vaccine reaction __whooping cough

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:_____