



**Intake Form
(615) 613-5486**

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During your first visit or consultation, we hope to come to understand your health concerns, answer questions you may have and give you an examination or consultation using the Oriental medical approach. Then we will review the results together and look at options available for treatment of your condition. If you elect to undertake treatment, we will begin as soon as possible. Treatment often begins at one's first visit. Your treatment with us is meant to compliment and not replace your regular visits to your Primary Care Practitioner or traditional Western (allopathic) medicine.

PLEASE NOTE: ALL INFORMATION IS STRICTLY CONFIDENTIAL.

Some of the questions that follow may seem unrelated to your condition: they do however play a major role in diagnosis and successful treatment.

PLEASE PRINT

Name _____ Date ____/____/____

Address _____ City _____ State ____ Zip _____

Country _____ Phone No. (____) _____ Work No. (____) _____

Email address: _____ S.S.# ____ - ____ - ____

Age: ____ Sex: ____ Height ____' ____" Weight _____ lb. Date Of Birth ____/____/____

Marital Status: _____ Occupation _____ Employer _____

Party responsible for payment _____ In case of emergency notify _____

Their relationship to you _____ Their phone _____

How Did You Hear About This Office? _____ Diagnosing/Referring practitioner: _____

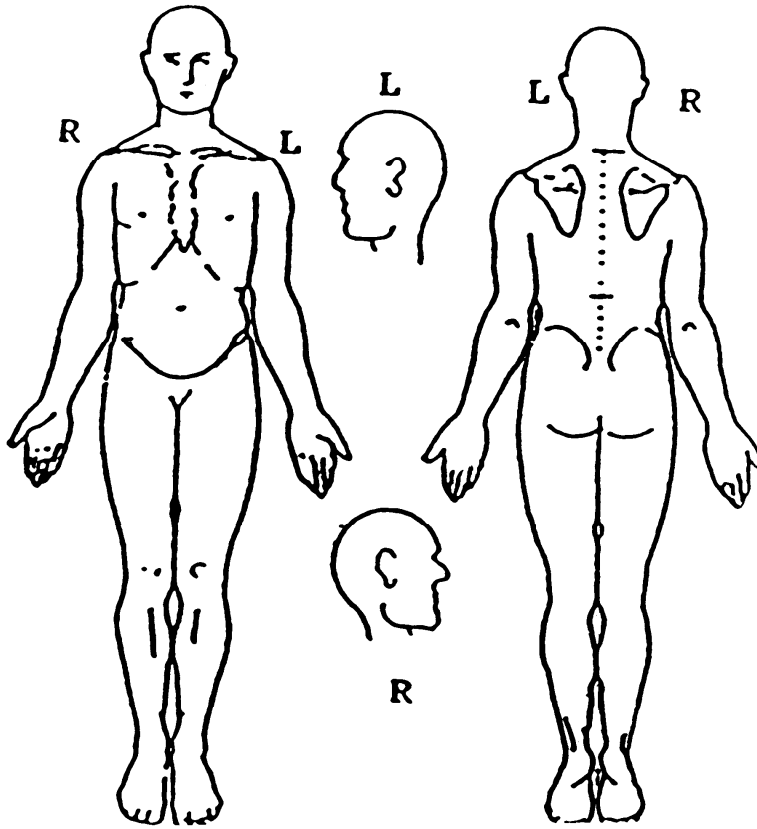
Please List The Main Health Problems You Would Like To Be Free Of In Order Of Importance:

- 1. _____
- 2. _____
- 3. _____

How And When Did These Conditions Begin? _____

How Do They Impair Your Daily Activities? _____

Health Professionals Seen for Them: _____



PLEASE MARK OR COLOR IN ALL AREAS OF PAIN OR DISCOMFORT, ON THE DIAGRAM ABOVE

Pain is: (check all that apply): Sharp Burning Moving Fixed Dull Aching Stabbing
 radiates to: _____

Please check if you ever have had any of the following	
<input type="checkbox"/>	AIDS
<input type="checkbox"/>	Positive test for AIDS/HIV antibodies
<input type="checkbox"/>	Blood transfusions
<input type="checkbox"/>	Bone disease
<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	Bursitis
<input type="checkbox"/>	Cancer or tumor
<input type="checkbox"/>	Chicken pox
<input type="checkbox"/>	Colon/bowel disease
<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Diphtheria
<input type="checkbox"/>	Drug habit
<input type="checkbox"/>	Drug sensitivity or reaction
<input type="checkbox"/>	Emotional or mental problems
<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Gall stones
<input type="checkbox"/>	Gall bladder problems
<input type="checkbox"/>	German measles
<input type="checkbox"/>	Heart trouble
<input type="checkbox"/>	Heart murmur
<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Hepatitis/jaundice
<input type="checkbox"/>	Herpes
<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Hives
<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	Kidney or bladder infection
<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Malaria
<input type="checkbox"/>	Measles
<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	Pleurisy
<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Polio
<input type="checkbox"/>	Prostatitis
<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	Scarlet fever
<input type="checkbox"/>	Small pox
<input type="checkbox"/>	Spinal meningitis
<input type="checkbox"/>	Stomach or duodenal ulcer
<input type="checkbox"/>	Tendonitis
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Thyroid or goiter trouble
<input type="checkbox"/>	Typhoid
<input type="checkbox"/>	Venereal disease
<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	Whooping cough
<input type="checkbox"/>	

If you have had any of the following symptoms, check the box that tells us if the symptom was in the past or if it is current. Also, circle one of the numbers that appears to the right of the symptom.

(Circle 1 for the least severe, and 5 for the most severe.)

Past	Current	Symptom	1=least severe 5=most severe	Past	Current	Symptom	1=least severe 5=most severe
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach pain	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or extended hoarseness	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Always hungry	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Hearing difficulties	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Black stools	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Sore throats	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Sounds/ringing in ears	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Gas	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Trouble with your eyes	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Lack of appetite	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Unusual taste in mouth	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Nausea	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Overweight	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Itching or burning skin	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Unusually thirsty	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Bloody urination	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Weight changes	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Burning urination	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding easily	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Difficult urination	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bruising easily	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Loss of bladder control	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or pressure	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells or blackouts	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Urination at night	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Concerns about sexual function	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Pounding heart beat	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Depression	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Racing heart beat	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue or tiredness	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Chest colds	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headache	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty getting to sleep	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Congested nose	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty staying asleep	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Smoking	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Shaking or trembling	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Chills	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Stuttering or stammering	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Excessive sweating	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Back trouble	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Fever	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Pain or swelling-any joint	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Lack of perspiration	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Painful feet	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Painful muscles	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to be too cold	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Stiff or painful neck	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to be too hot	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or legs	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Earaches	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>		1 2 3 4 5

Other specific symptoms or illnesses you have had

Please list all surgeries & hospitalizations you've had

Please list your typical daily meals

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List all current medicines or supplements

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Check if you have family history of any of these

<input type="checkbox"/>	AIDS	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mental illness
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Problems with alcohol
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Other potentially inheritable disease
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	

The Following Section is for Women

Past	Current	Symptom	1=least severe 5=most severe	Past	Current	Symptom	1=least severe 5=most severe
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain or cramping with menstruation	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal PAP smear	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	I.U.D.	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Abortion	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Menopause	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Back pain with menstruation	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual tension/syndrome	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding between periods	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>		1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding during or after intercourse	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Bloating before periods	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Scanty bleeding with period	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Blood discharge from nipples	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Tubal ligation	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Sickness/weakness with period	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Heavy bleeding with period	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	1 2 3 4 5
<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal dryness or itching	1 2 3 4 5

Duration of menstrual periods:

Interval between periods:

Dates of last period:

Number of births you have had

Ages of your children:

Birth control method you use: