TRADITIONAL CHINESE MEDICINE HEALTH INTAKE

Personal Information

Name ____________________________________ Date of Birth ____
Address __________________________________ Email ____
____ Occupation ____
Phone (primary) ___________________________ Emergency Contact ___________________________________
(secondary) ____________________________ Contact's Phone _____________________________________
How did you hear about Wellville? ____

Health History

Are you currently under the care of a physician? Yes____ No___
If yes, what is your chief complaint diagnosed as?____
Physician's name ___________________________________ Physician's phone ___________________________
Insurance Co.________________________________ID#______________________________Group#_________________
Please list all serious injury, past and current: ____
____
Please list any and all surgeries: ____
____
Please list all allergies: ____
Please list any skin problems pertaining to face or body: ____
Please list any medications and their use: ____
Please list and supplements and their use: ____

Please check all, past or current, which apply to you:

____Fibromyalgia ____Osteoporosis ____Stroke
____Heart Disease ____Arthritis ____Diabetes
____Disc Herniation ____High/Low BP ____Cancer/ Tumor
____Digestive Conditions ____Open Cuts/ Sores ____Joint Replacement
____Skeletal Injury/ Dysfunction ____Varicose Veins ____Neurological Problems
____Psoriasis ____Pregnant/Breastfeeding ____Contact Lenses
____Metal Implants ____High Cholesterol ____Seizures
____Tuberculosis ____HIV/Hepatitis/STD ____Thyroid Disease
____Other____
____Traumatic event or experience that may affect your ability to receive touch ___________________________________
____

Lifestyle

Do you drink Alcohol?___ Yes ___ No If yes, How often? ___________________________

Do you consume tobacco? ___Yes ___No If yes, How often?___________________________

Do you consume Coffee/ Black tea?___Yes ___No If yes, How often? ___________________

Do you take recreational Drugs?___ Yes ___ No If yes, How often?___________________

Have you ever had a problem /dependency with alcohol or other drugs?___Yes___No

Exercise:

What type? ______________________________ Hours per week__________

Sleep:

How many hours per night? ________ Do you sleep well?_____________ Do you wake rested?___________

Nutrition:

Do you follow a special diet? Please describe ____________________________________

Foods you crave:____

Foods you dislike:____

Emotional:

Have you ever been treated for emotional issues? ___ Yes ___ No If yes, What kind? ______________

Family History

Please check all which apply:

____Substance Abuse
____Heart Disease
____Stroke
____Auto Immune Disorders
____Allergies
____Asthma
____Cancer
____Hypertension
____Migraines
____Diabetes
____Depression
____Mental Illness

Symptoms

Please check all, past or current, which apply to you:

GENERAL

____Past ____Now **Poor appetite**
____Past ____Now **Excessive Appetite**
____Past ____Now **Insomnia**
____Past ____Now **Fatigue**
____Past ____Now **Sweats Easily**
____Past ____Now **Never Sweats**
____Past ____Now **Cold Tolerance**
____Past ____Now **Heat Intolerance**
____Past ____Now **Tense Neck/Shoulders**
____Past ____Now **Low Back Pain**
____Past ____Now **Joint Pain**
____Past ____Now **Low Libido**
____Past ____Now **Infertility**
____Past ____Now **Impotence**

HEAD, EARS, EYES, NOSE & THROAT

____Past ____Now **Headaches**
____Past ____Now **Ringing Ears**
____Past ____Now **Blurred Vision**
____Past ____Now **Sneezing Fits**
____Past ____Now **Sinus Congestion**
____Past ____Now **Swollen Glands**
____Past ____Now **Dry Thoat/Mouth**

GENITOURINARY

____Past ____Now **Frequent Urination**
____Past ____Now **Painful/Cloudy Urination**

RESPIRATORY

____Past ____Now **Frequent Colds**
____Past ____Now **Asthma**
____Past ____Now **Cough**

GASTROINTESTINAL

____Past ____Now **Constipation**

____Past ____Now **Indigestion**

____Past ____Now **Abdominal Pain**

____Past ____Now **Diarrhea/Loose BM**

____Past ____Now **Vomiting/Nausea**

CARDIOVASCULAR

____Past ____Now **Palpitations** ____Past ____Now **Cold Hands/Feet** ____Past ____Now**Hot Feet/Soles**

FEMALES ONLY

Age of 1st period (menarche) ______________________Age of last period ___________________________________

Number of days between periods ___________________Number of days of flow _____________________________

Color of flow __________________________________Clots? ___ Yes ___ No /Color? ______________________

Pain associated with periods :

Location: ___ Lower Abdomen ___ Lower back ___ Thighs Other:_______________________________________

Nature of pain (Please indicate before, during, or after menses) :

Cramping _____________ Stabbing ______________ Burning _______________ Aching ________________

Dull _________________ Bloating ______________ Consistent _____________ Intermittent _____________

Factors that alleviate pain ____

Factors that aggravate pain ____

Are you pregnant? ___ Yes ___ No # of pregnancies ____________ # of live births _________

How far a long are you? ________________________ # of abortions ______________ # of miscarriages _______

Date of last Gyn Exam ___________ Pap Smear _________ Mammogram ___________Bone density Scan ___________

Results____

Please indicate any conditions you have been diagnosed with :

___ Fibroids ___ Fibrocystic breasts ___ Breast cancer ___ Endometriosis ___Ovarian Cysts ___ PID

Symptoms(mark if experienced)

____Past ____Now **Nausea with period**

____Past ____Now **Diarrhea with period**

____Past ____Now **Constipation with period**

____Past ____Now **Swollen breasts**

____Past ____Now **Mood swings**

____Past ____Now **Pain with intercourse**

____Past ____Now **Bleeding between periods**

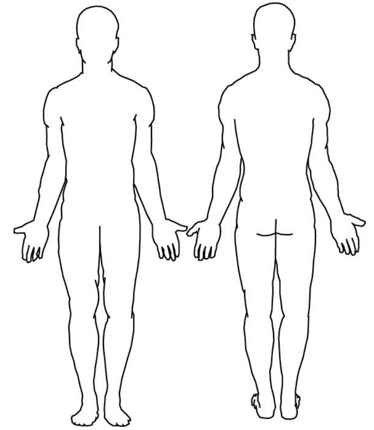
____Past ____Now **Vaginal discharge**

____Past ____Now **Vaginal dryness**

____Past ____Now **Increased Libido**

____Past ____Now **Decreased Libido**

Please mark the image to the right to indicate your areas of tension or discomfort.



Have you ever received acupuncture or been prescribed herbal medicine? Yes___ No___
Reason seeking treatment (Chief Complaint)

____

Diagnosis by physician____
Other Complaints (in order of significance):
1.____
2.____
3.____
4.____
Please indicate any areas of the body you would NOT like worked

____

Consent

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that I have a responsibility to inform my health care provider if I ever have a change in health.

I hereby request and consent to the performance of acupuncture treatments, massage and asian bodywork, and other procedures within the scope of the practice of Chinese Medicine. I realize there are some risks to treatment, including but not limited to some bruising of the skin and or/ slight bleeding. I am aware if moxibustion or heat therapies are used there is a risk of burn and/or scarring. I am aware that if cupping or gua sha therapies are used there may be temporary markings resembling bruises that require my aftercare.

I understand that acupuncture and herbal medicine are in no way a substitute for examination, diagnosis, or treatment by a physician. I understand that my acupuncturist/herbalist will not diagnose, prescribe, or treat any physical or mental illness that they are not qualified to perform, including spinal or skeletal adjustments. I acknowledge that any information I receive from my acupuncturist is educational in nature and to be used at my own discretion.

All services are non-sexual. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I understand Wellville requires a 24 hour notice for all reschedules and cancellations with the only exception being medical emergencies for me or a member of my immediate family. Missed appointments will be charged at 50% of the scheduled service. I accept payment for missed appointments if I fail to provide the required notice.

I have received and reviewed the Notice of Privacy Practices and Policies from Wellville Massage and Healing Arts.

PRINTED NAME ____ D.O.B. ___________________________________

SIGNATURE ____ DATE ________________________