QI REMEDIES

Acupuncture and Herbal Medicine

Patient Intake Form

Thank you for choosing Qi Remedies. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask.

Full Name:	Sex: ☐ F ☐ M	Date:
Date of Birth:	Age:	Occupation:
Main Phone #:	Other Phone #:	
Email Address:	May we contact you by email? ☐ Y ☐ N	
Address: Street:	City:	State: Zip:
Do you live alone?		
Family physician:	Chiropractor:	
Have you ever had acupuncture before? ☐ Y ☐ N		
How did you hear about us?		
Emergency Contact:	Phone #:	Relation:

Main problem(s): ______________________________

What diagnosis, if any, have you received for this problem? ______________________________

When did this problem begin? ____________ What are the causes of this problem? ____________

How does this problem interfere with daily activities (work, sleep, sex, etc.)? ______________________________

____

____

What kind of treatments have you tried? ______________________________

What makes the problem worse?____________ What makes it better?____________

Is there anyone in your family whit the same/similar problems?______________________________

Remarks or additional information:______________________________

Medical History:

DIAGNOSIS	SELF	FAMILY	DIAGNOSIS	SELF	FAMILY	DIAGNOSIS	SELF	FAMILY
Cancer			Heart Disease			High Blood Pressure		
Diabetes			Digestive problems			Emotional Disorders		
Hepatitis			Venereal Disease			Anemia		
Thyroid Disease			Alcoholism			Stroke		
Seizures			Depression/Anxiety			Addiction		
Arthritis			Tuberculosis			Auto Immune disease		
Breathing problem			High Cholesterol			Other:		

Other: ______________________________

____

____

Surgeries:______________________________ **Hospitalization:**______________________________

Significant trauma: (auto accidents, sports injuries, etc) ______________________________

Allergies: (drugs, chemicals, foods, environmental, pollens, molds, etc.): ______________________
____

Medicines and Supplements: (taken within the last two months including vitamins, OTC drugs, herbs, etc, along with their dosages): ____
____
____
____

Personal: Current Weight _________ Weight one year ago_________ Desired Weight_________________
Maximum weight ever and year _______________________ Height ___________________

Habits: Do you smoke? ☐ Y ☐ N If yes, what?___________ How many per day?______ Since when?______
Please describe any use of drugs for non-medical purposes:_________________________________
Do you exercise regularly? ☐ Y ☐ N Please describe:_______________________________________
How many hours do you generally sleep? ________ What time do you go to bed? ______________________
How many times do you wake in the night? _______________ What wakes you?________________________
Do you feel rested in the morning? ☐ Y ☐ N
Comments:____
____

Diet: Please describe your average daily diet, while being as specific as possible:
Morning: ____
Afternoon: ____
Evening: ____
Snacks: ____
Do you drink coffee? ☐ Y ☐ N Cups per day? ______ Comments: ______________________
Do you drink sodas? ☐ Y ☐ N How many per day? ______ Comments: ______________________
Do you drink alcoholic beverages: ☐ Y ☐ N How many per day? ______ Comments: ________________
How much water do you drink per day? _________
Are you a vegetarian? ☐ Y ☐ N ☐ Yes, but not so strict ☐ Yes, but I am vegan ☐ Yes, but I eat only raw foods
Do you eat a lot of spicy foods? ☐ Y ☐ N
Additional comments on your diet:
____
____

Please check if you have had (in the last 3 months) any of the following diseases or conditions:

General:

- ☐ Low energy
- ☐ Spontaneous sweating
- ☐ Hot/cold body temperature
- ☐ Excessive thirst
- ☐ Chills/Fever
- ☐ Aversion to heat or cold
- ☐ Cold hands or feet
- ☐ Sweaty palms or feet
- ☐ Hot flashes
- ☐ Night Sweats
- ☐ Lack of Sweating
- ☐ Weight gain
- ☐ Weight Loss
- ☐ Cravings
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dizziness
- ☐ Poor Balance

Skin & Hair:

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Excessive thirst
- ☐ Itching
- ☐ Eczema
- ☐ Slow wound healing
- ☐ Acne or Pimples
- ☐ Recent Moles
- ☐ Purpura
- ☐ Dry skin
- ☐ Loss of Hair
- ☐ Change in hair texture
- ☐ Dandruff
- ☐ Others:
- ☐
- ☐
- ☐

Respiratory:

- ☐ Cough
- ☐ Coughing Blood
- ☐ Wheezing
- ☐ Phlegm What color?
- ☐ Shortness of breath
- ☐ Difficult breathing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Chest pain

Allergies:

- ☐ Mold
- ☐ Cedar
- ☐ Oak
- ☐ Elm
- ☐ Dust
- ☐ Dander
- ☐ Other:
- ☐

Head, Eyes, Ears, Nose, Throat:

- ☐ Dizziness ☐ Vertigo ☐ Poor balance
- ☐ Concussions ☐ Seizures ☐ Epilepsy
- ☐ Migraines ☐ Frequent Headaches
- ☐ Jaw pain ☐ TMJ
- ☐ Eye strain ☐ Eye pain ☐ Dry eyes ☐ Tearing
- ☐ Wears glasses ☐ Uses reading glasses only
- ☐ Color blindness ☐ Night blindness
- ☐ Cataracts ☐ Glaucoma ☐ Blurry vision
- ☐ Spots in front of eyes
- ☐ Ringing in ears ☐ Earache ☐ Impaired hearing
- ☐ Sinus problems
- ☐ Nasal obstruction
- ☐ Runny nose ☐ Sneezing
- ☐ Nose bleed
- ☐ Loss of smell
- ☐ Teeth problems
- ☐ Mouth ulcers
- ☐ Tongue sores
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Dry mouth
- ☐ Oral thrush
- ☐ Recurrent sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐
- ☐
- ☐

Gastrointestinal:

□ Nausea □Vomiting □ Belching
□ Gas & bloating □ Low Appetite □ Huge Appetite
□ Diarrhea □ Constipation □ Black stools
□ Blood in stools □ Hemorrhoids □ Rectal pain
□ Stomach ulcer □ Reflux/Heartburn □ Gallstones
□ Stomach pain/cramping □ Indigestion
□ Hypoglycemia □ Parasites
Bowel movements: Frequency:________ Color:______
Odor: __________ □ Formed □ Loose □ Dry

Genito-urinary:

□ Painful urination □ Freq. urination
□ Blood in urine □ Urgency
□ Incontinence □ Dribbling
□ Pause of flow □ Kidney stones
□ Cloudy urine □ Profuse urine
□ Dilute urine □ Scanty urine
□ Genital pain □ Genital itching
□ Genital rashes □ STD
□

Cardiovascular

□ High blood pressure □ Low blood pressure
□ Chest pain □ Palpitation □ Fainting
□ Irregular heartbeat □ Rapid heartbeat
□ Poor circulation □ Blood clots
□ Varicose veins □ Swelling of ankles
□ High cholesterol
□ Other:
□
□

Emotional/Mental/Psychological

□ Insomnia □ Nervousness
□ Anxiety □ Depression
□ Mood swings □ Irritability
□ Angry often □ Worry
□ Poor memory □ Poor concentration
□ Restless mind □ Terrors
□ Fear □ Sadness □ Crying
□ History of abuse
□ Any diagnosis: __________________

Female

□ May be pregnant? □ Peri-menopausal □ Hot flashes
□ Menopausal □ Post-menopausal □ Hysterectomy
□ Chronic vaginal infections □ Endometriosis
□ Vaginal discharge □ Ovarian cysts □ PCOS
□ Uterine Fibroids □ Uterine prolapse □ PMS
□ Irregular periods □ Heavy periods □ Scanty periods
□ Clots □ Breast tenderness □ Breast lumps
□ Menstrual cramping □ Fertility problems
□ Period lasts _____ days. _______ Days between periods.

□ Number of pregnancies? _______
□ Number of miscarriages? _______
□ Number of abortions? _______
□ Number of births? _______
______ vaginal _____ cesarean
□ Other:
□
□
□

Male:

□ Prostate problems □ Discharge
□ Erectile dysfunction □ Ejaculation problems
□ Testicular pain/swelling □ Nocturnal emission
□ Fertility problems
□ Other:
□

Musculoskeletal:

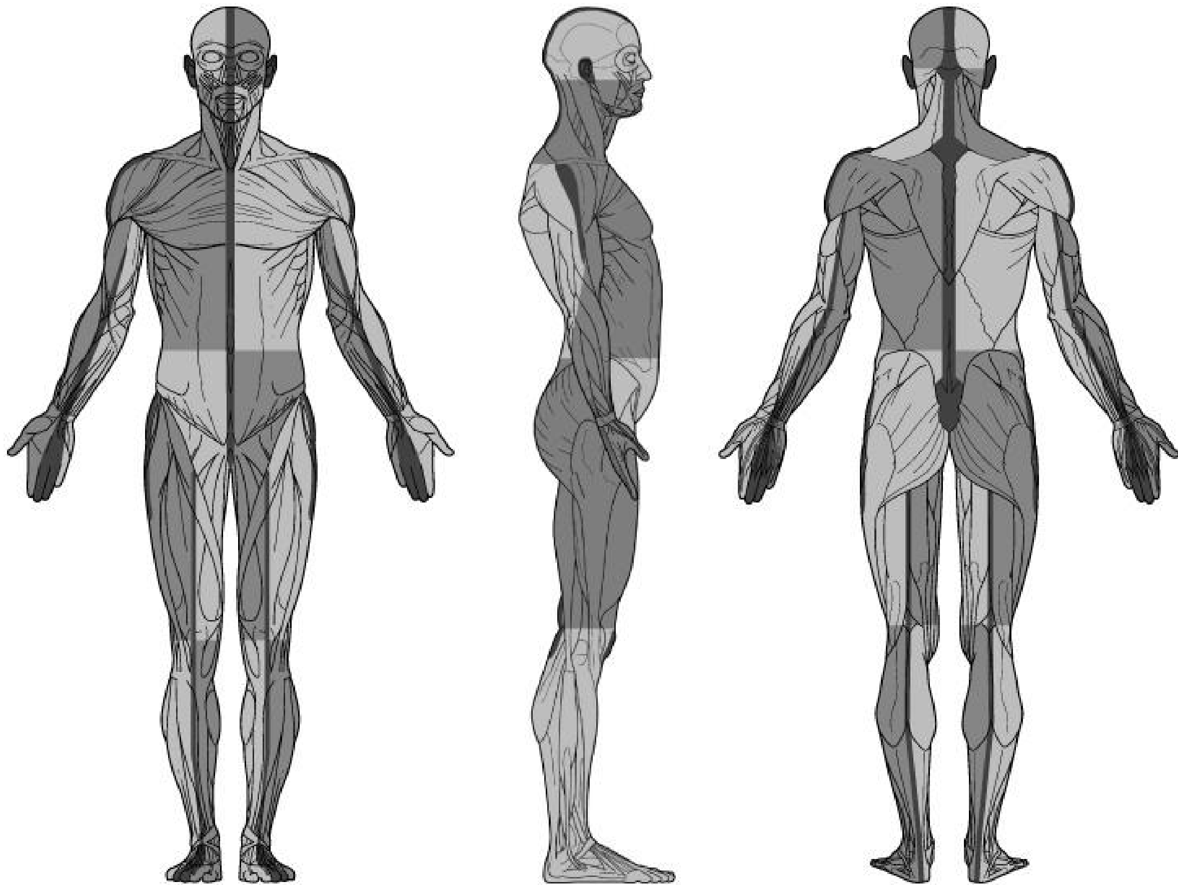
Pain/Weakness/Numbness

□ Arms □ Feet □ Hands □ Joints □ Legs □ Hips □ Neck
□ Shoulders □ Back

□ Difficulty walking □ Swelling of hands/feet

□ Muscle pain □ Muscle injury □ Paralysis

Please indicate painful or distressed areas:



I have completed this form correctly and to the best of my knowledge:

Signature: ____

□ Adult patient □ Parent or Guardian □ Spouse