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:
Family physician:		Chiropractor:		
Have you ever had acupuncture before? ☐ Y ☐ N				
How did you hear about us?				
Do you live alone?				
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 with 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:

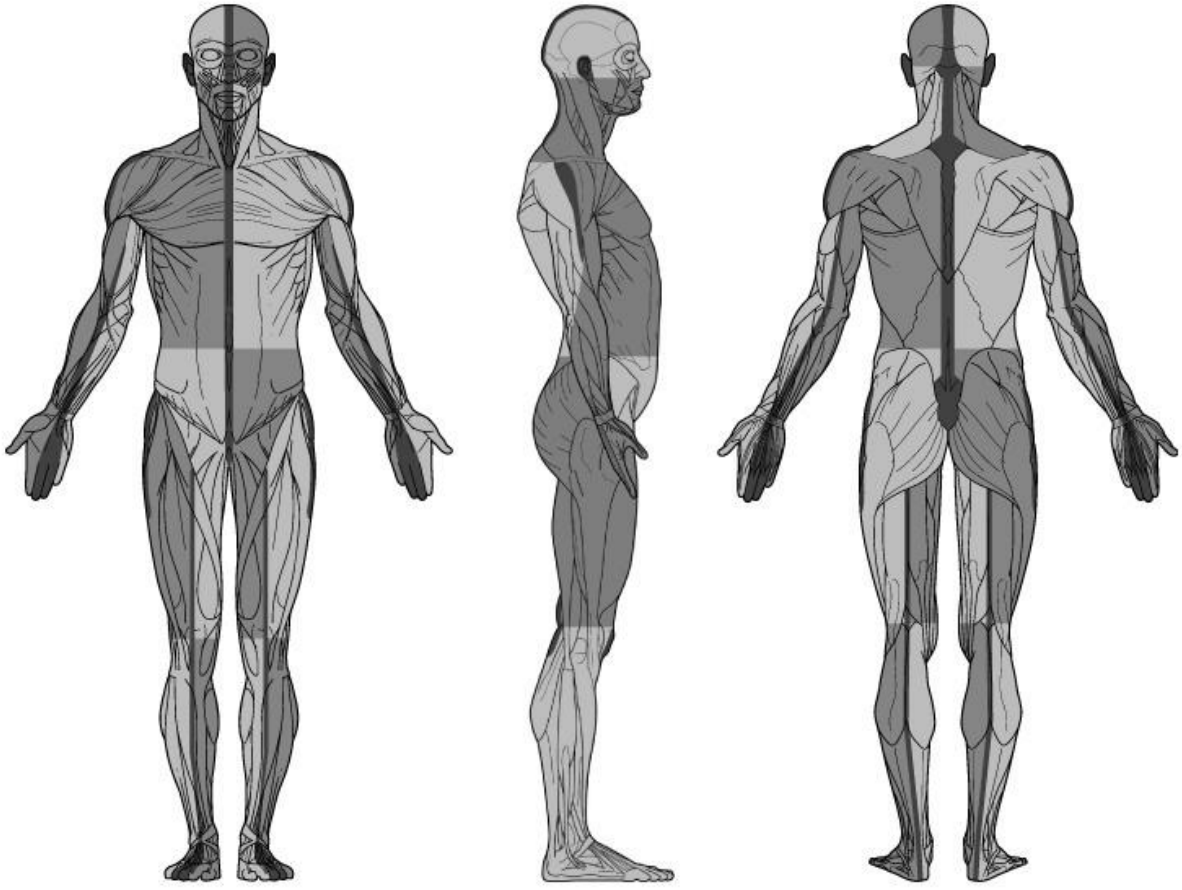
Pain/Weakness/Numbness

□ 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