gaia naturopathic clinic
where nature meets science

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CHINESE MEDICINE PATIENT INTAKE FORM

Please take a few minutes to complete this form to the best of your ability. The information provided in this form will help to provide me with a general overview of your health from a Traditional Chinese Medicine perspective, and assist me in preparing a treatment plan that will best meet your individual health needs and goals.

CHILLS AND FEVER

Do you ever have any of the following? □ chills □ fever □ both chills and fever
If so, please describe (how often, how long, time of day or circumstances, etc)

PERSPIRATION

Do you perspire? Y N
If so, do you perspire after slight exertion? Y N
Any odours or colour to the perspiration?
Do you perspire at night? Y N
Do you perspire spontaneously? Y N

HEAD AND BODY

Do you experience headaches? Y N
If yes,
What time of day do the headaches begin?
Where do the headaches occur (front, back, side of head, etc)?
What is the character of the headache (sharp, dull, throbbing, etc)?
Is there anything that makes the headaches better or worse (i.e., pressure, hot or cold applications, etc?

Do you ever experience dizziness? Y N
If yes, please describe:

Do you ever experience pain anywhere in your body? Y N
If yes,
Where?
How often?
Type of pain (dull, sharp, throbbing, etc):
Does the pain stay in one location or does it move around?
Does anything make it better or worse?

Do you have any other symptoms associated with the pain (fatigue, nausea, etc)?
Do you ever experience swelling in your joints? Y N
If yes,
Which joints?
How often?
Is there any redness or heat in the joints that occurs with the swelling? Y N
Does anything make it better or worse?

Do you ever experience numbness anywhere in your body? Y N
If yes,
Where?
How often?
Does anything make it better or worse?

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CHEST AND ABDOMEN

Do have any chest pain? Y N
If yes,
Where?
How often?
Type of pain (sharp, dull, crushing, heavy, aching, etc):
Does the pain radiate anywhere?
Does anything make it better or worse?

Do you ever have palpitations? Y N
Do you ever have anxiety? Y N
Do you have asthma? Y N
Do you have a cough? Y N
If yes,
Is there a particular time of day that it occurs?
Is the cough strong (hacking) or weak? _____ Is it wet or dry? _____

Do you have any phlegm/sputum with the cough? Y N
If yes, what is the colour and consistency (thick, watery, foamy, etc)?

Do you have any difficulty breathing? Y N
If yes, please describe:

Do you ever experience abdominal distension, pain, or a feeling of fullness in the abdomen? Y N
If yes,
Where? (upper, lower, middle) _____ How often? _____
Does anything make it better or worse? (bowel movements, eating, etc)?

If there is pain, describe the nature (sharp, dull, cramping):

APPETITE, THIRST AND TASTE

How is your appetite?
Any changes in your appetite?
Any weight gain or loss? If so, please describe amount and over what period of time

How is your thirst?
How much water/fluid do you drink per day?
Any preference for hot or cold drinks?
Do you tend to sip or gulp your drinks?

Any particular food cravings?
Any unusual tastes in your mouth? (e.g., bitter, sweet, salty, etc)?
Any bloating or gas?
Any belching, acid reflux, or vomiting?

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STOOL & URINE
Do you get constipated or have diarrhea?
Number of bowel movements per day:

Is the colour of the urine clear, yellow, dark, or cloudy?

Any pain or difficulty with either urination or defecation?

What is the consistency of your stool (hard, formed, loose, watery, soft, dry, etc)?
Any undigested food, mucous, or blood in the stool?

SLEEP
Do you sleep well? Y N Hours of sleep per night:
Do you have any trouble falling or staying asleep? Y N
Do you frequently dream or have nightmares?

EARS & EYES
How is your hearing?
Have you noticed any changes to your hearing recently?
Have you experienced deafness in either (specify) or both ears?
If yes, was the hearing loss sudden or gradual?

Do you ever experience ringing in either (specify) or both ears?
If yes,
Is the ringing □ low-pitched? □ high-pitched?
Is the ringing □ constant? □ comes and goes?
Did the ringing □ begin suddenly? □ come on gradually?

Is there anything that makes the ringing better or worse (e.g., pressure)?

How is your vision?
Have you noticed any changes to your vision lately?

Do you ever experience:
□ Blurred vision? □ Red eyes? □ Night blindness? □ Dry eyes? □ Floaters?

MENSES AND LEUKORRHEA *(Females)*
Is your period the same each month? Y N
Number of days in cycle: How many days is your period?

Number of pads or tampons, on average, used during heaviest day of period:
What colour is your flow (dark red, bright red, brown, etc)?
Any clots in your period? Y N

Any vaginal discharge? Y N
If so, please describe the colour, consistency, and odour

Is there anything else that you would like to mention that has not been covered or feel it is important for me to be aware of?

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Review of Systems

Please place a checkmark (√) next to any of the following symptoms that you currently experience and a (P) next to any that you have had in the past

SKIN & HAIR
__ Rashes
__ Itching
__ Eczema
__ Psoriasis
__ Boils/Cysts
__ Acne
__ Hives
__ Warts
__ Dryness
__ Colour changes
__ New/Changed moles
__ Lumps
__ Dandruff
__ Hair loss
__ Change in hair texture
__ Nail changes
__ Other

EYES
__ Impaired vision
__ Glasses/contacts
__ Far-sighted
__ Near-sighted
__ Double vision
__ Colour blindness
__ Night blindness
__ Sensitivity to sun
__ Pain
__ Redness
__ Itching
__ Dryness
__ Discharge
__ Blurring
__ Excessive tearing
__ Spots/Floaters
__ Blind spot
__ Glaucoma
__ Cataracts
__ Other

EARS
__ Ringing
__ Discharge
__ Pain/Aches
__ Deafness
__ Infections
__ Wax build-up
__ Ear tubes
__ Other

NOSE & SINUSES
__ Allergies
__ Loss of smell
__ Post nasal drip
__ Nosebleeds
__ Dryness
__ Sinus infections
__ Sinus pain
__ Nasal congestion
__ Sleep apnea
__ Snoring
__ Nasal Polyps
__ Other

MOUTH & THROAT
__ Dental cavities
__ Mercury fillings
__ Gum problems
__ Grinding/Clenching
__ Ulcers/sores
__ Loss of Taste
__ Pain/Soreness
__ Frequent Sore throat
__ Hoarseness
__ Tonsillitis
__ Phlegm/Mucous
__ Cold sores
__ Enlarged glands
__ Jaw pain/clicking
__ Facial pain/tics
__ Other

HEAD & NECK
__ Headache
__ Injury
__ Lumps
__ Swollen glands
__ Swollen lymph nodes
__ Goitre
__ Pain/stiffness
__ Other

RESPIRATORY
__ Cough
__ Sputum
__ Coughing blood
__ Wheezing
__ Asthma
__ Bronchitis
__ Pneumonia
__ Emphysema
__ Tuberculosis
__ Difficulty breathing
__ pain with breathing
__ shortness of breath (SOB)
__ SOB lying down
__ SOB at night
__ Other

CARDIOVASCULAR
__ High blood pressure
__ Low blood pressure
__ Irregular heart beat
__ Fast heart beat
__ Slow heart beat
__ Palpitations
__ Murmurs
__ Angina
__ Chest pain
__ Swelling of limbs
__ Cold hands or feet
__ Thrombophlebitis
__ Blood clots
__ Varicose veins
__ Elevated cholesterol
__ Past ECG test
__ Other Heart tests
__ Other

BLOOD & LYMPHATIC
__ Anemia
__ Easy bruising/bleeding
__ Slow clotting
__ Fatigue/weakness
__ Pallor (paleness)
__ Swollen lymph nodes
__ Past transfusions
__ Other

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GASTROINTESTINAL
__ Heartburn/acid reflux
__ Indigestion
__ Poor/change in appetite
__ Poor/change in thirst
__ Difficulty swallowing
__ Abdominal pain/cramps
__ Bloating
__ Gas or belching
__ Bad breath
__ Diarrhea
__ Constipation
__ Incomplete bowel movements
__ Nausea
__ Vomiting
__ Vomiting blood
__ Spitting blood
__ Chronic laxative use
__ Rectal pain
__ Rectal bleeding
__ Rectal incontinence
__ Hemorrhoids
__ Blood in stool
__ Black, tarry stools
__ Undigested food in stool
__ Mucous in stool
__ Hernia
__ Ulcer
__ Candida
__ Intestinal worms
__ Liver disease
__ Gall bladder stones/disease
__ Jaundice
__ Anal itching
__ Anal fistula
__ Anal fissures
__ Food allergies
__ Other

GENITOURINARY
__ Frequent urination
__ Pain/burning on urination
__ Urgency to urinate
__ Urinary incontinence
__ Hesitancy with urination
__ Waking at night to urinate
__ Recurrent urinary tract Infections
__ Kidney infection
__ Kidney stones
__ Blood in urine
__ Low back pain
__ Flank (side) pain
__ Other

ENDOCRINE
__ Excessive urination
__ Excessive sweating
__ Heat intolerance
__ Cold intolerance
__ Thyroid disease
__ Excessive thirst
__ Excessive hunger
__ Diabetes
__ Hypoglycemia
__ Hormone Therapy
__ Rapid weight gain
__ Rapid weight loss
__ Insomnia
__ Other

MUSCULOSKELETAL
__ Back pain
__ Muscle spasms/cramps
__ Muscle weakness
__ Arthritis
__ Tendonitis
__ Jaw pain/stiffness
__ Joint pain/stiffness
__ Joint swelling
__ Bursitis
__ Fractures
__ Osteoporosis
__ Sciatica
__ Other

NEUROLOGICAL
__ Dizziness
__ Seizures
__ Fainting
__ Paralysis
__ Stroke
__ Poor memory
__ Loss of balance
__ Concussion
__ Numbness/Tingling
__ Tremors
__ Speech difficulty
__ Poor coordination
__ Confusion
__ Dementia
__ Learning difficulties
__ Involuntary movements
__ Other

FEMALE REPRODUCTIVE
__ Heavy menses
__ Light menses
__ Irregular periods
__ Painful periods
__ Bleeding between periods
__ Menstrual blood clots
__ Vaginal discharge
__ Vaginal itching
__ Vaginal sores
__ Yeast infections
__ Painful intercourse
__ Low libido
__ Other sexual difficulty
__ Fibroids
__ Ovarian cysts/PCOS
__ Endometriosis
__ Hysterectomy
__ Menopause
__ Difficulty conceiving
__ Sexually transmitted disease
__ Sexually active
__ Birth control/Protection
Form: _____
__ Other

MALE REPRODUCTIVE
__ Testicular masses
__ Testicular pain
__ Hernia
__ Prostate problems
__ Discharge or sores
__ Low libido
__ Erectile dysfunction
__ Premature ejaculation
__ Low sperm count
__ Other sexual difficulty
__ Sexually transmitted disease
__ Sexually active
__ Use regular protection
Form: _____
__ Other

EMOTIONAL/PSYCHOSOCIAL
__ Depression
__ Anxiety
__ Mood swings or Irritability
__ Phobias
__ Hyperactivity
__ Aggression
__ Alcohol/Drug Abuse
__ Other