***Date:*_____**

New Patient Intake Form

Name: Birthdate: / / Marital Status: Age:
Address: [] M [] F Ht. _____Wt. _____
Home Phone: Work Phone: Occupation:
Emergency Contact - Name and Phone:
Allergies (medication, food, etc.)
Referred by/How did you hear about us?:
Reason for visit today? Have you had acupuncture before? [] Yes [] No Chinese herbal medicine? [] Yes [] No
How long have you had this condition?
Is it getting worse? Does it bother your: [] Sleep [] Work [] Other What?
What seemed to be the initial cause?
What seems to make it better?
What seems to make it worse?
Are you under the care of a physician now? []Yes [] No If yes, for what?
Who is your physician? Phone:
What treatments are you getting for this condition? (Physio-therapy, chiropractor, massage, yoga, aromotherapy, diet etc.)
Current Medications:

Family Medical History:

[] Heart disease	[] Diabetes	[] Cancer	[] High Blood Pressure
[] Stroke	[] Asthma	[] Asthma	[] Alcoholism

Your Past Medical History

[] AIDS/HIV	[] Diabetes	[] Multiple sclerosis	[] Thyroid
[] Alcoholism	[] Emphysema	[] Mumps	[] TB
[] Allergies	[] Epilepsy	[] Pacemaker	[] Typhoid fever
[] Appendicitis	[] Goiter	[] Pneumonia	[] Ulcers
[] Asthma	[] Heart Disease	[] Seizures	[] _____
[] Cancer	[] Hepatitis	[] Stroke	[] _____
[] Chicken Pox	[] High Blood Pressure	[] _____	[] _____

List any hospitalizations you have had during the past 5 years:_____

_____

Surgeries: (list)

Your Diet

Appetite:	[] Low	[] Coffee	[] Soft Drinks	[] Sugar
	[] Normal	[] Tea	[] Salty Food	[] Artificial Sweetener
	[] High			[] Thirst for water: #glass/day _____

Average daily menu:

Morning_____ Snack _____

Snack _____ Evening_____

Noon _____ Snack _____

Vitamin/supplements taken in past 2 months: _____

Your Lifestyle

:[] Alcohol [] Marijuana [] Stress [] Tobacco [] Drugs [] Occupational Hazards

Regular Exercise: Type: _____ How Often _____

Name: _____

Date: _____

Sign:_____

Patient Consent to Treatment

The services provided in this clinic include: acupuncture; tuina [Acupressure]; infra-red heat treatment; cupping; based on Traditional Chinese Medicine.

Side effects may occur in a small percentage of patients and may include the following: some pain following treatment in the treated area, minor bruising or bleeding, blisters after cupping, minor infection, needle sickness (fainting).

If you have a severe bleeding disorder, have a pacemaker, or you are pregnant, please let the treating practitioner know prior to treatment.

By signing below, I agree to receive treatments according to the diagnosis of Ms. Amey H'ng.

Name: _____ Date: _____

Patient Signature: _____

Witness: _____ Date: _____

10 - WORST; 1 MINOR; 5 AVERAGE

BLANK IF - NOT APPLICABLE

XIN		FEI		PI	
	PALPITATIONS		DRY COUGH		HEAVINESS IN THE HEAD / BODY
	CHEST PAIN / TIGHTNESS		COUGH WITH PHLEGM		FATIQUE / AFTER EATING
	INSOMNIA / SLEEP ROBLEMS		NASAL DISCHARGE / DRIP		DIFFICULT GETTING UP IN THE MORNING
	RESTLESS / EASILY AGITATED		SINUS INFECTION / CONGESTION		WATER RETENTION
	VIVID DREAM		ITCHY/PAINFUL THROAT		MUSCULAR TIRED / WEAK
	LACK OF JOY IN LIFE		DRY MOUTH / THROAT / NOSE		BRUISE EASILY
	FORGETFUL		SKIN RASHES / HIVES		UNUSUAL BLEEDING (STOOL, NOSE. ETC.)
	AVERSION TO HEAT		SNORING		BAD BREATH
	BITTER TASTE IN MOUTH		GRIEF / SADNESS		POOR APPETITE
	TONGUE/MOUTH ULCERS/ CANKERS		SHORTNESS OF BREATH		INCREASED APPETITE
	SWEAT / NIGHT / PALM & SOLE OF FEET		ALLERGIES / ASTHMA		CRAVE SWEETS
			WEAK IMMUNE SYSTEM		POOR DIGESTION
GAN		**SHEN**	ALTERNATE FEVER / CHILLS		NAUSEA /VOMITING
	IRRITABILITY / FRUSTRATION / IMPATIENT				BLOATING / GAS
	DEPRESSION / STRESS		FREQUENT URINATION		HEMORRHOIDS / BLEEDING / PAIN
	EMOTIONAL EATING		BLADDER INFECTION		CONSTIPATION
	UNFULFILLED DESIRES		LACK OF BLADDER CONTROL		LOOSE STOOL
	VISUAL PROBLEMS / FLOATERS		WAKE TO URINATE		ALTERNATE CONSTIPATION / LOOSE
	BLURRED VISION / POOR NIGHT VISION		FEEL COLD EASILY		ABDOMINAL PAIN
	RED / DRY / ITCHY EYES		COLD HANDS / FEET		INTESTINAL PAIN / CRAMPTING
	HEADACHES/MIGRAINES		NIGHT SWEATS / HOT FLUSHING		HEARTBURN
	DIZZINESS		LOW SEX DRIVE		PENSIVENESS / OVER THINKING
	FEELING OF LUMP IN THROAT		HIGH SEX DRIVE		OVERWEIGHT
	MUSCLE TWITCHING / SPASM		LOSS OF HEAD HAIR		FOGGY MIND
	NECK / SHOULDER TENSION		HEARING PROBLEMS		YEAST INFESTION
	BRITTER NAILS		CRAVE SALTY FOOD		AVERSION TO COLD
	SIGHING		FEAR		COLD NOSE
	SENSATION OR PAIN UNDER RIB CAGE		POOR LONG TERM MEMORY		INCREASED THIRST
	PMS		ANKLE SWELLING		PREFER WARM / COLD DRINKS
	GENITAL ITCHING/PAIN/LESIONS		TINNITUS (RING IN THE EAR)		

FILL UP OR CIRCLE BELOW

1 RE YOUR BOWEL MOVEMENTS REGULAR? HOW MANY TIMES ____PER DAY /__ WEEK?
ARE THEY FORMED___, LOOSED___, CONSTIPATED___, DO THEY ALTERNATE FROM LOOSE TO DIFFICULT TO PASS___?

2 DO YOU EXPERIENCE URINARY FREQUENCY? URGENCY____? BURNING? DRIBBLING? RETENTION____?
WHAT COLOR/ SHADE OF YELLOW IS IT? DO YOU HAVE A HISTORY OF URINARY TRACK INFECTIONS?

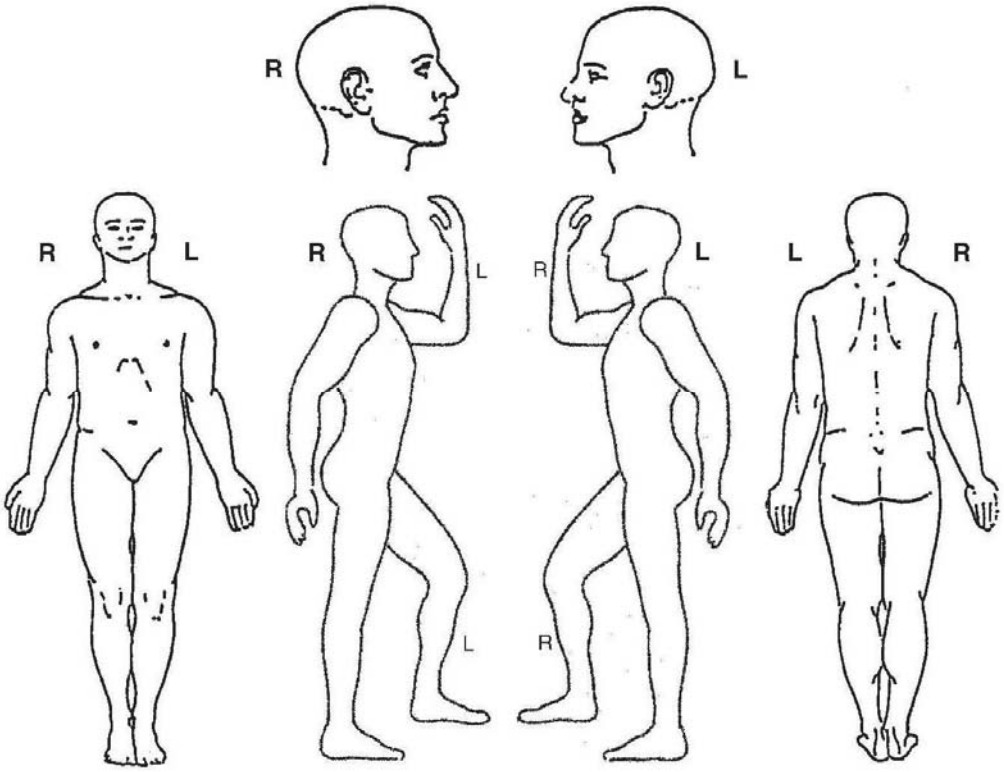
3 HOW MUCH WATER YOU DRINK A DAY?

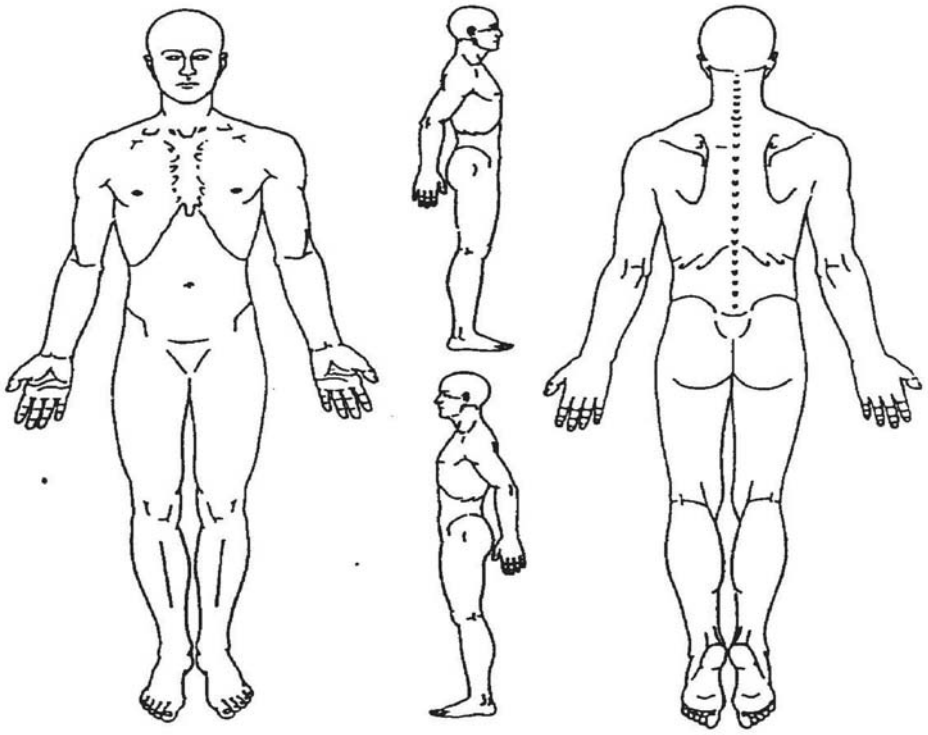
4 PLEASE DESCRIBE IN GENERAL WHAT YOU EAT, AND WHAT YOU CRAVE? (SWEET____, SOUR____, SPICY____, SALTY____)

5 DO YOU HAVE TROUBLE SLEEPING____? ARE YOU A NIGHT SLEEPER_____?
WAKE AND HAVING DIFFICULTY FALLING BACK TO SLEEP____?

6 IF YOU WERE TO DESCRIBE YOURSELF FROM AN EMOTIONAL STANDPOINT,
WHAT WOULD YOU SAY (I.E. IRRIBTABLE____, WORRIER____, ANXIOUS____, SAD____, IMPATIENT____, STRESSED____, ETC.)?

NOTES:





0 1 2 3 4 5 6 7 8 9 10

No pain

Highest pain