Acupuncture TCM Intake Form

This is for first time acupuncture clients to complete in order to help formulate a TCM (Traditional Chinese Medicine) diagnosis and treatment plan. I apologize for it's length, but it should be easy to complete. Answers should be based on CURRENT SYMPTOMS only (unless otherwise stated).

Please provide your NAME:

Please provide your EMAIL:

Please provide your PHONE:

If this is for a SKYPE consultation, please provide your Skype info:

Please provide your address

How did you hear about No Allergies Please? (circle one)

Friend/Family

Co-worker

Website

Oakville Beaver

Vitality Magazine

Show

Vehicle Ad

Social Media

Other

What is your chief health complaint/reason for this visit?

Please provide a brief history regarding your chief complaint

Do you have any of the following allergy/sensitivity symptoms: (check all that apply)

- [ ] Runny nose
- [ ] Itchy eyes
- [ ] Hives/Rash
- [ ] Stuffiness
- [ ] Seasonal/Pollen/Dust/Environmental
- [ ] Year round
- [ ] Animals
- [ ] Insects
- [ ] Foods
- [ ] Chemicals/Perfumes/Smoke
- [ ] Life-threatening/epi-pen
- [ ] Other

If you have food sensitivities/allergies, please list them

Currently experiencing any of the following COLD/FLU like symptoms (check all that apply)

- [ ] Fever and Chills
- [ ] Runny nose/nasal congestion
- [ ] Stiff neck/body aches
- [ ] Alternating Chills and Fever
- [ ] Fever only
- [ ] Chills only
- [ ] Frequently sick

- [ ] N/A

Body Temperature- Sweating and Cold: (check all that apply)

- [ ] Sweating Random/without cause
- [ ] Daytime
- [ ] Evenings (late afternoon to before bed)
- [ ] Nighttime(when sleeping)
- [ ] Cold sweats
- [ ] Hot flashes
- [ ] Sweat excessively (profuse)
- [ ] Yellow/sticky/staining clothes
- [ ] Smelly Sweat
- [ ] Never Sweat
- [ ] Never Cold

If applicable, where is the location of your sweat/cold: (check all that apply)

- [ ] Whole body
- [ ] Head/Face
- [ ] Beads on forehead
- [ ] Chest
- [ ] Palms/Soles
- [ ] Back
- [ ] Abdomen
- [ ] Limbs only
- [ ] Hands only
- [ ] Feet only
- [ ] Half body only

Sleep: (check all that apply)

- [ ] Trouble falling asleep
- [ ] Trouble staying asleep
- [ ] Light Sleeper
- [ ] Wake Early
- [ ] Wake rested
- [ ] Wake not rested /tired upon waking

- [ ] Dream disturbed sleep

How many hours to you sleep: (circle one)

More than 7

5-7

Less than 5

If you wake at night, what time do you usually wake up?

If you wake at night, how many times do you wake?

Appetite (check all that apply)

- [ ] High - eating a lot
- [ ] High - eating little
- [ ] High - eating a lot followed by diarrhea
- [ ] Get full quickly
- [ ] No appetite/Loss of appetite
- [ ] Normal appetite

Thirst: (check all that apply)

- [ ] Prefer warm liquids
- [ ] Prefer cold liquids
- [ ] Thirst - drinking a lot/gulps
- [ ] Thirst - drinking sips
- [ ] Thirst - with vomiting
- [ ] Thirst - but no desire to drink
- [ ] Dry Mouth
- [ ] No Thirst

How much WATER do you consume daily: (circle one)

Less than 1 cup

1 to 4 cups

5-8 cups

More than 8 cups

Digestion: (check all that apply)

- [ ] Crave sugar
- [ ] Crave salt
- [ ] Other cravings
- [ ] Bitter taste in mouth
- [ ] Sour taste in mouth
- [ ] Gas/Bloating
- [ ] Frequent nausea/vomiting
- [ ] Frequent burping/belching/heartburn
- [ ] Bad breath
- [ ] Abdominal pain/cramping

Lifestyle: (check all that apply)

- [ ] Prefer warming foods
- [ ] Spicy food
- [ ] Raw food
- [ ] Only eat cooked foods
- [ ] Vegetarian
- [ ] Paleo/Keto
- [ ] Wheat
- [ ] Dairy
- [ ] Soy
- [ ] Caffeine
- [ ] Alcohol
- [ ] Fast/Fried food/Restaurants
- [ ] Smoke
- [ ] Weight gain/loss

- [ ] Shift work
- [ ] Regular exercise

Urination: (check all that apply)

- [ ] Light yellow
- [ ] Pale/Clear
- [ ] Deep-Yellow/Dark/Concentrated
- [ ] Scanty
- [ ] Frequent/Excessive
- [ ] Urgent
- [ ] Pain Before
- [ ] Pain During
- [ ] Pain After
- [ ] Leakage when coughing sneezing or when bladder is full
- [ ] Bladder prolapse
- [ ] Feel need to go but nothing happens
- [ ] Dribbling/difficult
- [ ] Incontinence
- [ ] Night time urination (nocturia)
- [ ] Blood in Urine(hematuria)

Wake up at night to urinate?

◯ yes ◯ no

How often do you wake to urinate? (circle one)

0

1

2

3

4

5 or more

Stool: (check all that apply)

- [ ] Normal consistency (like a banana)
- [ ] Dry/Dark
- [ ] Like Rabbit Droppings
- [ ] Like a Bunch of Grapes
- [ ] Loose/Diarrhea
- [ ] Alternating Constipation/Diarrhea
- [ ] Hard followed by loose/diarrhea
- [ ] Recurring diarrhea at 5-7am
- [ ] Contains undigested food
- [ ] Contains mucous
- [ ] Foul Smell
- [ ] No Smell
- [ ] Red colour
- [ ] Blackish Color
- [ ] Painful
- [ ] Difficult/Straining
- [ ] Less than 1/day
- [ ] More than 3/day
- [ ] Rectal prolapse

If applicable, describe any pain: (check all that apply)

- [ ] Sudden onset
- [ ] Acute(less than 3 months)
- [ ] Gradual onset
- [ ] Constant
- [ ] Chronic(more than 3 months)
- [ ] Burning
- [ ] Dull
- [ ] Distending
- [ ] Contracting
- [ ] Sharp/Stabbing
- [ ] Numbness & Tingling
- [ ] Pain with heavy sensation
- [ ] Moving/Different locations
- [ ] Always same location

If applicable, where is the location of your pain: (check all that apply)

- [ ] Joints
- [ ] Neck
- [ ] Back
- [ ] Shoulder
- [ ] Knees
- [ ] Feet
- [ ] Muscles
- [ ] Other

Current Level of Pain(0=none, 10=high): (circle one)

0

1

2

3

4

5

6

7

8

9

10

Is Pain Better with: (check all that apply)

- [ ] Pressure
- [ ] Warmth
- [ ] Cold
- [ ] Rest
- [ ] Activity
- [ ] Food
- [ ] Bowel Movement

Is Pain Worse with: (check all that apply)

- [ ] Pressure
- [ ] Warmth
- [ ] Cold
- [ ] Rest
- [ ] Activity
- [ ] Food
- [ ] Bowel Movement

Mouth and Gums: (check all that apply)

- [ ] Bleeding gums
- [ ] Ulcers on gums/inside of cheeks
- [ ] Ulcers on tongue
- [ ] Painful ulcers
- [ ] Frequent Ulcers
- [ ] Occasional Ulcers
- [ ] N/A

Ears and Eyes: (check all that apply)

- [ ] Red eyes
- [ ] Eye pain
- [ ] Blurry vision
- [ ] Dry eyes
- [ ] Poor night vision
- [ ] Tired eyes
- [ ] Floaters/Spots
- [ ] Burning eyes
- [ ] Wear glasses
- [ ] Low-pitch chronic ringing in ears
- [ ] High-pitch acute ringing in ears
- [ ] Chronic loss of hearing
- [ ] Acute loss of hearing
- [ ] Earaches
- [ ] Ear infections
- [ ] Loss of Balance

- [ ] N/A

Chest: (check all that apply)

- [ ] Cough
- [ ] Expectoration
- [ ] Pain
- [ ] Heaviness in chest
- [ ] Shortness of Breath
- [ ] Frequent sighing
- [ ] Difficulty Inhaling
- [ ] Difficulty Exhaling

(Women) Still have a menstrual cycle?

- ◯ yes ◯ no

(Women) Menstruation details - if you no longer have your menses, please answer based on how they were: (check all that apply)

- [ ] Regular (25-35 days)
- [ ] Irregular (no consistent cycle)
- [ ] Clots larger than a nickel
- [ ] Pain
- [ ] Bleeding between periods
- [ ] Mood changes
- [ ] Breast tenderness
- [ ] Birth control

(Women) If you have pain during menstruation, when does/did it occur? (check all that apply)

- [ ] Before
- [ ] During
- [ ] After
- [ ] Better with Warmth
- [ ] Better with Cold
- [ ] Better with Pressure
- [ ] Worse with Pressure

(Women) Length of Period in days: (circle one)

1

2

3

4

5

6

7

8

9

10 or more

(Women) Number of days between cycles: (circle one)

26 or less

27

28

29

30

31

32 or more

(Women) Type of menstrual flow: (circle one)

Heavy

Light/Scanty

Long

Spotting between

None for 3+ months

(Women) Pregnancies Past/Present: (check all that apply)

- [ ] Morning sickness
- [ ] Miscarriages
- [ ] Edema
- [ ] Complications
- [ ] Currently pregnant

(Women) Vaginal Discharge: (check all that apply)

- [ ] White
- [ ] Light
- [ ] Watery
- [ ] Yellow
- [ ] Thick
- [ ] Sticky
- [ ] Smelly
- [ ] Pus

Men: (check all that apply)

- [ ] Nightly urination
- [ ] Difficult/Hesitant Urination
- [ ] Premature Ejaculation
- [ ] Unable to ejaculate
- [ ] High Libido
- [ ] Low Libido
- [ ] Enlarged Prostate

Energy levels right now (0=none, 10=lots): (circle one)

0

1

2

3

4

5

6

7

8

9

10

Any drops in energy during the day?

◯ yes ◯ no

If so, at what times?

Do any of these environments make you feel worse? (check all that apply)

- ☐ Wind
- ☐ Rain
- ☐ Damp
- ☐ Cold
- ☐ Dry
- ☐ Hot
- ☐ Mold

Do you currently suffer from any of the following: (check all that apply)

- ☐ Motion Sickness
- ☐ Headaches/Migraines
- ☐ Lower Back/Knee Problems
- ☐ Heart Palpitations
- ☐ Weak limbs
- ☐ Fluid retention
- ☐ Allergies/Sensitivities
- ☐ Sports Injuries
- ☐ Asthma/Wheezing
- ☐ Dizziness

- [ ] Poor Memory
- [ ] Mental fog
- [ ] Fatigue
- [ ] Fainting
- [ ] A feeling of heaviness in the body
- [ ] Tremors/Convulsions
- [ ] Thyroid issues
- [ ] Low Iron
- [ ] Other

If you currently have any phlegm, is it: (circle one)

Clear

White

Yellow

Green

Skin Conditions: (check all that apply)

- [ ] Itchy
- [ ] Eczema
- [ ] Rashes
- [ ] Psoriasis
- [ ] Urticaria
- [ ] Hives
- [ ] Acne/Blemishes
- [ ] Dry skin
- [ ] Ulcers
- [ ] Dandruff
- [ ] Hair loss

Do you experience any of the following symptoms? (check all that apply)

- [ ] rectal itching
- [ ] teeth grinding
- [ ] athletes foot
- [ ] thrush

- [ ] bladder infections
- [ ] jock itch
- [ ] yeast infections
- [ ] crawling sensations under skin

Mood - Are you easily or generally: (check all that apply)

- [ ] Depressed
- [ ] Anxious/Overthinking
- [ ] Irritated/Angry/Stressed
- [ ] Sad
- [ ] Fearful
- [ ] Happy

How's your memory? (circle one)

Great

Could Be Better

Awful

Would you like to join our mailing list (we send out monthly newsletters)? We will *never* share or sell your information)!

- ◯ yes ◯ no