TCM Intake Form:

This confidential information of your medical record and health history will be kept by Healing With Christine and will not be released to any individual except when you have authorized this release in writing or when required by law. Please complete this form as thoroughly as possible to optimize your health care outcomes.

Name: _____ Age: ____ Date of Birth: _____ Gender: ☐ M ☐ F

Address_____ Email: _____

Phone (H): _____ (W): _____ (C): _____

Occupation: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Medical doctor: _____ Phone: _____

Address:_____

How did you hear about Healing With Christine?

_____

Health Goals/Concerns:

What main health goal/concern brought you to the clinic today?

_____

_____

How long have you had it? _____

Describe any factors you suspect may have played a role in the onset and perpetuation of your condition: _____

List Previous practitioners consulted for this condition (ie. Family Doctor, Physiotherapist, etc.):

_____

Please describe their diagnosis, therapy and results where applicable:

_____

_____

What other types of therapy have you tried for this problem?

_____

What makes it better? _____

What makes it worse? _____

Please list any other health concerns or goals in **order of importance**:

_____

_____

Medical History:

How would you describe your general state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medical Conditions:

Please indicate any hospitalizations, surgeries and injuries you have experienced:

Hospitalization, Surgery, Injury	Date	Symptoms	Condition Resolved?

Allergies and/or food sensitivities:

Allergy/Sensitivity	Symptoms	Treatment/Avoidance?

Current medications/supplements:

Please list ALL medications or supplements you take on a regular basis:

Medication/Supplement	Dose (if known)	Length of Use	Prescribing Practitioner	Presently Taking?

Family History:

Have *you* or anyone in your family been diagnosed with any of the following conditions?

☐ Alcoholism	☐ Alzeimer's Disease	☐ Asthma	☐ Cancer
☐ Depression	☐ Diabetes	☐ Drug Abuse	☐ Eczema
☐ Epilepsy	☐ Fibromyalgia	☐ Heart Disease	☐ High Blood Cholesterol
☐ High Blood Pressure	☐ Kidney Disease	☐ Mental Illness	☐ Multiple Sclerosis
☐ Osteoporosis	☐ Osteoarthritis	☐ Psoriasis	☐ Thyroid Disorder

Please list any other illnesses of your relatives, such as parents' siblings, grandparents, aunts and uncles: _____

_____

Energy and Exercise:

Do you feel that you have enough energy during the day? ☐ Y ☐ N

Rate your average level of energy (please circle) - Lowest – 1 2 3 4 5 6 7 8 9 10 – Highest

How often do you exercise? _____

What type of exercise do you do? _____

Stress:

Please mark the appropriate box that best describes the level of stress you experience.

Overall Stress level	☐None ☐Minimal ☐Moderate ☐Severe
My relationship stress is:	☐None ☐Minimal ☐Moderate ☐Severe
My work stress is:	☐None ☐Minimal ☐Moderate ☐Severe
My financial stress is:	☐None ☐Minimal ☐Moderate ☐Severe
My health stress is:	☐None ☐Minimal ☐Moderate ☐Severe
Other stress _____	☐None ☐Minimal ☐Moderate ☐Severe

Emotions:

How would you describe your outlook on life lately? _____

_____

Have you been experiencing a feeling more often in the last few months? (Please check all that apply)

☐ Angry	☐ Anxious	☐ Worried	☐ Overworked	☐ Annoyed	☐ Grief
☐ Frustrated	☐ Fearful	☐ Hopeless	☐ Overwhelmed	☐ Outraged	☐ Guilty
☐ Sad	☐ Panic	☐ Helpless	☐ Easily Irritated	☐ Restless	☐ Depressed

Pain/Tension

Please describe any pain or tension that you have in your body:

Location	Nature of Pain (sharp, dull, throbbing, etc)	What makes it better?	What makes it worse?	How long?

For Women:

Age of first period: _____ Number of pregnancies: _____ Number of children: _____

Is your menstrual cycle regular? ☐ Y ☐ N Average days of entire cycle: _____

How many days does your period last? _____ Is the flow: ☐ Heavy ☐ Light ☐ Normal

What colour is the flow? ☐ Bright Red ☐ Pale Red ☐ Dark Red ☐ Purple ☐ Brown

Are there clots? ☐ Y ☐ N If so, what colour are the clots? _____

What size are the clots: _____

Which of the following pre-menstrual symptoms do you experience?

☐Breast Distension ☐Breast Tenderness ☐Food Cravings ☐Irritability
☐Water Retention ☐Headaches ☐Migraines ☐Anxiety
☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation
☐Alternating Diarrhea/Constipation ☐Depression ☐Other emotions: _____
☐Abdominal cramps
(If so, please describe where you feel the cramps: _____

Please describe nature of cramping:

☐Stabbing ☐Better with pressure ☐Better with heat ☐Better with exercise
☐Aching ☐Worse with pressure ☐Better with cold ☐Worse with exercise

Do you have vaginal discharge? ☐ Y ☐ N

Describe colour, viscosity and odor of discharge:

Colour	
Viscosity	
Odor	

Do you experience?

☐Vaginal dryness ☐Vaginal irritation ☐Bleeding between periods
☐Vaginal pain ☐Vaginal itch

Age of last period: _____ Please describe symptoms related to menopause: _____

_____

For Men:

Do you experience?

☐Swollen testes	☐Impotence	☐Feeling of coldness or numbness in

		external genatalia
☐Testicular pain	☐Premature ejaculation	☐Other: _____

Diet & Digestion:

How is your appetite? _____

How many meals do you eat per day? _____ What times do you usually eat? _____

Do you ever have indigestion after eating or stomach pain, discomfort, nausea, vomiting? If so, please describe: _____

_____

Do you eat dairy? ☐ Y ☐ N Do you eat meat? ☐ Y ☐ N

Do you crave flavors: ☐ Sweet ☐ Salty ☐ Sour ☐ Bitter ☐ Spicy

Do you avoid any foods? If so, please list _____

_____

Do you have thirst? ☐ Y ☐ N How much **water** do you drink per day? _____

Do you drink:	If so, how much in a day?
☐ Soda	
☐ Coffee	
☐ Alcohol	

Do you smoke? ☐ Y ☐ N If so, how much in a day? _____

Do you have a preference for hot or cold drinks? _____

How are your bowel movements? Do you have:

☐ Diarrhea ☐ Dry Stools ☐ Alternating Diarrhea/Constipation

☐ Constipation ☐ Loose Stools ☐ Straining

How many bowel movements do you have per day? _____ What times? _____

Do you have: ☐ Gas ☐ Bloating ☐ Bad Breath

Urination:

How often do you urinate in a day? _____

Do you have: ☐ Profuse Urine ☐ Scanty Urine ☐ Interrupted Flow?

Is it difficult to urinate? ☐ Y ☐ N Painful? ☐ Y ☐ N

If so, please explain: _____

What colour is the urine? ☐ Clear ☐ Light Yellow ☐ Dark Yellow

Do you wake up in the night to urinate? ☐ Y ☐ N If so, how often? _____

Sleep:

How easy is it for you to fall asleep? _____

Do you wake up in the night? ☐ Y ☐ N If so, what wakes you? _____

Do you feel rested in the morning? ☐ Y ☐ N Do you nap during the day? ☐ Y ☐ N

On average, how many hours of sleep do you get every night? _____

Head, Chest and Breathing:

Do you experience any of the following?

☐Shortness of Breath ☐Difficulty Breathing ☐Asthma/Weezing

☐Vertigo/Dizziness ☐Sinus Problems ☐Phlegm (please describe color and consistency)

_____

☐Palpitations ☐Chest Pain/Discomfort ☐Chest Tightness

Skin/Sweat:

Do you experience any of the following?

☐Sweat easily ☐Profuse sweat ☐Sweat at night

☐Sweaty hands and feet ☐Dry skin ☐Rashes

☐Acne or Boils ☐Easily bruised ☐Eczema

☐Other skin condition: _____

Does your sweat have an odor? ☐ Y ☐ N If so, please describe: _____

Temperature:

Do you tend to feel more hot or more cold? _____

Do you experience any of the following?

☐Cold hands ☐Cold feet ☐Other areas cold: _____

☐Hot hands ☐Hot feet ☐Other areas hot: _____

☐Fever ☐Chills ☐Alternating fever and chills

☐Aversion to heat ☐Aversion to cold

Vision:

Do you experience any of the following?

☐Blurred vision ☐Poor night vision ☐Dry eyes

☐Other eye condition: _____

Hearing:

Do you experience any of the following?

☐Ear ringing ☐Ear aches ☐Popping

☐Other ear condition: _____

Taste:

Do you ever get a particular taste in your mouth?

☐Bitter ☐Metalllic ☐Sweet ☐Sour

Other:

Is there anything else that you feel is important and hasn't been addressed on this form?

_____

_____

_____

TCM Diagnosis

Tongue:

Pulse: R -

L -