PATIENT INTAKE FORM

Katrine B. Hegillman Dr. TCM

The following information is essential for the diagnostic procedure,
Please Try to Be as Thorough and Accurate as You Can. *This information is strictly confidential.*

Date (DD/MM/YYYY): ___/___/_____

First name_____ Last name_____

Home Address_____

Home: ( ) ____ -_____ Cell Phone: ( ) ____ -_____ Work Phone: ( ) ____ -_____

Email Address:_____

Birth Date (DD/MM/YYYY) ___/___/_____ Height_____ Weight_____

Other Concurrent Therapies/Practitioners: _____

Referred By: _____

Describe Your Main Complaint:

Reason for Today's Visit: _____

How Long Have You Had This Condition? _____ Is It Getting Worse? Yes / No

What Seems to Be the Initial Cause? _____

What Makes It Better? _____

What Makes It Worse? _____

What Is Your Medical Doctor's Diagnosis?

_____

_____

_____

Family Medical History

- ☐ Allergies: _____ _____ _____ _____
- ☐ Heart Disease
- ☐ Stroke
- ☐ Alcoholism
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Arteriosclerosis
- ☐ Cancer: _____ _____ _____
- ☐ Diabetes
- ☐ Seizures
- ☐ Psychological disorders: _____ _____

Your Past Medical History:

(please check any of the following you currently have or have had in the past)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies: _____ _____
- ☐ Appendicitis
- ☐ Asthma
- ☐ Cancer: _____
- Chicken pox
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood
- ☐ Pressure
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough

Other (please specify):

_____

_____

_____

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Did You Experience Any Birth Trauma? If So, Please Describe:

_____

_____

Please List Your Vaccination History (i.e. Flu shots, Unusual Vaccines, Reactions, etc.):_____

_____

_____

Please List Your **Childhood** History (Surgeries, Traumas, Accidents, Location of Scars on Your Body):

_____

_____

_____

Please List Your **Adulthood** History (Surgeries, Traumas, Accidents, Location of Scars on Your Body):

_____

_____

_____

Current Medication (Prescription & Non-prescription):

_____

_____

_____

Current Supplements (Herbal & Nutritional *Even on Occasion*):

_____

_____

_____

_____

Diet: Check the ones that apply.

Appetite:
- ☐ High
- ☐ Low
- ☐ Eat for Comfort

- ☐ Coffee
- ☐ Artificial Sweeteners
- ☐ Sugar
- ☐ Soft Drinks

- ☐ Salty Foods
- ☐ Thirst for Water, # of Glasses Per Day (___)

Your Daily Menu:

Breakfast _____

Snack _____

Lunch _____

Snack _____

Dinner _____

Snack/Dessert _____

Symptom List: For each of the following conditions please mark the blank

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according to your situation:

R (*Recent-Occurrence*) **MI** (*Mild*) **LH** (*Long-History*) **MO** *(Moderate)* **S** *(Severe)*

General Symptoms:

___ Poor Sleep
___ Heavy Sleep
___ Dream-Disturbed Sleep
___ Night Sweats
___ Fatigue
___ Lack of Strength
___ Bodily Heaviness

___ Fever
___ Chills
___ Sweats Easily
___ Muscle Cramps
___ Vertigo/Dizziness
___ Bruise or Bleed Easily
___ Bad Breath

___ Cold Hands/Feet
___ Poor Circulation
___ Shortness of Breath
___ Recent Weight Gain/Loss

___ Rashes
___ Hives
___ Ulceration
___ Eczema
___ Psoriasis

___ Acne
___ Dandruff
___ Itching
___ Hair loss

Skin and Hair

___ Change in Hair/Skin Texture
___ Fungal Infection/Warts
___ Other Hair/Skin Problems
_____
_____

Head, Eyes, Ears, Nose and Throat

___ Glasses
___ Contacts
___ Poor Vision
___ Blurred Vision
___ Eye Strain
___ Eye Pain
___ Red Eyes
___ Itchy Eyes
___ Spots in Eyes
___ Night Blindness
___ Ringing in Ears
___ Poor Hearing
___ Earaches
___ Headaches
___ Migraines
___ Concussion
___ Other Head/Neck Problems
_____
_____

___ Teeth Problems
___ Grinding Teeth
___ TMJ
___ Facial Pain
___ Gum Problems
___ Mouth/Tongue Sores
___ Dry Mouth
___ Excessive Saliva
___ Condition of Teeth
_____
_____

___ Sinus Problems
___ Nose Bleeds
___ Lumps in Throat
___ Glaucoma
___ Cataracts
___ Swollen Glands
___ Enlarged Thyroid
___ Recurrent Sore Throat

Respiratory

- Difficulty Breathing While Lying Down
- Shortness of Breath
- Tight Chest
- Asthma/Wheezing
- Shallow Breathing
- Coughing Blood
- Pneumonia
- Cough: Please Describe
  Wet or Dry? _____
  Thick or Thin? _____
  Colour of Phlegm? _____

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Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Blood Clots/Infection of Veins
- ☐ Irregular Heartbeat
- ☐ Fainting
- ☐ Chest Pain/Sensation: _____
- ☐ Difficulty Breathing
- ☐ Heart Palpitations

Gastrointestinal

- ☐ Bloody Stools
- ☐ Mucous in Stools
- ☐ Itchy Anus
- ☐ Burning Anus
- ☐ Hemorrhoid(s)
- ☐ Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative Use
- ☐ Black Stools
- ☐ Intestinal Pain/Cramping
- ☐ Nausea
- ☐ Vomiting
- ☐ Acid Regurgitation
- ☐ Gas
- ☐ Hiccups
- ☐ Anal Fissures

Bowel Movements:
Frequency_____ Color_____ Texture/Form_____ Odor? _____

Musculoskeletal

- ☐ Neck/Shoulder Pain
- ☐ Muscle Pain
- ☐ Upper Back Pain
- ☐ Lower Back Pain
- ☐ Joint Pain
- ☐ Rib Pain
- ☐ Limited Range of Motion
- ☐ Limited Use

Other (Please Describe)
_____
_____
_____

Neuropsychological

- ☐ Seizures
- ☐ Numbness
- ☐ Tics
- ☐ Poor Memory
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily Stressed
- ☐ Abuse Survival
- ☐ Considered Suicide
- ☐ Attempted Suicide
- ☐ Seeing a Therapist
- ☐ Other (Please Specify
_____
_____
_____

Gen
ital & Urinary

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Urgent Urination
- ☐ Blood in Urine
- ☐ Unable to Hold Urine
- ☐ Incomplete Urination
- ☐ Venereal Disease
- ☐ Bedwetting
- ☐ Wake to Urinate
- ☐ Kidney stone
- ☐ Increased Libido
- ☐ Decreased Libido
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Nocturnal Emission

Gynecology

- ☐ Irregular Menstruation
- ☐ Painful Periods
- ☐ PMS
- ☐ Vaginal Sores
- ☐ Clots
- ☐ Breast Lumps
- ☐ Premature Births

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- Age Menstruation Began _____
- Length of Cycle _____
- Duration of Flow _____

Lifestyle: Please check each one you use.

All Answers are Confidential.

Vaginal Discharge Color: _____ // Vaginal Odor_____ Number of Pregnancies____

Number of Live Births _____ // Age at Menopause_____ // Date of Last Period _____//

Date of Last PAP Test_____ Birth Control [yes] or [no] //

Birth Control Type: _____

- Alcohol
- Tobacco
- Marijuana
- Prescription drugs
- Recreational drugs
- Stress

Occupational Hazards_____

Regular Exercise: [Yes] or [No]

Type _____

Frequency _____

Type _____

Frequency _____

Is There Anything Else We Should Know?

_____

_____

_____

_____

_____

_____

_____.

Thank you for taking the time to fill this out so that we may provide you with a Successful and Efficient Treatment.