Patient Intake

Quan Yin Medical Center

Name	Email	Phone
Street	Age Ht. Wt.	
City	Sex	
State Zip	Occupation	Referred By
Physician	Phone	
Main Problem		Onset
Other Concurrent Therapies	Emergency Contact	Phone

Past Medical History (include dates):

Significant Illnesses: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Heart Disease ___ Hepatitis ___ Rheumatic Fever ___ Thyroid Disease ___ Seizures ___ Other.

Surgeries:

Significant Trauma (auto accidents, falls, etc.) Birthdate

Birth History: (prolonged labor, forceps delivery, etc.)

Allergies: (drugs, chemicals, foods.)

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.)

Occupational Stresses (Chemical, physical, psychological,etc.)

Exercise:

Comments:

Average Daily Diet

Morning *Afternoon* *Evening*

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other _____

Family Medical History: ___Diabetes ___Cancer ___ High Blood Pressure ___ Heart Disease ___Stroke ___ Seizures ___ Asthma ___Allergies ___Alcoholism ___ Other _____

Notes _____

_____

_____

GENERAL

☐ Poor appetite ☐ Heavy appetite ☐ Poor sleep ☐ Heavy sleep
☐ Insomnia ☐ Fatigue ☐ Tremors ☐ Vertigo
☐ Cold hands ☐ Cold feet ☐ Cold back ☐ Cold abdomen
☐ Fevers ☐ Chills ☐ Night sweats ☐ Sweat easily
☐ Cravings ☐ Localized weakness ☐ Poor coordination ☐ Change in appetite
☐ Sudden energy drop at _____ (time) ☐ Peculiar tastes/smells_____
☐ Strong thirst (cold/hot drinks) _____ ☐ Bleed or bruise easily (where) _____

_____

_____

SKIN AND HAIR

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching
☐ Eczema ☐ Pimples ☐ Dandruff ☐ Loss of hair
☐ Change in hair/skin texture ☐ Purpura ☐ Other hair or skin problem_____

_____

_____

HEAD, EYES, EARS, NOSE, AND THROAT

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glassses
☐ Eye strain ☐ Eye pain ☐ Poor vision ☐ Night blindness
☐ Color blindness ☐ Cataracts ☐ Blurry vision ☐ Earaches
☐ Ringing in ears ☐ Poor hearing ☐ Nose bleeds ☐ Sinus problems
☐ Mucus ☐ Dry throat ☐ Dry mouth ☐ Copious saliva
☐ Teeth problems ☐ Jaw clicks ☐ Grinding teeth ☐ Facial pain
☐ Gum problems ☐ Spots in eyes ☐ Recurrent sore throats _____/month
☐ Sores on lips or tongue ☐ Headaches (where and when) _____
☐ Other head or neck problems _____

CARDIOVASCULAR

☐ High blood pressure ☐ Low blood pressure ☐ Chest Pain ☐ Irregular heartbeat
☐ Dizziness ☐ Fainting ☐ Cold hands/feet ☐ Swelling in hands/feet
☐ Blood clots ☐ Phlebitis ☐ Difficulty breathing ☐ Other

RESPIRATORY

☐ Cough ☐ Coughing blood ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Difficulty in breathing when lying down ☐ Tight chest
☐ Production of phlegm _____what color _____ ☐ Other lung problems

GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Diarrhea Bowel Movement:
☐ Gas ☐ Belching ☐ Black stools _____Frequency
☐ Bad Breath ☐ Rectal pain ☐ Hemorrhoids _____Color
☐ Constipation ☐ Bloody stools ☐ Sensitive abdomen _____Odor
☐ Pain or cramps ☐ Laxative use:_____ /week; type _____ _____Texture/form

GENITO-URINARY

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate
☐ Unable to hold urine ☐ Kidney stones ☐ Venereal disease ☐ Impotency
☐ Wake up to urinate How often_____/night; time:_____ ☐ Other G/U problems

PREGNANCY AND GYNECOLOGY

☐ Number pregnancies ☐ Number births ☐ Premature births ☐ Miscarriages
☐ Age at first menses ☐ Period (days) ☐ Duration ☐ Irregular periods
☐ Flow (describe) ☐ Clots Last PAP_____ Last menses _____
☐ Vaginal discharge ☐ Vaginal sores ☐ Breast lumps Menopause _____
☐ Birth control type and duration _____ ☐ Changes in body/psyche prior to menstruation

MUSCULOSKELETAL

☐ Neck pain ☐ Muscle pains ☐ Back pain (where) ☐ Joint pains (where)
☐ Other joint or bone problems? _____ _____

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Areas of numbness ☐ Poor memory ☐ Concussion
☐ Depression ☐ Anxiety ☐ Bad temper ☐ Easily stressed
☐ Treated for emotional problems ☐ Considered/attempted suicide
☐ Other neurological or psychological problems?

COMMENTS