

**Patient Intake Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Age: \_\_\_\_\_ Sex (biological): \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Complexion (pale, red, etc.): \_\_\_\_\_

**Chief Complaint** (keep it simple):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

- Your friends or partner would describe you as grumpy, irritable, impatient, or frustrated.
- PMS (any presentation) but especially sore breasts.
- You have "11" lines between eyebrows (knitted brow).
- Your friends or partner would say you hold grudges.
- You have unfulfilled desires and goals in your life.

- Fatigue (any time, regular or intermittent, after eating)
- Cold hands/Cold nose (circle one or both)
- Dizziness when standing up
- Weak feeling/lack of strength in arms and legs
- Easy bruising (bruises seem to just appear, not sure how)
- Sugar cravings (especially pre-menstrual)
- Friends/Partner say you have bad breath
- Large appetite/Always finish every meal/Rapid hungering
- Sores on lips

**Bowels:**

- Formed, unformed, sticky, foul odor (circle all that apply)
- Incomplete evacuation
- Wipe more than 3 to 4 times
- Have to deep breathe/push to initiate a bowel movement
- Abdominal bloating/discomfort

Please use the space below for any additional notes.

**Menstruation:** (practitioner will ask follow-up questions)

- Painful: location, sharp, fixed, dull, achy (circle all that apply)
  - Excessive volume (How many tampons, diva cups, etc.)
  - Mid-cycle spotting/pain (circle all that apply)
  - Cycle 28 to 30 days Y\_\_\_ N\_\_\_; if no, how long? \_\_\_\_\_
  - Menses are 3 to 5 days Y\_\_\_ N\_\_\_; if no, how long? \_\_\_\_\_
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- Poor night vision, blurry vision
  - Cramping of muscles (especially in calves in the night)
  - Twitching muscles
  - Dizziness
  - Poor memory/Forgetfulness
  - Pale nails, brittle nails, ridges/lines on nails (circle all that apply)
  - Heart palpitations (awareness of heart beating/fluttering sensation in chest/skipped beats, etc.)
  - Low back coldness/soreness/weakness
  - Frequent, clear and/or nighttime urination
  - Incontinence (leaking urine any time)
  - Cold feet
  - Low libido (This refers specifically to general lack of interest/drive for sex; not just with current partner, but in general. If fidelity/marriage/relationship were not a factor, would you be interested in sex?)
  - Ringing in the ears, difficulty hearing
  - Dry throat/mouth

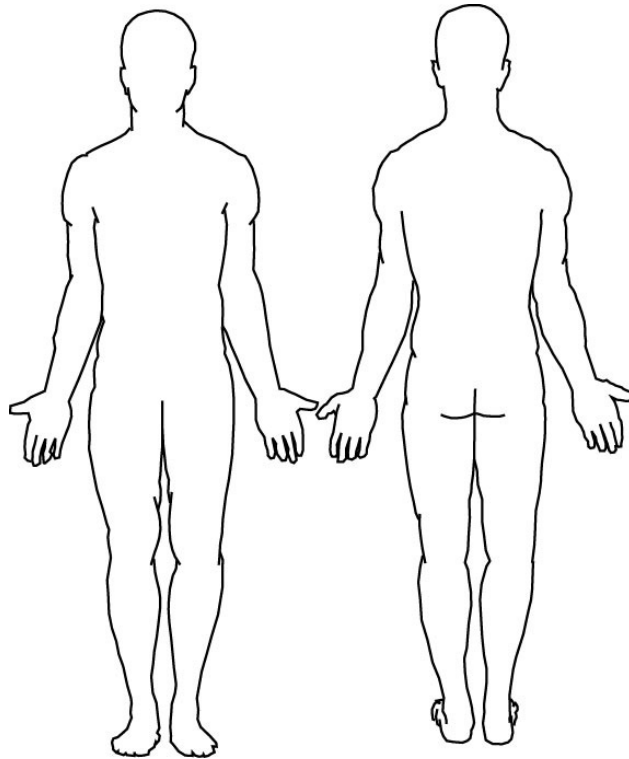
**Thirst/Urination:**

- Mouth feels dry
- Crave large amounts of liquid (large thirst)
- Crave small amounts of liquid (little to no thirst)
- Cloudy urine

## Pain Location, Radiation, Quantity and Quality

**Where is your pain now?** On the illustrations, mark the area of your body where you feel active pain, numbness or radiating pain using the appropriate symbols. Include all affected areas.

Active Pain	Numbness	Radiating Pain
^ ^ ^ ^ ^ ^ ^ ^	O O O O O O O O	/ / / / / / / /



**How bad is your pain now?** On a scale of 1-10 in which 1 equals no pain and 10 being the worst pain you ever felt, rate your level of pain.

- 1   2   3   4   5   6   7   8   9   10

**How consistent is your pain?** Indicate how you would describe your pain.

- Continuous      Positional      On and Off      Unable to rate