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? _____

- ◻ 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

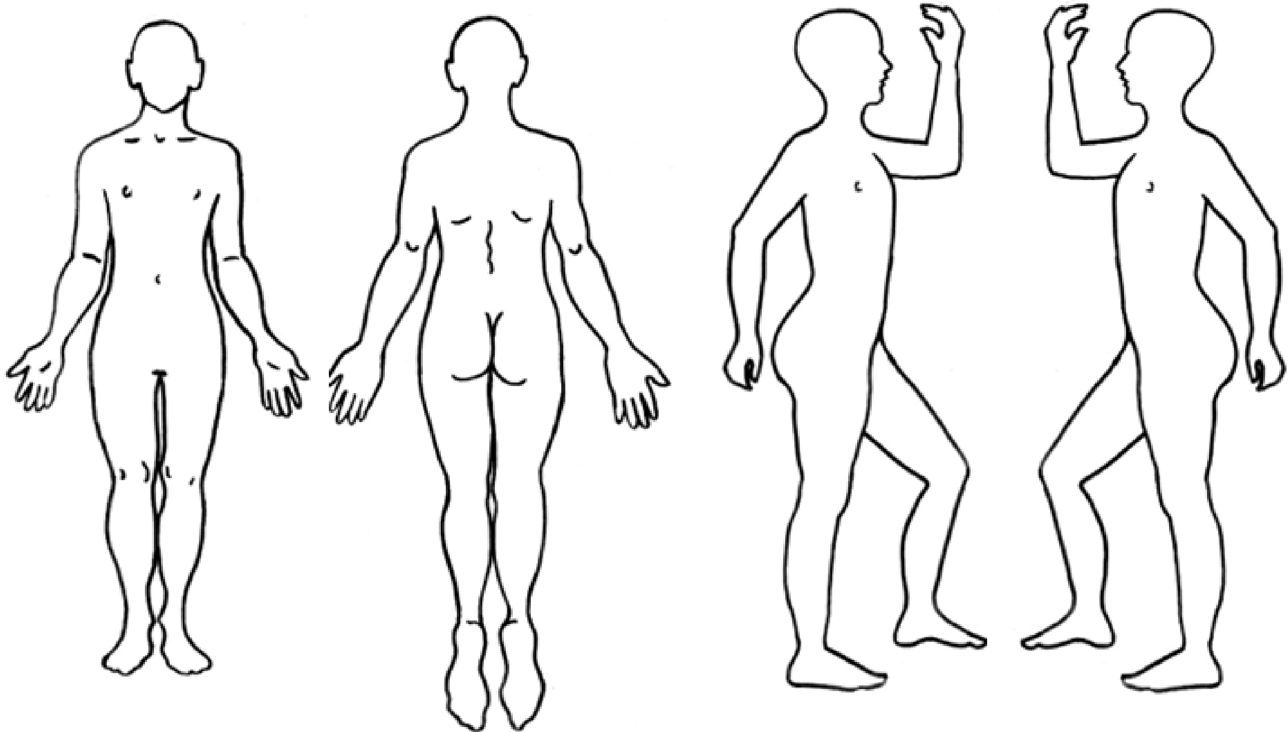
Thirst/Urination:

- ◻ 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
^^^^^^^	OOOOOOO	//////////



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