International Institute of Medical Qigong
Medical Qigong Clinic – Initial Intake

Personal Data

Name: ____ Birth date: _____________

Street Address ____

City ____State ______ Postal Code __________

Telephone ____

Relationship Status: __ single __ married __ domestic partner __ widowed __ children (# ___)

Occupation:____

Emergency Contact: ____________________________ Telephone: ______________ Relationship:________

Currently in physicians care? ____

(medical / acupuncturist / herbalist / nutritionist /psychotherapist)

Purpose of care? ____

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Current Medication / Herbs: ____

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Medical History

	Abortion		Emotional Problems		Hypo-tension
	Anemia		Environmental Sensitivity		Injuries
	Arthritis		Emphysema		Insomnia
	Asthma		Epilepsy		Irregular Pregnancy
	Bleeding Tendency		Headaches		Lung Disease
	Bronchitis		Heart Disease		Menstrual Irregularity
	Cancer		Hepatitis A B C		Surgery
	Chronic Fatigue		HIV Positive		Vaginal Infections
	Diabetes		Hypertension		Other:
	Digestive Disorder		Hypoglycemia		**Pregnant? ____ Yes ____ No**

Surgeries / Biopsies: ____

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Imaging Studies (Therapy or Diagnosis) ____

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Treatment History

Chemotherapy	Original	From		To:	
	Current	From		To:	
	Previous	From		To:	
Radiation	Original	From		To:	
	Current	From		To:	
	Previous	From		To:	

How and when was your current condition diagnosed? (Cyst, Tumor or Cancer) ____________________

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When did you first become aware of this condition? ____

Personal Reasons for Seeking Medical Qigong Treatment

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Lifestyle

Tobacco		Recreational drugs		Prayer/Higher Power	
Coffee		Birth control pills		Relaxation/Meditation	
Alcohol		Hormone replacement		Vitamins/Supplements	

1. **Diet**

   ___ Raw Foods ___Dairy ___Hot & Spicy food ___ Sugar ___ Vegetarian ___ Vegan

2. **Emotional Environment**

   Are you happy? ____

   Home: ______________________________ Work: ______________________________________

   Current mood / Emotional state? ____

   Recurring emotional pattern? ____

3. **Current level of pain or discomfort?**

   Rate level of pain (0=No Pain / 10=Unbearable Pain) __________________

   Frequency of pain: _____________ often _____________ occasionally ___________ infrequently