Intake Form

Name: _____ Birth Date: _____

Street Address: _____

City: _____ State: _____ Zipcode: _____

Phone: _____ Mobile: _____ Other: _____

Email: _____ Preferred method of communication: _____

Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

What is your main reason for seeking treatment? _____

_____

_____

Duration of present condition(s)? _____

What do you believe caused this condition? _____

_____

Please list all Current Medications and supplements in the appropriate column:

Prescription Drugs	Over the Counter Drugs	Supplements (vitamins, herbs, etc.)

Please list all current health care providers:

Medical Doctor (list primary and specialists)	
Chiropractor	
Acupuncturist/herbalist	
Physical Therapist	
Massage Therapist	
Psychotherapist/counselor	

Medical History (Briefly describe any checked boxes in space below)

❒ Asthma
❒ Autoimmune disorder
❒ Allergies
❒ Heart disease
❒ Hypertension
❒ Hx of heart attack
❒ Stroke
❒ Anemia
❒ Headaches
❒ Arthritis
❒ Epilepsy
❒ Kidney disease
❒ Diabetes
❒ Skin disorder
❒ Infertility
❒ Fibroids/cysts
❒ Hepatitis
❒ HIV
❒ Tuberculosis
❒ Cancer
❒ Alcoholism/drug addiction
❒ Depression
❒ Mental illness
❒ Weight problems
❒ Surgeries
❒ Physical trauma/accidents

Comments/explanation: _____

_____

_____

_____

_____

Treatment history

Have you had treatments from a Chinese medical practitioner before? _____

Have you had energetic treatments before? _____

Do you have a previous background in Qigong? _____

Is your primary interest: ❒ Medical Qigong Treatments ❒ Learning Qigong Practice ❒ I have no idea!!

Spirituality

Religious preference: _____
Do you have any current spiritual concerns? _____

Your Health and Well Being

How would you rate your **current level of health**? (Please circle): (*Very Poor*) 1 2 3 4 5 6 7 8 9 10 (*Excellent*)

How would you rate your **current level of energy**? (Please circle): (*Very Poor*) 1 2 3 4 5 6 7 8 9 10 (*Excellent*)

How would you rate your **current emotional status**? (Please circle): (*Very Poor*) 1 2 3 4 5 6 7 8 9 10 (*Excellent*)

How do you feel upon getting up in the morning? ❒ Refreshed ❒Takes a while to get going ❒Tired

Do you feel sleepy during the day? ❒Yes ❒No If so, what times? _____

Do you experience sensations of: ❒ **Heat** ❒ **Cold**
If so, where: *Please indicate with an '**H**' (for heat) or a '**C**' (for Cold) in the appropriate space*

___ Hands ___ Low back ___ Chest
___ Feet ___ Groin ___ Other _____
___ Head ___ Buttocks
___ Abdomen ___ Knees

Do you experience any **pain**? ❒Yes ❒No If so, where? _____
Is the pain: ❒ Dull ❒ Sharp ❒Throbbing ❒ Constant
Does it: ❒ Improve with heat ❒ Improve with cold
❒ Improve with pressure ❒ Get worse with pressure

Diet and Fluids

What type of drink do you prefer: ❒ Hot ❒ Cold ❒ No preference
Are you thirsty a lot? ❒ Yes ❒No
What type of food do you prefer: ❒ Hot/warm, cooked meals ❒ Cold/raw meals ❒ No preference
Special diet: ❒ Vegetarian ❒ Vegan ❒ Diabetic ❒ Other: _____

HABITUAL CONSUMPTION:

❒ Coffee (# cups a day ___)
❒ Diet soda (# cups a day)
❒ Regular soda (# cups a day _____)
❒ Alcohol (# drinks a day _____)
❒ Cigarettes (# packs a day _____)

SLEEP

How many hours a night do you sleep? _____
Do you experience any of the following:

❒ Difficulty falling asleep
❒ Waking up frequently through night
If yes, what time do you wake: _____
Are you able to get back to sleep: _____
❒ Excessive sleeping
❒ Dream disturbed sleep
❒ Dreams that seem meaningful
❒ Nightmares
❒ Sleep talking
❒ Sleep walking

LU/LI

Indicate if you have any of the following:

❒ Shortness of Breath
❒ Asthma
❒ Difficulty exhaling
❒ Cough with sputum (color _____)
❒ Dry cough
❒ Dry or itchy throat
❒Dry Mouth
❒ Nasal discharge _____
❒ Poor sense of smell
❒ Sinus problems
❒ Rashes
❒ Allergies
❒ Catch colds easily
❒ Sweating in day
❒ Night sweats
❒ Fatigue

SP/ST

❒ Poor appetite
❒ Excessive appetite
❒ Loss of sense of taste
❒ Craving sugar
❒ Indigestion/belching
❒Abdominal distention/bloating
❒Excessive thirst
❒ Thirst but no desire to drink
❒ Weight gain/loss
❒Frequent gas
❒ Bad breath
❒ Nausea/Vomiting
❒ Cold arms/legs
❒ Hemorrhoids
❒ Diarrhea
❒ Gastric ulcers
❒ Difficulty concentrating
❒ Lethargic
❒ Feeling of heaviness
❒ Muscles often tired
❒ Bruising or bleeding easily
❒ Edema

Bowel Elimination

How often do you have a bowel movement? _____

Check any of the following that apply to you:

❒ Constipation
❒ Diarrhea
❒ Blood in stools
❒ Pale stools
❒ Dry stools or small pebble-like stools
❒ Loose/soft stools
❒ Loose stools alternating with small, dry stools
❒ Mucous in stools
❒ Undigested food in stools
❒ Other: _____

HT/SI

❒ Heart Palpitations
❒ Chest pain
❒ Blood pressure low
❒ Blood pressure low
❒ Chest pain
❒ Dizziness
❒ Insomnia
❒ Difficulty falling asleep
❒ Bitter taste in morning
❒ Vivid dreams
❒dream disturbed sleep
❒ Waking frequently in night
❒ Easily startled.
❒ Fainting
❒ Long term memory problems
❒ Anxiety/nervousness

KI/UB

❒ Difficulty inhaling
❒ Poor short term memory
❒ Kidney stones
❒ Feel cold easily
❒ Weak teeth or bones
❒ Hearing problems
❒ Tinnitus (ringing in ears)
❒ Earaches/ infections
❒ Hair loss
❒ Hair graying
❒ Low back pain
❒ Weak or cold knees
❒ Fertility issues
❒ Fearful

Urination:

❒ Urgent ❒ Painful ❒ Difficult ❒Frequent ❒ Excessive ❒ Incontinent
❒ Clear ❒ Yellow ❒ Cloudy ❒ Dark ❒ Scant ❒ Large amounts

Hx of: ❒ Kidney stones ❒ Urinary tract infections

Libido (sex drive): ❒ Normal ❒ High ❒ Low

LV/GB

❒ Rib pain
❒ Headache / migraine
❒ Vomiting
❒ Poor eyesight
❒ Eyes sensitive to light
❒ Other eye problems (Dry, itchy, sore, blurred)
❒ Muscular cramps / spasms
❒ High blood pressure
❒ Neck stiffness / pain
❒ Shoulder stiffness / pain
❒ Dry skin / hair
❒ Dizziness / vertigo
❒ Brittle / ridged nails
❒ Tinnitus, high pitched
❒ Deafness
❒ Depression
❒ Procrastination / indecision
❒ Irritation / Anger / Frustration
❒ Feeling “wound up”

Allergies to fragrances or "scent sensitive"? ❒ Yes ❒ No If yes, indicate sensitivities _____

_____

Women Only

Are you pregnant or trying to become pregnant? ❒ Yes ❒ No
Date of last period _____ Length of cycle: _____ Birth control method: _____

Number of Pregnancies: _____ Number of miscarriages: _____
Number of live births: _____ Number of abortions: _____

Is your period usually: ❒Early ❒ Late ❒ Regular ❒Alternating ❒Painful
Color of flow: ❒ Red ❒ Dark red ❒ Bright red ❒ Pale or thin ❒ Dark with clots ❒ Brown
Amount of flow: ❒ Heavy ❒ Light ❒ Scanty ❒ Normal Do you spot? ❒ Yes ❒ No When?_____
Leucorrhea (excess vaginal discharge): ❒ White ❒ Yellow ❒ Clear

PMS Symptoms:

❒ Cravings
❒ Depresson
❒ Crying
❒ Fluid retention
❒ Breast tenderness/swelling
❒ Anxiety
❒ Bloating
❒ Weight gain
❒ Headaches
❒ Cramping
❒ Dizziness
❒ Irritability
❒ Forgetfulness
❒ Fatigue

Other gynaecological or sexual issues: _____

_____

_____

Men Only

❒ Impotence (difficulty attaining/maintaining erection)
❒ Low libido
❒ Premature ejaculation
❒ Seminal emission
❒ Sterility
❒ Testicular swelling / pain
❒Involuntary night emissions (wet dreams)

Other sexual issues: _____

_____

_____

Anything else?

_____ _____

Signature of client or legal representative *Date*