INTEGRATE EASTERN MEDICINE

Patient Initial Intake form Date:

Last name: First: Middle:

Height Weight: Temperature:
BP: / Pulse:

CHIEF COMPLAINTS

_____

_____

_____

WESTERN PHYSICAL EXAM & TEST:
MEDICATIONS:

PAST & PRESENT MEDICAL HISTORY (Mark PA for past or PR for present condition)

___ Cancer ___ Diabetes ___Hepatitis ___ Hypertension
___ Stroke ___ Heart disease ___ Seizures ___ Thyroid disease
___ Arthritis ___ Rheumatic fever ___Pneumonia ___ Bronchitis ___ Asthma
Others: _____

Surgeries: _____

Trauma (auto accident, fall or other trauma): _____

Allergies (drug, chemical, food or other): _____

FAMILY MEDICAL HISTORY

___ Cancer ___ Diabetes ___Hepatitis ___ Hypertension
___ Stroke ___ Heart disease ___ Seizures ___ Thyroid disease
___ Arthritis ___ Rheumatic fever

Others:

PRESENT SIGNS & SYMPTOMS

<u>HEART</u>

___ High blood pressure ___ Chest pain ___ Excessive dreams ___ Palpitation
___ Low blood pressure ___ Night sweating ___ Cold hands/feet ___ Insomnia
___ Dizziness ___ Easily wakes up ___ Poor memory ___ Oversleeping
___ Irregular heartbeat ___ Swollen hands/feet

Sleep quality:

Other:

<u>LUNG</u>

___ Cough ___ Coughing blood ___ Coughing phlegm
___ Skin problem ___ Shortness of breath ___ Difficulty breathing
___ Sinus problem ___ Hoarse voice
___ Sore throat ___ Spontaneous sweating
___ Easily catch colds

Other:

SPLEEN & STOMACH

___ Stomach pain ___ Gas/bloating ___ Heartburn ___ Acid reflux
___ Nausea ___ Vomiting ___ Indigestion ___ Belching
___ Foul breath ___ Prolapse ___ Bruise easily ___ Fatigue
___ Constipation ___ Hemorrhoids ___ Loose stool ___ Diarrhea
___ Cramps/abdominal pain ___ Abdominal distention
Appetite: Digestion: Bowel movement:
Other:

LIVER

___ Easily upset/angry ___ Headache ___ Easily sigh ___ Dizziness
___ Bitter taste ___ Facial redness ___ Hair loss ___ Brittle nails
___ Twitching/Muscle spasms/ Numbness ___ Pain in ribs ___ Eye/vision problem
Other:

KIDNEY

___ Ringing ear ___ Urinary problem ___ Back pain ___ Knee pain
___ Difficulty hearing ___ Easily frightened ___ Joint pain ___ Sexual dysfunction
___ Edema (water retention)
Quality & Quantity of urine:
Other:

OBGYN

Menstrual cycle (circle): Regular Irregular (early/late) Painful periods Painful breasts
Low back pain Abdominal pain

Amount (circle) : Heavy Normal Scanty With clots
Color (circle): Dark red Bright red Light red/ Pink

When did menstruation begin _____ / end _____?

Vaginal discharge between periods: Yes/No Color: Amount: Odor:

History of pregnancy/Number of pregnancies: _____

_____ Births _____ Miscarriages _____ Abortions _____ C-sections

Are you currently pregnant? Yes/No/ Don't know How many weeks/months are you pregnant?

TONGUE:
PULSE:
FACIAL COLOR

DIAGNOSIS **ICD.10.CM**

DIFFERENTIATION

TREATMENT PLAN

TREATMENT MODALITY: Acupuncture / Cupping / Exercise / Herbs / Auricular acupuncture/ Other

ACUPUNCTURE points:

PRACTITIONER
Name: **Signature:** **Date:**