

LOUISVILLE CLINIC OF TRADITIONAL CHINESE MEDICINE

317 W South Boulder Road, Suite 5, Louisville, Colorado 80027 • Tel: 303.604.0919

Welcome to the Louisville Clinic of Traditional Chinese Medicine. To help us provide you with the best possible care, please complete this form. If you need more space, feel free to write on the back. This information will be kept in strict confidentiality.

Your Name:	Date of Birth:	/	/	Age:
<input type="checkbox"/> Male <input type="checkbox"/> Female	MM/DD/YY			
Social Security Number:				
Street Address:				
City:	State:	Zip:		
Phone (day):	Phone (evening):			
Phone (cell):	Occupation:			
In case of emergency, contact:				
Name:				Relationship:
Phone:				
Street Address:	City:	State:	Zip:	
How did you hear about us?				
Please describe your reason for today's visit:				
Have you ever had this difficulty or a similar one before? <input type="checkbox"/> Yes <input type="checkbox"/> No — If yes, please explain:				
Is it getting <input type="checkbox"/> better <input type="checkbox"/> worse or <input type="checkbox"/> staying about the same?				
What seems to make it feel better?				
What seems to make it feel worse?				
Are you being treated elsewhere? <input type="checkbox"/> Yes <input type="checkbox"/> No				
By whom?				
What was the diagnosis?				
What were the results of treatment?				

Please continue on the next page

Are you currently taking prescription or patent medicines, herbal remedies or dietary supplements?

Yes No — If so, which ones?

Please check all of the boxes that are now or have been part of your health history.

- | | | |
|-------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Addiction (drugs or alcohol) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio |
| <input type="checkbox"/> AIDS/ARC | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gout | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Surgery (list) _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | _____ |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> HIV positive | _____ |
| <input type="checkbox"/> Blood Pressure (low) | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Blood Pressure (high) | <input type="checkbox"/> Injuries | <input type="checkbox"/> Trauma (falls, accidents) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Intestinal Parasites | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Multiple Sclerosis | _____ |
| <input type="checkbox"/> Emotional Difficulties | <input type="checkbox"/> Mumps | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pacemaker | |

Family Medical History

- | | | |
|----------------------------------------------------|-------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Allergies (list)
_____ | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| _____ | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |

Please describe the foods you eat in a typical day:

Breakfast:

Lunch:

Dinner:

Snacks:

Which of the following is/are part of your lifestyle?

- | | | |
|-------------------------------------------|----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Tobacco Smoking | <input type="checkbox"/> Recreational Drugs | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Coffee Drinking | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Relaxation/Meditation |
| <input type="checkbox"/> Alcohol Drinking | <input type="checkbox"/> Special Diet | <input type="checkbox"/> Vitamins/Supplements |

How would you describe the state of your immune system?

- Excellent Good Fair Poor

Are you under any unusual stress right now? Yes No — **If yes, please describe:**

Please continue on the next page

Symptom Review

Please put one check mark by a symptom you sometimes experience; use two checks for those which often occur, and three checks for symptoms that are a major concern.

Head and Face

- Headaches
- Dizziness
- Memory loss
- Other

Eyes

- Blurred vision
- Eyelid problem
- Pain
- Other

Ears

- Hearing difficulty
- Earaches
- Discharge
- Ringing
- Other

Nose

- Frequent colds
- Sinus trouble
- Bleeding
- Other

Mouth

- Dental problems
- Gum problems
- Tongue problems
- Lip problems
- Jaw problems
- Unusual tastes
- Other

Throat

- Sore throat
- Hoarseness
- Difficulty swallowing
- Other

Respiration

- Difficulty inhaling
- Difficulty exhaling
- Pain
- Cough
- Congestion
- Other

Heart and Chest

- Palpitations
- High blood pressure
- Tightness in chest
- Low blood pressure
- Difficulty lying flat
- Other

Circulation

- Bruise easily
- Bleed easily
- Cold limbs
- Other

Gastrointestinal

- Excessive thirst
- Never thirsty
- Excessive appetite
- Poor appetite
- Digestive pain
- Nausea
- Diarrhea
- Constipation
- Rectal bleeding
- Colon problems
- Other

Urination

- Frequent
- Difficult
- Painful
- Nighttime
- Bleeding
- Other

Skin

- Rashes
- Dryness
- Moles or lumps that change
- Excessive sweating
- Night sweating
- Rarely sweat
- Other

Neurological

- Nervousness
- Tremors

- Convulsions
- Numbness or tingling
- Lack of coordination
- Nerve pain
- Other

Sleep

- Insomnia
- Drowsiness
- Excessive dreaming
- Other

Energy Level

- Low
- High
- Other

Pain (please describe below)

Other Comments:

Please continue on the next page

Women Only

Are you or might you be pregnant? Yes No Maybe. If yes, what month? _____

What method of birth control do you use? _____

Do you have regular PAP tests? Yes No. How often? _____

Are you experiencing unusually low or high sexual desire? Other difficulties? _____

Age at first menstruation: _____ Age at menopause: _____

Date of first day of last menstrual cycle: _____

Number of days of last menstruation: _____

Usual length of cycle (from first day of bleeding until day before next bleeding): _____

Are your periods:

Irregular: Short Long Variable

Painful: Before After During

Relieved by: : Heat Cold Pressure

Heavy bleeding

Light bleeding

Dark blood: Red Purple Brown

Do you have any pre-menstrual symptoms?

Painful or swollen breasts

Irritability

Depression

Crying

Food cravings: _____

Vaginal Discharge:

Normal

Watery

Thick

Yellow

Clear or white

Gynecological surgeries or diseases: (please describe)

Ovaries: _____

Uterus: _____

Fallopian Tubes: _____

Pregnancies

Total number: _____

Number of children: _____

Number of abortions or miscarriages: _____

Light blood

Thick blood

Watery blood

Heavy clotting

Stop and start again

Spotting: Before After Mid-cycle

Nausea

Cramps or pain

Other: _____

Bad odor

Itching

Dryness

Other: _____

Vagina: _____

Breasts: _____

Other: _____

Complications: _____

How long ago was your last pregnancy? _____

Men Only

Do you experience:

Reduced libido

Excessive libido

Premature ejaculation

Seminal emission (spontaneous ejaculation without sexual stimulation)

Urinary frequency

Impotence

Genital discharge

Pain associated with genitals

Other: _____

Thank you for taking the time to complete this form.