New Patient

Today's Date:

First Name:

Last Name:

Date of Birth:

Address:

Cell Phone: Work Phone:

Email:

Emergency contact name:
Phone number:

Regular Physician:

Today's Visit

List of prescription medications:

List of supplements:

List all allergies:

Do you use/consume the following:

- ☐ Tobacco: How often:
- ☐ Alcohol: How often:
- ☐ Marijuana: How often:
- ☐ Other drugs: How often:

Chief Complaint

Reason's for today's visit:

Since when:

Main symptoms:

Health Care Providers

List of all health care providers (name & phone number):

History

List all surgeries with dates:

Do any of the following apply to you:

- ☐ Haemophiliac
- ☐ Serious heart or lung condition
- ☐ Wear a pacemaker
- ☐ Epilepsy
- ☐ Taking anticoagulant medications
- ☐ Contagious illness
- ☐ Cancer

List any disorder you've had in the past:

Heart System

- do you take a long time to fall asleep
- do you toss & turn all night
- do you wake up between 1 & 3 am
- recurring dreams or nightmares
- night sweats – hot at night
- do you sweat when anxious
- palpitations – chest tightness

Lung System

- Shortness of breath
- breathing difficulties, asthma
- environmental allergies
- do you catch colds & flu easily
  - does it take a long time to recover
- any cough, dry or phlegmy
- sinus issues, post nasal drip
- sleep apnea

Brain Health

Stress level: 1-2-3-4-5-6-7-8-9-10

Anxiety level: 1-2-3-4-5-6-7-8-9-10

- poor short term memory
- poor long term memory
- can't retain information
- poor focus, poor concentration
- worry – overthink – oversensitive
- irritable – frustrated – angry
- feeling stuck
- depressed – sad – feelling blue
- can't make decisions
- self doubt – low self esteem
- envious – jealous of others
- difficulty in letting go

Vision & Hearing

- tinnitus high pitch – comes & goes
- tinnitus low pitch – constant
- ear pain
- ear feeling stuffy
- blurred vision
- floaters – spots
- poor night vision
- dry eyes
- tearing when windy or crusty eyes
- eye twitch
- dizziness

Female Health

menarche age:_____
today is cycle day____
cycle length _____
period lasts ___to___days
blood colour _____
flow is light - medium - heavy - flooding

- ☐ clots: small - medium - large
- ☐ cramps: mild - stabbing
- ☐ PMS: tender breasts - bloating - craving - fatigue - low back pain
- ☐ ovulation pain
- ☐ intercourse pain
- ☐ abnormal vaginal discharge

Kidneys/Bladder

- ☐ dark scanty urination
- ☐ dribbling urination
- ☐ strong smelling urine
- ☐ frequent urgent urination
- ☐ painful urination - burning
- ☐ bladder incontinence
- ☐ getting up at night to urinate

- ☐ premature grey hair
- ☐ hair loss
- ☐ wore braces as a child
- ☐ history of broken bone(s)
- ☐ low bone density
- ☐ edema of the lower legs

Fertility

- ☐ birth control
- ☐ seeing a reproductive endocrinologist
- ☐ trying to conceive since _____
- ☐ day 3 - day 21 blood test:

blood test results: _____
fertility diagnosis: _____

- ☐ IUI - with drugs
- ☐ IVF

- ☐ menopause began at ____ years old
- ☐ night sweats - hot flushes
- ☐ vaginal dryness

Male Health

- ☐ low libido
- ☐ seminal emission
- ☐ premature ejaculation
- ☐ erectile disfunction
- ☐ prostate hyperplasia
- ☐ prostatitis
- ☐ low sperm count - motility
- ☐ low sperm morphology

- ☐ pregnant

how many weeks ____
due date _____

- ☐ children
- ☐ c-section

Spleen System

Energy level: 1-2-3-4-5-6-7-8-9-10

- [ ] mental fatigue
- [ ] difficulty in getting out of bed in am
- [ ] not hungry for breakfast
- [ ] poor appetite
- [ ] bloating after meals
- [ ] cravings: sweet - salty - greasy food
- [ ] food sensitivities

Diet:

Stomach System

- [ ] canker sores: mouth - tongue
- [ ] bad breath - bleeding gums
- [ ] acid reflux - hearthburn
- [ ] thirst for cold drinks
- [ ] dry mouth
- [ ] constant hunger
- [ ] nausea - vomiting
- [ ] difficulty in digesting fats

Skin Health

- [ ] history of skin issues
- [ ] acne

acne location: _____

- [ ] eczema

eczema location: _____

- [ ] psoriasis
- [ ] greasy skin
- [ ] dry skin
- [ ] rashes

Large Intestine

- [ ] constipation
- [ ] straining while having a BM
- [ ] gas - unfinished feeling after BM
- [ ] loose stools
- [ ] diarrhea
- [ ] smelly diarrhea - blood in stools
- [ ] urgent painful diarrhea
- [ ] alternating diarrhea & constipation
- [ ] hard, small, dry pebble-like stools
- [ ] sticky stools
- [ ] undigested food in the stool

Headaches

- [ ] frontal and orbital
- [ ] temporal
- [ ] occipital
- [ ] vertex
- [ ] whole head
- [ ] better with heat
- [ ] better with cold
- [ ] better with rest
- [ ] better with exercise
- [ ] mild – stabbing – moving pain
- [ ] migraine

Temperature

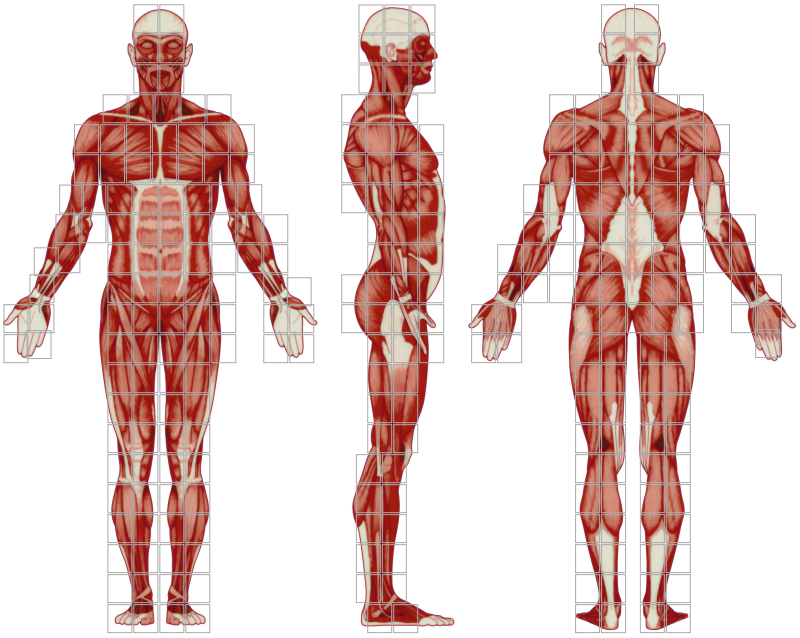
- [ ] cold hands
- [ ] hot palms
- [ ] cold feet
- [ ] hot soles
- [ ] cold body
- [ ] runs hot
- [ ] cold nose
- [ ] hot at night
- [ ] loves summer
- [ ] loves winter
- [ ] loves warm foods
- [ ] loves salads
- [ ] alternate between cold & hot, doesn't like extreme temperature changes

Muskuloskeletal

Pain level: 1-2-3-4-5-6-7-8-9-10

- [ ] constant pain
- [ ] comes and goes
- [ ] stiffness
- [ ] swollen
- [ ] local pain
- [ ] travelling pain
- [ ] poor range of motion
- [ ] better with heat
- [ ] better with cold
- [ ] better with rest
- [ ] better with exercise
- [ ] better with massage

Pain location



Observation

constitution: great - average - weak

body type:

face mapping:

hair

eyes

lips

nose

nails

palm

Tongue:

body colour

coating

moisture

shape

Palpation

Pulse

front right:

front left:

middle right:

middle left:

rear right:

rear left:

skin temperature:

4 limbs:

tender areas:

tender points:

Diagnosis

causes

5 elements

pattern 1

pattern 2

pattern 3

Treatment

acupuncture points:

ear points:

e-stim:

cupping:

gua sha:

tui na:

herbal formula:

dosage:

diet:

Treatment Plan

Treatment principles

Recommendations

Long term plan