Qihuang Medical Group Corp.
16573 Los Gatos Almaden Rd., Los Gatos, CA 95032

Patient Intake Form

Patient Name:_____Age:_____Date of Birth:___/___/___

Main problem(s): You would like treated_____

When did this problem begin?_____

What are the possible causes of current issue(s)?_____

Have you been given a diagnosis for this problem? If so, what?_____

To what extent does this problem interfere with your daily activities (work, sleep, etc.)?

_____

What kind of treatment(s) have you tried?_____

What makes this problem worse?_____

What makes it better?_____

Is there anybody in your family with the same/similar problem?_____

Recent Medical Tests or Procedures (please indicate test results and dates below)

□ Physical □ Cholesterol □ Prostate Exam □ Blood Test

□ HIV/STD □ Pap Smear □ Mammogram □ Other

Test Results and Date:_____

Past Medical History: (Please include month/year when the diagnose was established)

Significant illness: □ Cancer □ Diabetes □ Hepatitis □ Thyroid Dz □ Seizures

□ Fibromyalgia □ Arthritis □ TB □ Anemia □ Hypertension

□ Breathing Problems □ Heart Dz □ Digestive Disorder □ HIV/AIDS Positive

□ Veneral Dz □ Other (please specify):_____

Surgeries_____ Hospitalization_____

Significant trauma_____

Allergies_____

Family Medical History (Please specify family member)

□ Hypertension □ Heart Dz □ Stroke □ Asthma □ Alcoholism □ Cancer

□ Miscarriage □ Diabetes □ Other

Medicines: Taken within the last two months (Including vitamins, over the counter drugs, herbs, etc.)

_____

_____

Occupation

Do you usually work □ indoors □ outdoors ?

Any occupational stress (chemical, physical, psychological, etc.)_____

Personal

Height_____ Weight now_____ one year ago_____ Weight maximum at year_____

Habits

Do you smoke? Y/N What?_____ How many per day?_____ Since when?_____

If you are a smoker, do you want to quit? Y/N [Level of determination to quit- 1 2 3 4 5 6 7 8 9 10]

Please describe any use of drugs for non-medical purposes_____

Do you exercise regularly? Y/N Please describe your exercise program_____

How many hours do you sleep in general?_____When do you usually go to bed?_____

Diet

How much coffee do you drink?_____cups/day; Colas_____#/day; Tea_____cups/day_____

What kind of alcoholic beverages do you usually drink?_____ Average # of drinks/week_____

How much water do you drink per day?_____cups/day

Are you a vegetarian? □ Yes □ No □ Yes, but not so strict Do you eat a lot of spicy food? Y/N

Remarks and additional information (e.g. diet)_____

Please describe your average daily diet (Please be as specific as possible):

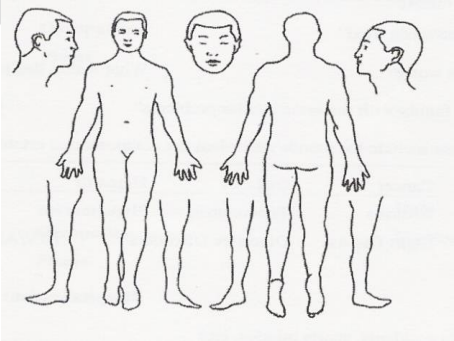
Morning_____

Afternoon_____

Evening_____

Snacks_____

Indicate painful or distressed area:



Rate: No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General

□ Poor appetite □ Poor sleeping □ Fatigue □ Fevers □ Chills
□ Night sweats □Sweat easily □Tremors □ Cravings □ Change in appetite
□ Poor balance □ Bleed or bruise easily □ Localized weakness □ Weightloss □ Weight gain
□ Peculiar tastes □ Desire for spicy food □ Desire cold foods □ Strong thirst (cold or hot drinks)
□ Sudden energy drop (what time of day)_____

Favorite time of year_____ Worst time of year_____

Skin & Hair

□ Rashes □ Ulceration □ Hives □ Itching □ Eczema □ Pimples □ Dandruff
□ Dry skin □ Recent Moles □ Loss of Hair □ Change of hair or skin textures □ Other:

Musculoskeletal

□ Joint disorders □ Muscle weakness □ Pain/soreness in the muscles □ Tremors
□ Difficulty walking □ Cold hands/feet □ Swelling of hands/feet □ Back pain
□ Spinal curvature □ Hernia □ Numbness □ Tingling
□ Paralysis □ Neck tightness □ Neck pain □ Shoulder pain
□ Hand/wrist pain □ Hip pain □ Knee pain □ Sprain of joint
□ Other:

Head, Eyes, Ears, Nose and Throat

□ Dizziness □ Concussions □ Migraines
□ Glasses/lens □ Eye strain □ Eye pain □ Color blindness □ Night blindness
□ Poor vision □ Cataracts □ Blurry vision □ Spots in front of eyes
□ Earaches □ Ringing in ears □ Poor hearing □ Sinus problems □ Nose bleeding
□ Sore throat □ Grinding teeth □ Teeth problems □ Sores on lips/tongue □ Facial pains
□ Jaw clicks □ Difficulty swallowing □ Other:

Cardiovascular

□ High blood pressure □ Low blood pressure □ Chest pain □ Palpitation □ Fainting
□ Rapid heartbeat □ Irregular heartbeat □ Phlebitis □ Varicose veins □ Other:

Respiratory/LU

□ Persistent cough □ Coughing blood □ Wheezing □ Difficulty breathing □ Bronchitis
□ Nosebleeds □ Sinus congestion □ Sore throat □ Chronic allergies □ Asthma
□ Dry skin □ Hives □ Eczema □ Grief □ Emphysema
□ Pneumonia □ Chest pain □ Production of phlegm – What color?_____

Allergies to: □ Mold □ Cedar □ Dust □ Pet Fur □ Oak □ Hay Fever □ Grass □ Environmentally sensitive

Gastrointestinal/SP-ST

□ Bloating □ Cravings □ Acid Reflux □ Fatigue after meals

□ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas □ Belching

□ Indigestion □ Black stools □ Blood in stools □ Bad breath □ Rectal pain □ Hemorrhoids

□ Abdominal pain/cramps □ Gallbladder problems □ Parasites □ Chronic laxative use

Bowel movements: Frequency_____ Color_____ Odor_____ Texture/form_____

Accumulated Damp

□ Foggy mind □ Swollen hands/feet □ Edema in the legs □ Edema in the abdomen

□ Joint stiffiness/ache □ Symptoms worsen in rainy weather

□ Heaviness of the head, the limbs, or of the whole body

Neuro-psychological

□ Loss of balance □ Lack of coordination □ Concussion □ Depression □ Anxiety □ Stress

□ Bad temper □ Bi-polar

Genito-urinary

□ Pain on urination □ Frequent urination □ Blood in urine □ Urgent to urinate □ Kidney stones

□ Unable to hold urine □ Dribbling □ Pause of flow □ Frequent urinary tract infection

□ Pain in genitals □ Itching of genitals □ Strong odor □ Other:

Female

□ Frequent vaginal infections □ Pelvic infection □ Endometriosis □ Fibroids □ Clots

□ Vaginal/genital discharge □ Ovarian cysts □ Breast tenderness □ Breast lumps

□ Irregular periods □ Pain/cramps prior/during periods □ Hot flashes

□ Moodiness related to periods □ Fertility problems ___# of pregnancies ___# of births ___Miscarriages ___Abortions ___Premature births ___Cesareans ___Difficult delivery

First day of last period_____ Age of first menses___ Duration of periods _____days, cycle_____days

Do you practice birth control? Y/N. If yes, what type and for how long?_____

If you are on birth control pills, what are you taking and for how long?_____

Male

□ Prostate problems □ Discharge □ Impotence □ Frequent seminal emission

□ Fertility problems □ Ejaculation problems □ Painful/swollen testicles □ Other

Both □ Normal □ High sex drive □ Diminished sex drive □ Infertility □ Fatigue following sex

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I understand the above information and guarantee this form was completed correctly to the best of my knowledge.

Signature: _____ □ Adult Patient □ Parent or Guardian □ Spouse