Fitzroy Chinese Medicine Clinic

Confidential New Patient Intake Form - please list as much detail as possible

Personal Details

Name: _____ Age: _____ Date of Birth: ____/____/____ Gender: ▫ M ▫ F

Address:_____ Postcode:_____

Phone: _____ Email: _____

Health Fund: _____ Occupation: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Medical doctor (if applicable): _____Phone: _____

How did you hear about us? _____ ▫ ***Tick to not be signed up for email newsletter***

Presenting Health Condition/s:

How would you describe your state of health at present: ▫ Excellent ▫ Good ▫ Fair ▫ Not doing so well

What is your main health concern for seeking Chinese Medicine / Massage today, and how long has it been occurring?

_____

_____

Medical History

Please list your medical history: including current conditions, surgeries, injuries, hospitalisations

Condition	Date/duration	Symptoms	Is it Resolved?

Current Medications / Supplements/ Vitamins:

Medication / Supplement	Dose	Length of use	Prescribed by whom

Allergies / Food Sensitivities:

Allergy / Sensitivity	Symptoms	Treatment / Avoidance

Diet and Digestion

How is your appetite generally? _____ How many meals do you eat per day? _____

After eating do you experience: ▫ Bloating ▫ Nausea ▫ Pain ▫ Vomiting ▫ Excessive gas/gurgling ▫ Reflux ▫ Belching

Do you eat dairy? ▫ Y ▫ N Do you eat red meat? ▫ Y ▫ N Do you eat seafood? ▫ Y ▫ N

How often are your bowel movements per day? _____ and what times? _____

Do you suffer from? ▫ Constipation ▫ Diarrhoea ▫ Alternating Diarrhoea/ Constipation ▫ Loose stools ▫ Mucus ▫ Bleeding ▫ Straining ▫ Flatulence with no odour ▫ Foul smelling flatulence ▫ Haemorrhoids

Urination

How many times per day do you urinate? _____ Do you find it difficult? ▫ Y ▫ N Any pain? ▫ Y ▫ N

Are you waking at night to urinate? ▫ Y ▫ N what times? _____

Is it: ▫ Clear ▫ Light Yellow ▫ Dark Yellow ▫ Murky/ Cloudy ▫ Copious ▫ Scanty ▫ Strong smelling

Sleep

What time do you generally go to sleep? _____ Wake up? _____ How many hours? ___ Is it ▫ Easy ▫ Hard to go to sleep?

Is it ▫ Easy ▫ Hard to wake up? Are you easily woken? ▫ Y ▫ N Do you wake frequently? ▫ Y ▫ N What times? _____

Energy

Rate your energy: (cant move) 1 2 3 4 5 6 7 8 9 10 (feel great)

When do you feel most energetic? _____ When do you feel least energetic? _____

Breath, Chest, Head

Are you a smoker? ▫ Y ▫ N How many per day? _____ Do you ever have any of the following?

▫ Shortness of breath ▫ Asthma/wheezing ▫ Palpitations ▫ Chest tightness ▫ Chest pain

▫ Sinus Congestion ▫ Sinus Allergies ▫ Vertigo/Dizziness ▫ Phlegm

Temperature

Do you ever have any of the following? Circle which is appropriate.

▫ Cold Hands / Feet ▫ Hot Hands / Feet ▫ Aversion to Heat / Cold ▫ Fever ▫ Chills

Hearing and Vision

Do you suffer from any of the following?

▫ Ear ache/infections ▫ Tinnitus High Pitch ▫ Tinnitus Dull Roar ▫ Popping ▫ Blurred Vision

▫ Night Blindness ▫ Dry Eyes ▫ Nystagmus ▫ Blepharitis ▫ Other

Musculoskeletal

Do you have any pain? ▫ Y ▫ N If so, where? Please describe the pain you're experiencing?

_____

_____

Emotions

Do you experience major mood changes? ▫ Y ▫ N Been diagnosed/treated for depression/anxiety? ▫ Y ▫ N When? _____

Men's Health

Have you ever experienced any of the following?

▫ STD ▫ Low libido ▫ Erectile dysfunction ▫ Hernia ▫ Low sperm count

▫ Prostate disorders ▫ Testicular pain / masses ▫ Premature Ejaculation ▫ Sores or Discharge ▫ Other _____

Women's Health

Age of onset? ____ How often do you menstruate? ____ How many days period lasts? ____ Consistency of period? ▫ Heavy ▫ Light ▫ Scanty ▫ Non existent Colour of flow? ▫ Dark Brown ▫ Purple ▫ Dark Red ▫ Pale Red ▫ Bright Red ▫ Clots

Have you experiences Menopause? ▫ No ▫ Pre ▫ Now ▫ Post Date started:_____ Date finished: _____

Do you suffer any of the following pre-menstrual symptoms?

▫ Breast Tenderness ▫ Water Retention ▫ Nausea ▫ Sadness/ Depression ▫ Irritability

▫ Acne ▫ Headaches ▫ Vomiting ▫ Pain / Cramping ▫ Anxiety

▫ Food Cravings ▫ Migraines ▫ Diarrhoea ▫ Temperature Change ▫ Constipation

Consent to treatment:

* I hereby acknowledge and state that all information outlined is true to this date and any information gathered for the purposes of Chinese medicine treatments and Remedial Massage will not be disclosed to any other parties without prior consent to do so from my behalf.
* I understand the slight risks in receiving acupuncture, remedial massage and herbal medicine and accept that the practitioner will in their duty of care, maintain safe and risk free sessions holding my safety and health as number one priority.
* My signature authorises the practitioner to treat myself (or patient I am responsible for) with agreed upon modalities of acupuncture, remedial massage and herbal medicine. I acknowledge the payment terms and conditions.

Patient Signature: ***Date:***