LOUISVILLE CLINIC OF TRADITIONAL CHINESE MEDICINE

225 W South Boulder Road, Suite 202, 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:
MM/DD/YY

❏ Male ❏ Female

Email Address:

❏ Check if you do *not* wish to receive our quarterly e-newsletter.

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? ❏ Yes ❏ No — If yes, please explain:

Is it getting ❏ better ❏ worse or ❏ staying about the same?

What seems to make it feel better?

What seems to make it feel worse?

Are you being treated elsewhere? ❏ Yes ❏ 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.

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

Family Medical History

❏ Alcoholism
❏ Allergies (list)
____
____
❏ Arteriosclerosis
❏ Asthma
❏ Cancer
❏ Diabetes
❏ Heart Disease
❏ High Blood Pressure
❏ Seizures
❏ 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?

❏ Tobacco Smoking
❏ Coffee Drinking
❏ Alcohol Drinking
❏ Recreational Drugs
❏ Birth Control Pills
❏ Special Diet
❏ Exercise
❏ Relaxation/Meditation
❏ 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)
____
____
____
____
____
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____
____
____
____
____

Other Comments:
____
____
____
____
____
____
____

Please continue on the next page

Women Only *(Men, please see your section at the bottom of the page)*

Are your 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
❑ Light blood
❑ Thick blood
❑ Watery blood
❑ Heavy clotting
❑ Stop and start again
❑ Spotting: ❑ Before ❑ After ❑ Mid-cycle

Do you have any pre-menstrual symptoms?

❑ Painful or swollen breasts
❑ Irritability
❑ Depression
❑ Crying
❑ Food cravings: ____________________
❑ Nausea
❑ Cramps or pain
❑ Other: ____________________
____

Vaginal Discharge:

❑ Normal
❑ Watery
❑ Thick
❑ Yellow
❑ Clear or white
❑ Bad odor
❑ Itching
❑ Dryness
❑ Other: ____________________

Gynecological surgeries or diseases: (please describe)

❑ Ovaries: ____________________
❑ Uterus: ____________________
❑ Fallopian Tubes: ____________________
❑ Vagina: ____________________
❑ Breasts: ____________________
❑ Other: ____________________

Pregnancies

Total number: ____________________
Number of children: ____________________
Number of abortions or miscarriages: __________
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.