+MIDDLE PATH CLINIC - 4/920 Heidelberg-Kinglake Road, Hurstbridge, Vic. 3099 Date: _ _ / _ _ _ _ _ _ / 20_ _

PATIENT INTAKE FORM *(confidential)*
Please read the following information carefully, and ask your practitioner if there is anything that you do not understand. **While acupuncture, Chinese medicine and the other treatments provided at this clinic have proven to be highly effective in correcting conditions and maintaining overall wellbeing, practitioners are required to advise patients that there may be some risks. You should be aware that the following side effects can occur.** • **Drowsiness can occur in a small number of patients (if drowsiness happens, we recommend that you do not drive);** • **Minor bleeding or bruising can occur from acupuncture;** • **Please advise your practitioner if symptoms worsen for more than 2 days;** • **Fainting can occur in certain patients, particularly at the first treatment;** • **In less than 3% of patients, symptoms may worsen for 1-2 days before improving;**
First Name _ _ _ _ _ _ _ _ _ _ _ _ _ _ Last Name _ Date of Birth: _ _ / _ _ / _ _ _ _ Age: _ _ years
Address _
Phone (Home) _ _ _ _ _ _ _ _ _ _ _ ; (Work) _ _ _ _ _ _ _ _ _ _ _; Mobile _ _ _ _ _ _ _ _ _ _ _
Occupation:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Emergency Contact: _ Phone _ _ _ _ _ _ _ _ _ _ _ Mobile _ _ _ _ _ _ _ _ _ _ _
Family Physician's Name:_ Phone:_ _ _ _ _ _ _ _ _ _ _
Physician's Diagnosis:_ _
Reason for today's Visit:_ _
Treatment Goals: **O** Relief of Present Symptoms **O** General Well Being **O** Long Term Health Care **O** Other _ _ _ _ _ _ _ _ _
MEDICAL HISTORY:
Please check the forms of therapy/treatment you have had in past:
O Massage **O** Acupuncture **O** Cupping **O** Moxibustion **O** Herbal Medicine **O** Physio **O** Yoga **O** Naturopath **O** Chiropractor **O** Osteopath **O** None **O** Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Please check the forms of therapy/treatment you are currently having:
O Massage **O** Acupuncture **O** Cupping **O** Moxibustion **O** Herbal Medicine **O** Physio **O** Yoga **O** Naturopath **O** Chiropractor **O** Osteopath **O** None **O** Other _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Please check if you currently have or ever had any of the following:
O Aids **O** Alcoholism **O** Anaemic **O** Arthritis **O** Asthma **O** Cancer **O** DVT **O** Diabetes **O** Digestive Disorder **O** Drug Addiction **O** Epilepsy **O** Fibromyalgia **O** Gall Stones **O** HIV **O** Heart Condition **O** Haemophilia Hepatitis **O** High/Low Blood Pressure **O** Jaw Pain **O** Kidney Disease/Stones **O** Stroke **O** Liver Conditions **O** Migraine/Headaches **O** Multiple Sclerosis **O** Osteoporosis **O** Pacemaker **O** Respiratory Condition **O** Rheumatic Fever **O** Sinus **O** Skin Disorder **O** Spinal Injury/Sprain/ Fracture **O** Thyroid **O** Tuberculosis **O** Ulcers **O** Ulcerative Colitis **O** Shortness of Breath **O** Night Sweats **O** Other _

Please check if you have or ever had any of the impairment/disorder:
O Allergy _ **O** Emotional Disorder _
O Mental Illness _ **O** Impairment/Disability _

If you are currently taking any medication, please write here: _

If you have had any surgical procedures, please provide details including date/s _

Any other information that you would like to provide including relevant family history _

Lifestyle:

Please describe your diet _

Please describe your physical exercise regime _

Stress Level: Low 1 2 3 4 5 6 7 8 9 10 High

Sleeping Pattern: Light / Disturb / Sound; Average Hours: _ _
Do you get up more than once to urinate? Yes / No; How many times? _ _

Do you work? Yes / No	Hours per week: _ _ _	Do you enjoy your work? Yes / No

Hobbies: _

Please provide following information:

Have you ever been a smoker?	Yes / No	How long? _ _ _ _ _ _ _ _ _
Are you a smoker?	Yes / No	Daily Qty _ _ _ _ _ _ _ _ _
Do you drink coffee?	Yes / No	Daily Qty _ _ _ _ _ _ _ _ _
Do you take tobacco?	Yes / No	Daily Qty _ _ _ _ _ _ _ _ _
Do you consume alcohol?	Yes / No	Daily Qty _ _ _ _ _ _ _ _ _
Do you drink water?	Yes / No	Daily Qty _ _ _ _ _ _ _ _ _
Do you take recreational drug?	Yes / No	Daily Qty _ _ _ _ _ _ ____
Do you drink soft drink (coke, sprite, etc.)?	Yes / No	Daily Qty _ _ _ _ _ _ _ _ _
Do you drink iced water?	Yes / No	Daily Qty _ _ _ _ _ _ _ _ _

Symptom Survey (please check all that apply):

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0 1 2 3 4 ravenous appetite 0 1 2 3 4 loose stools 0 1 2 3 4 heartburn/acid reflux 0 1 2 3 4 gas/abdominal bloating 0 1 2 3 4 mouth sores	0 1 2 3 4 fatigue after eating 0 1 2 3 4 belching or vomiting 0 1 2 3 4 haemorrhoids 0 1 2 3 4 gums bleeding/swollen	0 1 2 3 4 bruise easily 0 1 2 3 4 thirst Hot? Cold? 0 1 2 3 4 anaemia 0 1 2 3 4 bad breath
0 1 2 3 4 shortness of breath 0 1 2 3 4 fatigue 0 1 2 3 4 cough 0 1 2 3 4 catch colds easily	0 1 2 3 4 abnormal sweating 0 1 2 3 4 tired after little exertion 0 1 2 3 4 allergies 0 1 2 3 4 gener2al weakness	0 1 2 3 4 asthma 0 1 2 3 4 nasal discharge 0 1 2 3 4 sinus congestion 0 1 2 3 4 dry mouth/nose/throat
0 1 2 3 4 sore, cold or weak knees 0 1 2 3 4 feels cold easily 0 1 2 3 4 low back pain 0 1 2 3 4 swollen ankles	0 1 2 3 4 frequent urination 0 1 2 3 4 poor memory 0 1 2 3 4 urinary incontinence 0 1 2 3 4 hair loss	0 1 2 3 4 ear/hearing problems 0 1 2 3 4 infertility

0 1 2 3 4 irritable 0 1 2 3 4 Ligament/tendon issues 0 1 2 3 4 tight feeling in chests	0 1 2 3 4 diarrhoea / constipation 0 1 2 3 4 sigh frequently	0 1 2 3 4 neck shoulder tension 0 1 2 3 4 muscle spasms/twitches
0 1 2 3 4 numb extremities 0 1 2 3 4 ears ringing	0 1 2 3 4 anger easily 0 1 2 3 4 Red eyes	0 1 2 3 4 dry, irritated eyes 0 1 2 3 4 vivid dreams
0 1 2 3 4 feel heart beating 0 1 2 3 4 chest pain 0 1 2 3 4 insomnia 0 1 2 3 4 disturbing dreams	0 1 2 3 4 sores on tip of tongue 0 1 2 3 4 restlessness	0 1 2 3 4 anxiety 0 1 2 3 4 palpitations
0 1 2 3 4 dizzy upon standing 0 1 2 3 4 feeling of heaviness 0 1 2 3 4 see floaters in eyes 0 1 2 3 4 nausea	0 1 2 3 4 heat in palms or soles 0 1 2 3 4 foggy thinking 0 1 2 3 4 afternoon fever 0 1 2 3 4 enlarged lymph nodes	0 1 2 3 4 night sweats 0 1 2 3 4 cloudy urine 0 1 2 3 4 frequently flushed face

Urination: (Please circle that applies) Frequency (night): _ _ _ _ _
Burning Urgent Scanty Difficult Profuse Dribble
Bowel Movement: Frequency: _ _ _ _ _ _ _ _
Consistency (please circle): well-formed hard loose alternate between formed & loose
Do you ever notice traces of undigested food, blood or mucus? _
Do you feel thirsty? Yes / No Do you crave warm or cold drinks? _ _ _ _ _ _ _ _ _ _ _ _ _
Do you have bitter taste in mouth after waking up from sleep? Yes /No
How is energy level, generally? Low 1 2 3 4 5 6 7 8 9 10 High
Women Only: (Please circle around your selection)
Are you currently pregnant? Yes / No Are you taking contraceptive/birth control pill? Yes / No
# of pregnancies: _ _ # of live births: _ _ # of miscarriages: _ _ # of abortions: _ _
Age at your first period? _ _ years Is your period regular? Yes / No When was your last period? _ _ /_ _ _ / 20_ _
# of days from the start of one period to the start of your last period: _ _ Flow: Spotty / Scanty / Normal / Heavy
Colour: Pale / Normal / Dark / Bright Red / Brown / Purple Blood Clots: Yes / No
Do you experience back/abdominal pain/cramps? Yes / No (severe / dull / constant / intermittent / burning / aching)
Do you experience any of the following before or during your menstrual period? Water Retention / Breast tenderness or swelling / Depression / Irritating / Migraine / Insomnia / Diarrheic / Constipation / Nausea / Hot Flushes / Night Sweat
Have you experienced menopause? Yes / No When? _ _ _ _ 20_ _
Do you experience vaginal discharge? Yes / No (Clear / White / Yellow / Green) (Itch / Burn / Pain / Foul / Odour)
Men Only: (Please circle around your selection)
Painful urination / Difficult Urination / Dribbling Urination / Incontinence / Premature ejaculation / Groin pain / Decreased libido / Testicular pain / Impotence / Nocturnal emissions
Have you had prostate check-up? Yes / No Date of last prostate check-up: _ _ / _ _ _ / 20 _ _ Results: _
PLEASE TURN PAGE OVER AND SIGN

I, the undersigned, have been explained the treatment regime and understand the nature of treatment and consent to receive treatment offered at Middle Path General Practice of Chinese Medicine; I also acknowledge full responsibility for payment of services.

I, the undersigned, certify that all of the above medical history provided is true to the best of my knowledge, and I have not knowingly omitted information.

Name (Patient)**:** _
(Please PRINT) (Signature)

Name (parent/guardian)**:** _
Parent consent (Under 18) (Please PRINT) (Signature)

Date Signed: _ _ _ / _ _ _ _ _ _ _ _ _ _ _ _ / 20 _ _
Day Month Year