Patient Name: DOB
Date of Service:

Heidi von Brockdorff, Dipl. OM, L.AC
970-250-0940
1400 Executive Pkwy, #245
Eugene OR 97401

PATIENT INTAKE FORM

Date:_____

NAME:_____PHONE:HOME_____WORK_____
STREET:_____AGE:_____HEIGHT:_____WEIGHT:_____
CITY:_____BIRTHDATE:_____SEX:_____
STATE:_____ZIP:_____OCCUPATION:_____
EMPLOYER'S NAME AND ADDRESS:_____
MARITAL STATUS:_____# OF CHILDREN:_____
PERSONAL PHYSICIAN:_____
DATE OF LAST PHYSICAL EXAM:_____
INSURANCE COMPANY:_____
POLICY NUMBER:_____
EMERGENCY CONTACT:_____
RELATIONSHIP:_____PHONE:_____
REFERRED BY:_____

FAMILY MEDICAL HISTORY:

___Cancer	___Diabetes	___High/Low Blood Pressure
___Heart Trouble	___TB	___Allergies
___Kidney Disease	___Epilepsy	____Asthma
___Liver Disease	___Ulcers	____Sinus Problems
___Eye Disease	___Arthritis	___Alcholism
___Spinal Problems	___Mental Disorders	___Drug Addiction

Other:_____

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Age Parents Died: Mother_____ Father_____

PERSONAL MEDICAL HISTORY (Include date)

Major surgeries – Illnesses – Diseases –Accidents

_____
_____
_____
_____

CONTAGIOUS DISEASES (Check if you have had one of the following): ____HIV+

____AIDS _____Hepatitis _____Venereal Disease ____Herpes _____Other

ALLERGIES (Drugs, chemicals, food, animals, seasonal, etc.)_____

MEDICATIONS PRESENTLY TAKING:_____

HABITS;

____Cigarettes (Tobacco)	_____Soft Drinks	_____Salt
____Coffee	_____Alcohol	_____Recreational Drugs
____Black Tea	_____Sugar	_____Stress

EXERCISE:

____Never ____Little _____Moderate ____Heavy

EMOTIONAL:

____Happy	_____Easily Irritable	_____Difficulty making decisions
____Angry	_____Cry Easily	_____Hurry to do things
____Depression	_____Stressed	_____Restless

DIET: (Typical Foods):

_____Beef	___Eggs	___Cheese	___Grains	____Tofu
_____Pork	___Bread	___Margarine	___Fried Foods	____Yogurt
_____Poultry	___Milk	___Ice Cream	___Sweets	____Health Foods
_____Fish	___Butter	___Vegetables	___Salads	____Hot Spicy Food

Other_____
Cravings_____
Do you eat 3 meals per day? _____ Do you eat at regular hours? _____

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APPETITE:

____Up and Down ____Poor _____Good _____Hungry a lot ____Loss of Taste

WEIGHT:

____Normal ____Underweight _____Overweight ____Recent Gain ____Recent Loss

ENERGY:

____Up and Down ____Low ____Normal _____Excess ____Low after eating
____Tired in the afternoon

MAJOR COMPLAINT, INJURY OR ILLNESS

_____
_____
_____

DATE BEGAN:_____
HOW DID THE CONDITION START:_____
_____
HAVE YOU HAD THIS CONDITION BEFORE?_____
_____
HAVE YOU RECEIVED TREATMENT FOR THIS CONDITION?_____
IF YES, WHEN?_____
BY WHOM?_____
WHAT WAS THE DIAGNOSIS?_____
WHAT WERE THE RESULTS FOR THE TREATMENT?_____
HAS THE CONDITION GOTTEN: ____Better ____Worse _____Is about the same
WHAT MAKES IT BETTER?_____
WHAT MAKES IT WORSE?_____

BODY TEMPERATURE:

_____Warm natured ____Flushed face _____Feet warmer late afternoon and night
_____Cold Natured ____Warm Palms _____Alternate chills and fever
_____Cold Hand and Feet ____Warm Soles _____Normal

Other_____

PERSPIRATION:

____Very Little _____Easily ____Night sweats
____Profuse _____Palms ____Bad smell
____Without exertion _____Feet ____Normal

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Other_____

DIGESTION:

___Indigestion
___Heartburn
___Belch or burp
___Gas
___Bitter taste in mouth
____Nervous stomach
____Nausea/Vomiting
____Stomach noises
____Bad breath
____Gallstones
_____Bloating
_____Full feeling or distention
_____Abdominal pain or cramps
_____Difficulty digesting fats & oils
_____Weight problems
_____Normal

Other_____

BOWELS:

____Loose stool
____Diarrhea
____Constipation
____Colon problems
____Black stool
____Pain or cramps
_____Blood in Stool
_____Hemorrhoids
_____Anus Itch
_____Burning anus
_____Hard Stool
_____Use laxatives
_____Undigested food in stool
_____Stool with bad smell
_____Mucous in stool
_____Small amount of stool
_____Intestinal worms
_____Normal

Other_____

URINATION; (three to four times per day is normal):

____Frequent
____Nightime
____Profuse
____Scanty
_____Burning
_____Blood
_____Pus
_____Painful
_____Bladder infections
_____Incontinence
_____Strong smell
_____Not normal color
______Urgency
______Kidney stones
______Cloudy
______Kidney infection
______Normal

Other_____

THIRST:

____Less than normal
____Thirsty but do not drink
____Excessive
_____Prefer cold drinks
_____Prefer hot drinks
_____Normal

Other_____

SLEEP:

____Difficulty falling asleep
____Awake easily
____Difficulty going back to sleep
_____Lots of dreams
_____Nightmares
_____Restless
______Wake up tired in a.m.
______Sleep too much
______Normal

Other_____

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HEADACHES – DIZZINESS;

____Headaches ______Vertigo _____Bend down and stand up getting dizzy
____Dizziness ______Motion sickness _____Poor Balance
____Faint easily ______Migraines _____Poor memory
Other_____

SKIN:

___Dry ___Hives ____Clammy
___Oily ___Pimples ____Bruise easily
___Rashes ___Moles ____Cuts heal slowly
___Itching ___Warts ____Yellow skin
___Eczema ___Boils ____Normal
___Ulcers ___Body odor
Other_____

HAIR:

____Dry ____Oily ____Dandruff ___Falling out ___Early grey ___Normal
Other_____

NAILS:

____Soft ____Break easily ____Spots
____Grow slowly ____Pale ____Grow fast
____Ridges and lines ____Purple ____Normal
Other_____

EYES:

____Wear glasses or contacts ____Eyelids swollen ____Cataracts ___Red
____Spots or lines in vision ____Inflammation ____Glaucoma ___Dry
____Pale under eyelids ____Yellow sclera ____Blink ___Itch
____Poor night vision ____Failing vision ____Twitch ___Pain
____Sensitive to light ____Sty history ____Strain ___Normal
____Color blindness ____Blurry vision ____Tear easily
Other_____

EARS:

____Poor hearing ____Ringing (high pitch) ____Discharges
____Ear aches ____Ringing (low pitch) ____Normal
Other_____

MOUTH AND THROAT:

____Dry ____Gum problems ____Hoarseness
____Frequent sore throats ____Sores in mouth/tongue ____Frequent colds
____Difficulty swallowing ____TMJ ____Dry cracked lips
____Thyroid problems ____Hiccups ____Drool a lot

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____Swollen glands ____Grind teeth ____Normal
____Feel lump in throat ____Teeth problems
Other_____

RESPIRATORY:

____Shortness of breath _____Difficulty inhaling _____Sigh a lot
____Chest pain _____Difficulty exhaling _____Dry cough
____Asthma _____Difficulty breathing _____Cough with phlegm
____Bronchitis when lying down _____Cough with blood
____Tightness in chest _____Cough a lot _____Normal
Other_____

CARDIOVASCULAR:

____Diagnosed heart problems ____Palpitations _____Broken blood vessel/capillaries
____Low blood pressure ____Bleed easily _____Purple palms and fingers
____High blood pressure ____High cholesterol _____Ankle swelling
____Murmur ____Varicose veins _____Facial swelling
____History of anemia ____Chest pain _____Hand swelling
____Slow beating of heart ____Bruise easily _____Irregular heart beat
____Numbness in extremities ____Normal
Other_____

PAIN:

____Low back ____Shoulder ____Muscle weakness
____Sciatica ____Hands or wrists ____Muscle cramps
____Upper back ____Hips ____Muscle twitching or spasm
____Mid back ____Knees ____Damp weather
____Neck ____Foot or ankle ____Nerve
____Spine ____Arthritis ____Flank pain
Other_____

ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS

FOR MALES ONLY: (Please check or explain if applicable)

_____Reduced sex drive_____
_____Premature ejaculation_____
_____Seminal emission_____
_____Impotence_____
_____Discharges_____
_____Genital pain_____

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_____Prostate problems_____
_____Pain or burning urination_____
_____Dribbling_____

If you are male, congratulations you have just completed this form.
If you are female, please continue….

ARE YOU OR MIGHT YOU BE PREGNANT? ____Yes ___No ___Maybe
IF YES, THE APPROXIMATE DATE OF CONCEPTION?_____
ARE YOU EXPERIENCING REDUCED SEX DRIVE? ____YES ____NO
OTHER DIFFICULTIES? ____Yes ___No
EXPLAIN_____
_____

DO YOU HAVE REGULAR PAP TESTS? ___YES __NO DATE OF LAST___
DO YOU HAVE REGULAR BREAST EXAMS ? __YES __NO DATE OF LAST___
DO YOU HAVE FACIAL HAIR OR EXCESS BODY HAIR? ___YES ___NO

MENSTRUAL CYCLE: (Please check and explain as applicable)

Age started____ Days of flow____ Age stopped_____
HOW MANY DAYS FRFOM THE BEGINNING OF YOUR PERIOD TO THE START OF YOUR NEXT PERIOD?
___Irregular_____
___Painful_____
___Heavy Flow_____
___Scanty flow_____
___Dark Color flow_____
___Light Color flow_____
___Clotting_____
___Fluid retention_____
___Abdominal bloating_____
___Painful or tender breasts_____
___Breast lumps_____
___Emotional changes_____
___Spotting between periods_____
___Lump in throat feeling_____
___Constipation or diarrhea_____
___Tightness in chest_____

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___Hormonal problems_____
___Backache_____
___Sigh a lot_____

VAGINAL DISCHARGE:

___Yellow_____
___Thick_____
___Bad odor_____
___White_____
___Clear_____
___Other_____

OVULATORY SYMPTOMS:

MENOPAUSAL SYMPTOMS:

PREGNANCIES:

Total number_____ Number of miscarriages_____
Number of live births_____ Number of therapeutic abortions_____

PREGNANCY OR CHILDBIRTH COMPLICATIONS:

GYNECOLOGICAL HISTORY AND OPERATIONS:

METHOD OF BIRTH CONTROL USED?_____

DATE:

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CHIEF COMPLAINT:

Location:
Quality:
Duration:
Intensity: (1-10 scale, 10 being worse)
Frequency:
Onset:
Radiation:
Timing:
Paliative/Aggravating factors:

PHYSICAL EXAM:

BLOOD PRESSURE:

TONGUE:

PULSE:

Rate:
Rhythm:
Right:
Left:

DIAGNOSIS:

TCM DIAGNOSIS:

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TREATMENT PLAN:

Next scheduled treatment date:

Next schedules examination date:

ACUPUNCTURE PRESCRIPTION;

HERBAL PRESCIPTION:

MODALITIES USED: (Including Tui Na, Gua Sha, Electro-stimuation, Cupping, Moxabustion)

Patient Instructions:

Provider signature:
Date:

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