**Traditional Chinese Medicine Intake Form**

**Patient Information**

* **Full Name:**
* **Date of Birth:**
* **Gender:**
* **Phone Number:**
* **Email:**
* **Address:**
* **Emergency Contact:**
* **Occupation:**
* **Date of Visit:**
* **Referred By (if any):**

**Chief Complaint(s)**

What is your main reason for seeking treatment?

**Onset:**  
**Duration:**  
**Frequency:**  
**Aggravating/Relieving Factors:**  
**Western Diagnosis (if any):**  
**Treatments Received:**

**Medical History**

☐ Hypertension

☐ Diabetes

☐ Thyroid issues

☐ Heart disease

☐ Asthma

☐ Digestive disorders

☐ Autoimmune disorders

☐ Neurological conditions

☐ Cancer

☐ Surgeries (list):

☐ Other (please specify):

**Medications & Supplements**

* Prescription medications:
* Over-the-counter meds:
* Herbal supplements/vitamins:

**Family Medical History**

☐ Cardiovascular

☐ Cancer

☐ Autoimmune

☐ Diabetes

☐ Neurological

☐ Other:

**The Ten TCM Diagnostic Questions**

**1. Cold & Heat Sensation**

* Do you often feel cold? ☐ Yes ☐ No
* Do you feel hot easily? ☐ Yes ☐ No
* Do you prefer warmth or coolness?
* Any chills, fever, or alternating symptoms?
* ☐ Spontaneous sweating
* ☐ Night sweats
* ☐ No sweating

**2. Sweating**

* Sweat amount: ☐ None ☐ Minimal ☐ Moderate ☐ Excessive
* Timing: ☐ Daytime ☐ Nighttime ☐ During activity
* Is there odor present? ☐ Yes ☐ No

**3. Head & Body Pain**

* Headache: ☐ Yes ☐ No — Location:
* Body pain: ☐ Migrating ☐ Fixed ☐ Sore ☐ Sharp
* Muscle/joint stiffness: ☐ Yes ☐ No
* Better/worse with: ☐ Cold ☐ Heat ☐ Pressure

**4. Urination & Bowel Movements**

**Urine:**

* Frequency:
* Color: ☐ Clear ☐ Yellow ☐ Dark ☐ Cloudy
* Pain/burning: ☐ Yes ☐ No

**Stool:**

* Frequency:
* Consistency: ☐ Normal ☐ Loose ☐ Hard ☐ Alternating
* Color: ☐ Normal ☐ Pale ☐ Dark ☐ With mucus ☐ With blood
* Urgency or incomplete feeling: ☐ Yes ☐ No

**5. Appetite, Thirst, Taste**

* Appetite: ☐ Normal ☐ Poor ☐ Excessive ☐ Cravings
* Thirst: ☐ Normal ☐ Dry mouth ☐ No thirst
* Preference: ☐ Hot ☐ Cold drinks
* Taste in mouth: ☐ Normal ☐ Bitter ☐ Sweet ☐ Metallic

**6. Chest & Abdomen**

* Chest discomfort: ☐ Tightness ☐ Pain ☐ Palpitations
* Abdominal bloating: ☐ Yes ☐ No
* Epigastric pain: ☐ Yes ☐ No
* Rib-side pain: ☐ Yes ☐ No
* Worse/better with food or pressure?

**7. Sleep**

* ☐ Fall asleep easily
* ☐ Wake during night
* ☐ Wake early
* ☐ Restless dreams
* Sleep quality: ☐ Good ☐ Fair ☐ Poor
* Sleep hours per night:

**8. Emotions & Mental Health**

* Mood: ☐ Calm ☐ Irritable ☐ Anxious ☐ Depressed ☐ Worrying
* Are emotions affecting your health? ☐ Yes ☐ No
* Energy level: ☐ High ☐ Average ☐ Low
* Concentration/memory issues? ☐ Yes ☐ No

**9. Reproductive / Gynecological / Urological Health**

**For Women:**

* Menstrual cycle length:
* Flow: ☐ Light ☐ Normal ☐ Heavy
* Color: ☐ Pale ☐ Red ☐ Dark ☐ Purple
* PMS: ☐ Cramps ☐ Breast tenderness ☐ Mood changes
* Menopause: ☐ Yes ☐ No — Symptoms:
* Pregnancy history:
* Birth control use:

**For Men:**

* Libido: ☐ Normal ☐ Low ☐ High
* Sexual dysfunction: ☐ Yes ☐ No
* Prostate or urinary issues:

**10. Other Symptoms or Concerns**

* Skin issues (rashes, dryness, eczema):
* Hair or nail changes:
* Vision/hearing concerns:
* Recent weight change:
* Any chronic or unusual odors?

**Lifestyle & Habits**

* Diet: ☐ Balanced ☐ Irregular ☐ Vegetarian ☐ Sugar-heavy
* Caffeine:
* Alcohol:
* Tobacco:
* Sleep routine:
* Stress level (1–10):
* Exercise: ☐ None ☐ Occasional ☐ Regular — Type:

**Practitioner Section (Internal Use)**

**Pulse Findings:**

* Rate:
* Depth:
* Quality (wiry, slippery, thready, etc.):

**Tongue Observation:**

* Body color:
* Shape:
* Coating:
* Moisture:

**Preliminary Pattern Diagnosis (辨证):**

**Treatment Principle:**

**Acupuncture Points / Strategy:**

**Herbal Prescription (if applicable):**

**Lifestyle / Diet Recommendations:**

**Follow-Up Plan:**

**✅ Consent**

☐ I understand that this form is part of my medical evaluation and will remain confidential in accordance with clinic policies and local health regulations.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_