OXANA GETMAN

CLIENT INTAKE FORM

First name: _____ Last name: _____ Sex: M / F

Address: _____

Postal code: _____ Occupation: _____ Date of Birth_____
(mm/dd/yyyy)

Home phone : _____ Cell: _____ Work: _____

May we leave messages for you at these numbers? Yes No

Email: _____

Would you like to receive follow-ups and our special offers via email? Yes No

Emergency contact name: _____ Phone: _____

How did you hear about us? _____

Goals: What would you most like to achieve with Traditional Chinese Medicine?

_____

_____

Major Symptoms: Please list in order of importance what symptoms concern you and for how long

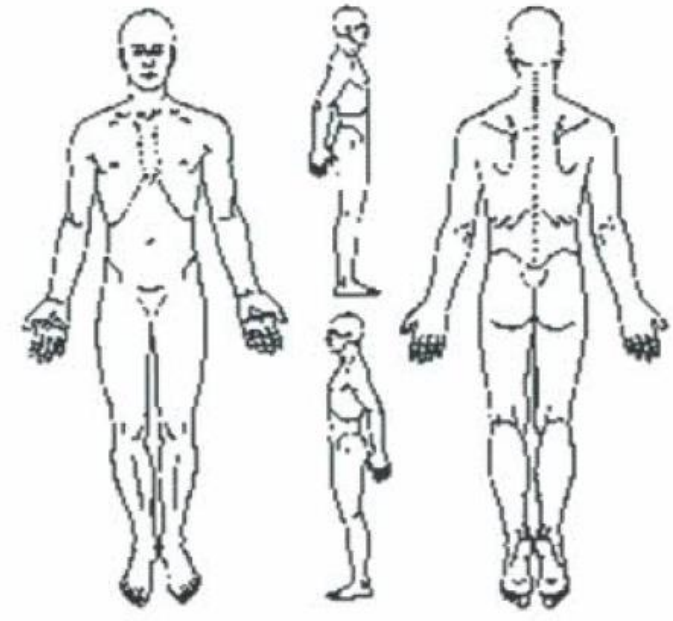
_____

_____

Please describe your pain **(Circle for pain # 1, X for pain #2)**

Pain#1
Constant ( ) Comes & Goes ( ) Fixed ( ) Moves ( )
Unilateral () Dull ( ) Sharp ( ) Burning ( )
Aching ( ) Spastic ( ) Numb ( )
Better: Heat ( ) Cold ( ) Motion ( ) Rest ( ) Pressure ( )
When: am / pm
Worse: Heat ( ) Cold ( ) Motion ( ) Rest ( ) Pressure ( )
When: am / pm
Rate from 0 (better) to 9 (worse) _____

Pain#2
Constant ( ) Comes & Goes ( ) Fixed ( ) Moves ( )
Unilateral () Dull ( ) Sharp ( ) Burning ( )
Aching ( ) Spastic ( ) Numb ( )
Better: Heat ( ) Cold ( ) Motion ( ) Rest ( ) Pressure ( )
When: am / pm
Worse: Heat ( ) Cold ( ) Motion ( ) Rest ( ) Pressure ( )
When: am / pm
Rate from 0 (better) to 9 (worse) ___



For Women:

Are you pregnant now? Yes No Unsure Age: First period _____ Menopause (if applicable) _____

How many times: Live Births _____ Pregnancies _____ Miscarriages _____ Abortions _____

Date: Last pap smear _____ Last mammogram _____

Any history of an abnormal pap smear? Yes No If yes, what / when? _____

Is your menses cycle regular? Yes No Average number of days of flow _____

The flow is: Normal Heavy Light

The color is: Normal Dark Purple Light Brown Brown

Do you have the following menstruation related signs/symptoms?

Blood clots		PMS		Breast distention		Cramps	
Pain with intercourse		Bleeding between periods		Vaginal discharge		Nausea	

For Men:

Do you have any bothersome urinary symptoms? Yes No

Describe:_____

Do you have the following signs/symptoms?

Frequent need to urinate at night		Pain of testicles		Premature ejaculation	
Impotence/erectile dysfunction		Pain or swelling of the testicles		Feeling of coldness or numbness in genitalia	

Do you get up at night to urinate? Yes No If yes, how often? _____

To what extent do these conditions interfere with your daily activities (work, sleep, socializing, etc.)?

_____

Have you sought medical intervention for these problems? If so, when? _____

What treatments have you tried for these problems and how successful have they been? _____

_____

MEDICAL HISTORY

Medications / Supplements
(Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____

_____

How was your general health as a child? _____

Do you have a contagious disease at this time? (ie. hepatitis, flu, HIV etc.) Yes No

How much do you consume per day of? Water: ____ Coffee: ____ Tea: _____ Soda: ____ Cigarettes: _____

Are you? Always Thirsty Never Thirsty for sips later in the Day

Do you like: Cold Drinks Warm Drinks

What are your typical eating habits?

Skip breakfast	Eat in a rush	Eat when not hungry	Eat too fast
Eat late at night	Cannot eat when worried/stressed	Excess hunger	No desire to eat

Do you dislike: Cold Wind Dampness Heat Loud Noises Crowds

What is your approximate: Height _____ Weight _____

Do you have: Pacemaker Surgical Replacements Implants Hemophilia Sensitive Skin Fear of Needles

Which conditions do you have now (N) or had in the past (P)

	N	P		N	P		N	P		N	P		N	P
Anemia			Cataracts			Gout			Lyme Disease			Prostate Disorder		
Appendicitis			Celiac decease			Heart Disease			Meningitis			Scarlet Fever		
Arteriosclerosis			Chicken Pox			Hernia			Mononucleosis			Arthritis		
Bladder Disease			Chronic Fatigue			Herpes			Multiple Sclerosis			Stomach Disorder		
Blood Disorder			Chronic Pain			High Cholesterol			Mumps			Stroke		
Bronchitis			Diabetes			Intestinal Disorder			Osteoarthritis			Thyroid Disorder		
Broken Bones			Emphysema			Impotence			Osteoporosis			Tonsillitis		
Bulimia			Epilepsy			Kidney Disease			Parkinson's			Tuberculosis		
Cancer			Measles			Liver Disease			Pneumonia			Ulcers		
Candidiasis			Goiter			Lupus			Polio			Other:		

Is any of your family members (Siblings, Parents, Grandparents) is or was dealing with any of following?

Alcoholism		Bleeding disorders		Diabetes		Kidney disease		Stroke	
Allergies		Cancer		Heart Disease		Mental illness		Other:	
Asthma		Depression		High blood pressure		Seizures			

Do you frequently experience any of these emotions?

Anger		Depression		Impatience		Frustration		Worry	
Anxiety		Stress		Impulsiveness		Mood swings		Sadness	
Bitterness		Fear		Irritability		Over excitement		Grief	

Please check all the conditions that apply to your health history:

General:

Low energy		Excessively thirsty		Sweaty palms/feet		Weight loss	
Spontaneous sweating		Chills/fever		Hot flashes		Weight gain	
Feel too hot		Avoid heat or cold		Night sweats		Other:	
Feel too cold		Cold hands/feet		Lack of sweating			

Head, Eyes, Ears, Nose, Throat:

Headaches		Ringing in ears		Contacts or glasses		Nasal obstruction		Mouth ulcers	
Migraines		Dizziness		Tearing of eye		Runny nose		Sores/ulcers on tongue	
Jaw pain/TMJ		Spots in vision		Dry or burning eye		Sneezing		Bad breath	
Impaired hearing		Poor night vision		Itchy eye		Nose bleeds		Bleeding gums	
Hearing loss		Double/blurred vision		Red or inflamed eye		Loss of smell		Dry mouth	
Ear aches		Eye pain/strain		Sinus problems		Teeth problems		Recurrent sore throat	

Respiratory:

Cough		Wheezing		Coughing up blood		Recurrent sinus infections	
Production of phlegm		Shortness of breath		Frequent colds/flus		Chronic allergies:	

Cardiovascular:

Chest pain		Low blood pressure		Palpitations		Poor circulation		Fainting spells	
High blood pressure		High cholesterol		Heart racing		Irregular heartbeat		Blood clots	

Digestive:

Nausea		Excessive hunger		Indigestion		Stomach ulcer		Constipation	
Vomiting		Hypoglycemia		Bloating after meals		Reflux or heartburn		Stomach ache	
Low appetite		Fatigue after meals		Gas		Diarrhea/loose stool		Abdominal pain	
Hemorrhoids		Gallstones		Jaundice		Blood in stool		Eating disorder	

Musculoskeletal (Pain/weakness/numbness):

Joints		Hips		Neck		Abdomen		Joint stiffness	
Arms		Legs		Shoulders		Lower abdomen		Broken bones	
Hands		Feet		Upper back		Lower back		Other:	

Urinary tract:

Frequent urination		Burning/pain on urinating		Cloudy urine		Frequent UTI's	
Frequent night urination		Very pale urine		Scanty urine		Blood in urine	
Poor bladder control / Incontinence		Dark urine		Profuse urine		Kidney or bladder stones	

Emotional/ Psychological/Mental:

Trouble falling asleep		Poor memory		Cry uncontrollably		Worry a lot		Mentally restless	
Trouble staying asleep		Trouble concentrating		History of abuse		Poor coordination		Vivid/disturbing dreams	

Skin and nails:

Rashes		Bruise easily		Boils		Weak or brittle nails	
Itching		Slow wound healing		Hives		Pitted nails	
Color change of skin		Acne		Hair falling out		Grooves in nails	

Thank you for taking the time to fill out this form. This will help me assess your health and give you a better treatment. All information is confidential and will not be shared without your explicit permission.