SPOT SPA
urban wellness

Traditional Chinese Medicine Initial Intake Form

Patient Information

Date _____

Name _____

Address _____

City, State, Zip _____

Phone _____

Email _____

Age _____ Birth Date _____

Gender _____

Occupation_____

Relationship Status: Single / Partnered / Married

Separated / Divorced / Widowed # of Children ____

Primary Physician _____

Physician phone _____

How long since your last medical exam? _____

May we discuss your treatment with your Primary Care Physician? Yes / No

Emergency Contact _____

Relationship _____

Phone _____

Would you like to get our newsletter? Yes / No

How did you hear about us? _____

Health History

Reason(s) for today's visit?

1. _____
2. _____
3. _____

How and when did these conditions begin?

1. _____
2. _____
3. _____

What treatments have your tried? _____

_____

Have you seen a medical doctor for this? Yes / No

List medications, supplements, & herbs you take:

_____

_____

_____

List serious illnesses, accidents or surgeries _____

_____

_____

Do you have? Pacemaker / implant / seizures bleeding disorder / on blood thinners / cancer

Describe what you eat _____

_____

_____

_____

How much per week? Cigarettes _____

Alcohol _____ Coffee _____

Sugar _____

Family Health History _____

_____

_____

Medical History
Please supply details for any that apply to you in the last year (common examples in parenthesis)
Sleep / Energy (insomnia, night sweats, restless leg, fatigue)
Digestive / Thirst (constipation, loose stool, bloating, gas, acid reflux, ulcer, cravings, excessive thirst)
Cardiovascular (high blood pressure, high cholesterol, poor circulation)
Head / Ear / Nose / Throat / Eyes (headaches, tinnitus, sinus congestion, dryness, halitosis)
Respiratory / Allergies (asthma, shortness of breath, frequent common colds, food sensitivity)
Musculo-skeletal (tension, pain, traumatic injury, arthritis, fibromyalgia)
Urinary (UTI, prostate troubles, frequent urination at night)
Menstrual / Genitalia (PMS, irregular menstruation, infertility, menopausal, STD, low libido, candida)
Emotion / Memory (stress, anxiety, depression, irritability, frustration, psychiatric diagnosis)
Skin Conditions (acne, premature aging, rosacea, eczema, psoriasis, hives, dermatitis, dry skin, sweaty)
Other:

Notice of Privacy Practices Acknowledgment
We keep a record of the health care service we provide you. You may ask to see and copy your records. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used, disclosed, and how you can access your information.
Patient or legal guardian Printed Name: _____ Relationship to Patient: _____ Signature: _____ Date: _____