Zhi Dao Guan
The Clinic for Traditional Chinese Medicine
3824 MacArthur Blvd., Oakland, CA 94619
510-336-0129

Patient Intake and History

Date: _____ Name: _____ _____
First name **Last Name**

Address: _____ _____
Street address or POBox **City**

Email: _____ **State** **Zip code**

Would you like to receive the monthly Zhi Dao Guan newsletter by email?

☐ YES ☐ NO, THANKS

Phones: _____ _____
Home **Business**

_____
Other (cell)

Birthdate: ___ __ _____ **M F**
Mo **day** **year** **Circle one**

Age: _____

Circle one: Single Partnered Married Widowed

Employed Y N If employed, employer's name: _____
Circle one

Referred by: _____

Emergency contact name: _____
Address:

Telephone:

Briefly describe what brings you to Dr. Feng for treatment. Include major complaints and symptoms and diagnoses you have been given:

Other treatments received for this condition:

Condition	Provider	When	Outcome

Health history:	Yes	No	If yes, what and date
Any serious illnesses	___	___	
Operations	___	___	
Hospitalizations	___	___	
Family history of serious illness	___	___	

Medications used currently – list name of medication and who prescribed it:

How would you describe your state of health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

Does pain interfere with one or more of your basic activities? ☐Yes ☐No
If Yes, please describe the location of the pain:

Describe the intensity of the pain on a scale of 1 to 10 (10 is most severe and 1 is least painful): _____
How frequently do you have this pain? _____

Check all of the following which apply to you:

General

- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Easy bruising
- ☐ Fatigue
- ☐ Loss of appetite

Head

- ☐ Headache

Skin

- ☐ Rash
- ☐ Changing mole
- ☐ Yellow skin
- ☐ Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne

Neck

- ☐ Stiffness
- ☐ Lump
- ☐ Pain

If you have headaches, describe location:
__Frontal __Top __ Back __ Nose __Sides __Entire head __ Eyes __ Temples
Heavy sensation in head __Yes __ No

Eyes

- ☐ Pain
- ☐ Burning
- ☐ Itching
- ☐ Blurred vision
- ☐ Discharge/exudate
- ☐ Sensitivity to light

Ears

- ☐ Ringing
- ☐ Pain
- ☐ Loss of hearing
- ☐ Decrease in hearing
- ☐ Stuffy sensation
- ☐ Discharge If yes, color_____

Nose

- ☐ Congested
- ☐ Pain
- ☐ Blood
- ☐ Phlegm If yes, color_____

Throat

- ☐ Pain, soreness
- ☐ Cough
- ☐ Dry
- ☐ Swollen glands
- ☐ Thirstiness
- ☐ Phlegm If yes, color_____

Chest, heart, lungs

- ☐ Short of breath
- ☐ Asthma
- ☐ Chest tightness
- ☐ Heart murmur
- ☐ Racing heart
- ☐ Palpitations
- ☐ Chest pain

Gastrointestinal

- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Belching
- ☐ Bloating
- ☐ Hemorrhoids
- ☐ Blood with bowel movements
- ☐ Abdominal pain
- ☐ Regurgitation
- ☐ Nausea
- ☐ No appetite

Urination

- ☐ Pain/discomfort during urination
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Frequent night urination If yes, how often? _____
- ☐ Urinary tract discomfort
- ☐ Kidney pain or infection
- ☐ Genital pain/discomfort

Musculoskeletal (joints, muscles, bones)

- ☐ Pain If yes, where? _____How long? _____
- ☐ Numbness If yes, where? _____How long? __
- ☐ Weakness If yes, where? _____How long? __
- ☐ Swelling If yes, where? _____How long? __
- ☐ Limited motion If yes, where? _____How long? __

Neurologic

- ☐ Loss of balance or coordination If yes, how long? _____
- ☐ Tingling in arms or legs If yes, where? _____How long? __
- ☐ Fainting, loss of consciousness If yes, how frequently? _____
- ☐ Recent visual changes – such as double vision
- ☐ Memory loss that is disruptive to your ability to function
- ☐ Problems with speech

Reproductive/sexual

- ☐ I have sexual concerns – please describe:

For Women:

Reproductive history – Number of pregnancies: _____

- ☐ Number of children and ages:

Menstrual Cycle:

- ☐ I have concerns about my menstrual cycle – please describe:

Check those that apply: ____early menstruation ___late menstruation ___irregular menstruation ____Breast swelling _____Breast nodules
___Blood clots If yes, color – circle one: red maroon purple

- ☐ Symptoms of PMS – describe:

Menopausal

- Menopausal – If yes, date of last period_____ If peri-menopausal, date when menstrual cycle began changing_____

Last Pap smear _____ Results: __Normal or __Other – please describe:

Last mammogram _____ Results: __Normal or __Other – please describe:

For Men:

Reproductive history – Number of children and ages:

Last prostate exam_____ Results: __Normal or __Other – please describe:

Nutrition

Please describe any nutritional issues you may have:

How many meals do you eat a day?_____ Which is your biggest meal of the day?
__breakfast ___lunch ___dinner
Number of servings of fruit a day_____ Servings of vegetables a day_____ Servings of grains, nuts, legumes or beans _____

Check all that apply:

- Vegetarian
- Coffee drinker If yes, how many cups a day? __
- I have one or more of these symptoms after eating: bloating, nausea, heartburn, abdominal pain, excessive gas

How do you describe your weight?

- ☐ Very underweight
- ☐ Slightly underweight
- ☐ About right
- ☐ Slightly overweight
- ☐ Very overweight

Blood pressure __high __low Last reading, if known _____

Exercise

How many times a week do you exercise (for 20 minutes or longer at a time)? _____
Favorite exercise:

Sleep

How many hours of sleep do you typically get? ____

Do you awake feeling rested? __Yes __No

Describe any problems associated with sleep (insomnia, waking in the middle of the night, snoring, etc.)

Emotional Fulfillment

Check all of the following that apply – I often experience:

- ☐ Anxiety
- ☐ Depression
- ☐ Weepy, tearfulness
- ☐ Being easily discouraged

How do you currently feel in your daily life?

- ☐ All in all, I feel very happy.
- ☐ For the most part, I feel pretty happy
- ☐ I am neither happy, nor unhappy; I am content in my daily life.
- ☐ I feel unhappy but I don't want help at this time.
- ☐ I feel unhappy or as if things are hopeless and I have considered getting help.

PLEASE READ AND SIGN:

I acknowledge that with the exception of workers compensation, the responsibility for payment of the fees for services provided is the patient's.

_____

Signature

☐ **I will pay for my visits myself.**

❑ **Please bill my insurance*; I agree to pay the difference from what my insurance covers.**

Member # _____ Name of insured if not self: _____

Insured's birthdate_____Insured's SSN#_____

Insurance carrier: _____

Telephone: _____

Address:

☐ **Workers Compensation: Claim # _____ Date of Injury ___/___/___**
Mo. Day Year

Insurance carrier: _____

Claims adjuster name_____ Telephone: _____

Address:

***Please read and sign only if you are expecting your insurance to cover the cost of services:**

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT
I hereby give lifetime authorization or payment of insurance benefits to be made directly to Dr. Alex Feng/Clinic for Traditional Chinese Medicine, for all services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize Dr. Feng to release all information necessary to secure the payment of benefits.

Your signature: _____ Date: _____