The Way of Water
Chinese Medicine Centre
Hamish Brown - B. App.SC (TCM)

Consultation Date: _____

Welcome!

This form will assist me in gaining a more complete picture of your health. Please fill it in with as much detail as possible. All information will be kept confidential.

Name: _____ Male/ Female _____

Date of Birth: _____ Age: _____ Place of Birth: _____ Current weight: _____

Address: _____

Home Phone: _____ Mobile/Work Phone: _____

E-mail: _____ Occupation: _____

Please Circle: Married Partnership Single Separated Widowed

Primary Doctor: _____ Private Health Fund: _____

How did you hear about the Chinese Medicine Centre? _____

Have you had acupuncture or Chinese herbs before? _____

What are the main health concerns you wish to address?

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____

What treatment have you received previously for these concerns?

_____

What makes your condition generally worse and/or better?

_____

Have you had any surgeries/ operations in the past? Y ☐ N ☐

If yes, which: _____

Have you had any major accidents? Y ☐ N ☐

If yes, which: _____

Do you have any major scars? Y ☐ N ☐ If so, where: _____

Have you had any major illnesses? Y ☐ N ☐

If yes, which: _____

Are you allergic to any foods/ medications/ or environmental allergens? Y ☐ N ☐

If yes, which: _____

What medications are you currently taking? Please also specify how long you have been taking them, for what complaint and dosage

	Medication	For how long	For what complaint	Dose
Prescription				
Non-Prescription				
Supplements/ Vitamins				
Foods/ Herbs/ Others				

Diet / Lifestyle

Please give a selection of what you normally eat for:

Breakfast _____

Lunch _____

Dinner _____

In between Meals/ Snacks _____

Fluids (how much, how often)

Tea _____ Coffee _____

Alcohol _____ Water _____

Juices _____ Soft Drink _____

Do you, or did you smoke? Y ☐ N ☐ How is your appetite? Weak ☐ Normal ☐ Strong ☐

Do you often have a particular taste in your mouth? Y ☐ N ☐ If yes, describe:_____

Do you experience bloating? Y ☐ N ☐ Are you thirsty generally? Not at all ☐ Not much Normal ☐ Very ☐

How often do you have a bowel movement? _____

Is the consistency closer to: Hard ☐ Soft ☐ Dry ☐ Normal/Formed ☐ Sticky ☐

Do you experience excessive or unusual sweating? Y ☐ N ☐

Do you get cold hands or feet often? Y ☐ N ☐

What has been your average energy level lately between 1 (extremely low) and 10 (abundant energy): _____

How many hours sleep do you get at night? _____ What time do you go to sleep and wake up? _____

Do you dream very much? Y ☐ N ☐ If yes, are they vivid:_____ If yes, are they disturbing: _____

Do you fall asleep easily? Y ☐ N ☐ If no, how long does it take? _____ Do you sleep lightly? Y ☐ N ☐

Do you often wake through the night? Y ☐ N ☐ If yes, how often:_____ If yes, what wakes you: _____ Do you wake up feeling refreshed? Y ☐ N ☐

Communicable Diseases

Do you have any contagious illness? Y ☐ N ☐ If yes, which? _____

Family History

Are there are any health issues that run in the family such as asthma, eczema, diabetes, cancer, stroke, or heart disease for example?

Review of Systems

***Y**es/ **N**o/ **P**revious. If only mild or occasional please tick yes, no if never experienced, and previous if an old issue.*

Cardiovascular-Circulatory-Hematological	**Yes**	**No**	**Previous**
Heart Disease	Y ☐	N ☐	P ☐
Chest Pain	Y ☐	N ☐	P ☐
Palpitations	Y ☐	N ☐	P ☐
High Blood Pressure	Y ☐	N ☐	P ☐
Low Blood Pressure	Y ☐	N ☐	P ☐
Stroke	Y ☐	N ☐	P ☐
Swelling of Ankles	Y ☐	N ☐	P ☐
Varicose Veins	Y ☐	N ☐	P ☐
Easy Bleeding	Y ☐	N ☐	P ☐
Easily Bruised	Y ☐	N ☐	P ☐
Anemia	Y ☐	N ☐	P ☐

Musculoskeletal			
Muscle Cramps	Y ☐	N ☐	P ☐
Arm Pain	Y ☐	N ☐	P ☐
Upper Back Pain	Y ☐	N ☐	P ☐
Mid Back Pain	Y ☐	N ☐	P ☐
Lower Back Pain	Y ☐	N ☐	P ☐
Shoulder Pain	Y ☐	N ☐	P ☐
Leg Pain	Y ☐	N ☐	P ☐
Joint Pain	Y ☐	N ☐	P ☐
Neck Pain	Y ☐	N ☐	P ☐

Head			
Headaches	Y ☐	N ☐	P ☐
Migraines	Y ☐	N ☐	P ☐
TMJ/ Jaw Problems	Y ☐	N ☐	P ☐

Respiratory			
Asthma	Y ☐	N ☐	P ☐
Persistent Cough	Y ☐	N ☐	P ☐
Difficulty Breathing	Y ☐	N ☐	P ☐
Frequent Colds	Y ☐	N ☐	P ☐
Shortness of Breath	Y ☐	N ☐	P ☐

Neurological			
Dizziness	Y ☐	N ☐	P ☐
Loss of Balance	Y ☐	N ☐	P ☐
Muscle Weakness	Y ☐	N ☐	P ☐
Numbness	Y ☐	N ☐	P ☐
Tingling	Y ☐	N ☐	P ☐
Seizures	Y ☐	N ☐	P ☐
Epilepsy	Y ☐	N ☐	P ☐
Memory Loss	Y ☐	N ☐	P ☐
Insomnia	Y ☐	N ☐	P ☐

Gastrointestinal			
Ulcers	Y ☐	N ☐	P ☐
Nausea/ Vomiting	Y ☐	N ☐	P ☐
Passing Gas	Y ☐	N ☐	P ☐
Heartburn	Y ☐	N ☐	P ☐
Belching	Y ☐	N ☐	P ☐
Liver Disease	Y ☐	N ☐	P ☐
Abdominal Pain	Y ☐	N ☐	P ☐
Hemorrhoids	Y ☐	N ☐	P ☐
Blood in Stool	Y ☐	N ☐	P ☐
Undigested Food in stool	Y ☐	N ☐	P ☐
Diarrhea	Y ☐	N ☐	P ☐
Constipation	Y ☐	N ☐	P ☐
Alternating Bowel Movements	Y ☐	N ☐	P ☐

Nose, Ear, Throat, Mouth			
Sinus Problems	Y ☐	N ☐	P ☐
Hay Fever	Y ☐	N ☐	P ☐
Loss of Smell	Y ☐	N ☐	P ☐
Nose Bleeds	Y ☐	N ☐	P ☐
Impaired Hearing	Y ☐	N ☐	P ☐
Ear Ringing	Y ☐	N ☐	P ☐
Earaches	Y ☐	N ☐	P ☐
Dry Throat	Y ☐	N ☐	P ☐
Sore Throat	Y ☐	N ☐	P ☐
Phlegm/ Mucus Production	Y ☐	N ☐	P ☐

Endocrine			
Hypo/Hyperthyroid	Y ☐	N ☐	P ☐
Diabetes	Y ☐	N ☐	P ☐
Excessive Hunger	Y ☐	N ☐	P ☐
Night Sweats	Y ☐	N ☐	P ☐
Feelings of Hot or Cold	Y ☐	N ☐	P ☐
Hot flushes	Y ☐	N ☐	P ☐
Swollen Glands	Y ☐	N ☐	P ☐

Integumentary			
Lumps	Y ☐	N ☐	P ☐
Itching	Y ☐	N ☐	P ☐
Hair Loss	Y ☐	N ☐	P ☐
Brittle Nails	Y ☐	N ☐	P ☐

Genitourinary			
Painful Urination	Y ☐	N ☐	P ☐
Difficult Urination	Y ☐	N ☐	P ☐
Frequent Urination	Y ☐	N ☐	P ☐
Urinary Dribbling/Leaking	Y ☐	N ☐	P ☐
Urination at Night	Y ☐	N ☐	P ☐
Kidney Stones	Y ☐	N ☐	P ☐
Blood in Urine	Y ☐	N ☐	P ☐
Urinary Tract Infections	Y ☐	N ☐	P ☐
Small Bladder Capacity	Y ☐	N ☐	P ☐

Female Reproductive			
Age of first Menses?			
Age of Menopause? _____ (please provide information still about a typical cycle before menopause, see below)			
Date when last menstruation started			
Duration of menstrual cycle? (ie, 28, 30, 32)			
Duration of bleeding in days			
Irregular Cycles	Y ☐	N ☐	P ☐
PMS	Y ☐	N ☐	P ☐
Period Pain	Y ☐	N ☐	P ☐
Heavy Flow	Y ☐	N ☐	P ☐
Spotting	Y ☐	N ☐	P ☐
Clotting	Y ☐	N ☐	P ☐
Vaginal Discharge	Y ☐	N ☐	P ☐
Endometriosis	Y ☐	N ☐	P ☐
Ovarian Cysts	Y ☐	N ☐	P ☐
Breast Lumps	Y ☐	N ☐	P ☐
Breast Tenderness	Y ☐	N ☐	P ☐
Low Libido	Y ☐	N ☐	P ☐
Pain with Intercourse	Y ☐	N ☐	P ☐
Vaginal Dryness	Y ☐	N ☐	P ☐
STD's	Y ☐	N ☐	P ☐
Birth Control	Y ☐	N ☐	P ☐
What type?			
Number of pregnancies			
Number of live births			
Number of miscarriages			
Number of abortions			
Difficulty Conceiving	Y ☐	N ☐	P ☐

Male Reproductive			
Hernia	Y ☐	N ☐	P ☐
Sexual Difficulties	Y ☐	N ☐	P ☐
Low Libido	Y ☐	N ☐	P ☐
Impotence	Y ☐	N ☐	P ☐
Premature Ejaculation	Y ☐	N ☐	P ☐
STD's	Y ☐	N ☐	P ☐
Prostate Problems	Y ☐	N ☐	P ☐
Testicular Swelling/Pain	Y ☐	N ☐	P ☐
Testicular Pain	Y ☐	N ☐	P ☐

Mental, Emotional			
Mood Swings	Y ☐	N ☐	P ☐
Nervousness	Y ☐	N ☐	P ☐
Bi-Polar	Y ☐	N ☐	P ☐
ADHD	Y ☐	N ☐	P ☐
Suicidal Tendencies	Y ☐	N ☐	P ☐
Mental Tension	Y ☐	N ☐	P ☐
Do you tend to:			
Get irritable/ frustrated/angry	Y ☐	N ☐	P ☐
Worry	Y ☐	N ☐	P ☐
Think too much	Y ☐	N ☐	P ☐
Be anxious or fearful	Y ☐	N ☐	P ☐
Be sad or depressed	Y ☐	N ☐	P ☐

Eyes			
Impaired Vision	Y ☐	N ☐	P ☐
Night Blindness	Y ☐	N ☐	P ☐
Blurriness	Y ☐	N ☐	P ☐
Spots in vision/floaters	Y ☐	N ☐	P ☐
Eye Pain/ Strain	Y ☐	N ☐	P ☐
Glaucoma	Y ☐	N ☐	P ☐
Cataracts	Y ☐	N ☐	P ☐
Watering/Tearing Eyes	Y ☐	N ☐	P ☐
Red Eyes	Y ☐	N ☐	P ☐

Immune			
Low-grade Fever	Y ☐	N ☐	P ☐
Chronic Infections	Y ☐	N ☐	P ☐
Slow Wound Healing	Y ☐	N ☐	P ☐
Cold sores	Y ☐	N ☐	P ☐

Have you had any noticeable reactions from any immunizations?

Is there any other health issues or symptoms that you have?

Please list any skin conditions you may have:

Thank you for filling in this form. The next thing I will do to complete the picture of your health is pulse and tongue diagnosis. I will review your form and ask if you have any questions before recommending a treatment strategy.

Practitioner Only

Pulse: Date:

L. Cun -

Guan -

Chi -

R. Cun -

Guan -

Chi -

Tongue: Body Colour

Coat Sub. Veins

Acupuncture:

Herbs

Other herbs to think of:

No of Packets – Cost of Herbs – Cost of Consult – Other –

Total =

Other Recommendations: