Cleveland Clinic
Wellness

Tanya I. Edwards MD Center for Integrative Medicine
Traditional Chinese Herbal Therapy Intake Form

Name _____ CLINIC # _____
Last, First Middle

Date of Birth:_____ Gender: ☐M ☐F

Your e-mail: _____

Personal Physician:_____ Address:_____

Emergency Contact:_____ Phone:_____

How did you hear about Traditional Chinese Herbal Therapy?

☐Physician:_____ ☐ Friend:_____ ☐ Pamphlet ☐ Seminar ☐ Other:_____

Purpose for Visit

Main issue(s), in order of significance to you:

1.	☐ Severe	☐ Moderate	☐ Slight	☐ Normal	_____
2.	☐ Severe	☐ Moderate	☐ Slight	☐ Normal	_____
3.	☐ Severe	☐ Moderate	☐ Slight	☐ Normal	_____
4.	☐ Severe	☐ Moderate	☐ Slight	☐ Normal	_____

How do these conditions impair your daily activities?_____

Other treatments you have used:_____

How long have you had these symptoms?_____

What makes your symptoms better?_____ Worse?_____

Have you received a medical diagnosis? ☐ Yes ☐ No If yes, what is it?_____

Current Medications: _____

Food Allergies ☐ Yes ☐ No If yes, circle all that apply: Soy, Gluten, Wheat, Tree Nuts, Citrus, Sesame, Latex, Other_

_____

Medication Allergies: _____

Please check all that apply: ☐ Pregnant ☐ Pacemaker ☐ Lymphedema ☐ Infection of skin; location:_____

Patient Medical History

How was your childhood health? _____
Hospital visits/stays: _____
Immunizations: _____
Surgeries: _____

EMOTIONS & SLEEP:

How do you feel emotionally?_____

Are you: ☐ Married/Stable Relationship ☐ Single ☐ Widowed How do you feel about your relationship?_____

How do you hold your stress?_____

How do you relax?_____

How would you rate your stress level? (0 little or no stress to 10 high stress):_____

How long do you normally sleep? _____ Hours a night Do you feel rested upon waking? _____

Do you have any of the following (please check all those that apply):

√	Overall Temperature (KI Fxn)
	Cold Hands
	Cold Feet
	Sweaty Hands
	Sweaty Feet
	Hot body temperature (sensation)
	Cold body temperature (sensation)
	Afternoon flushes
	Night sweats
	Heat in the hands, feet and chest
	Hot flashes any time of the day
	Thirsty
	Perspire easily
	Lack of perspiration
	Take water to bed
	Difficulty keeping eyes open in the daytime

√	Overall Energy (LU,KI Fxn)
	Shortness of breath
	Difficulty keeping eyes open in the daytime
	General Weakness
	Easily catch colds
	Feel worse after exercise

√	Blood (LIV,SP,HT Fxn)
	Dizziness
	See floating black spots

√	HT Fxn
	Palpitations
	Anxiety
	Sores on the tip of the tongue
	Restlessness
	Mental confusion
	Chest pain traveling to shoulder
	Frequent dreams
	Wake unrefreshed
	Drink coffee (#of cups per day:___)

√	LU Fxn
	Nasal discharge (Color:_____)
	Cough
	Nose bleeds
	Sinus congestion
	Dry mouth
	Dry throat
	Dry nose
	Dry skin
	Allergies (to what?_____)
	Alternating fevers and chills
	Sneezing
	Headache (location:_____)
	Overall achy feeling in the body
	Stiff neck
	Stiff shoulders
	Sore throat
	Difficulty breathing
	Smoke cigarettes (#per day:___)
	Sadness
	Melancholy

√	SP Fxn
	Low appetite
	Abrupt weight gain
	Abrupt weight loss
	Abdominal bloating
	Abdominal gas
	Gurgling noise in the stomach
	Fatigue after eating
	Prolapsed organs (organ:_____)
	Easily bruised
	Hemorrhoids
	Pensive/Reflective/Day dreaming
	Over thinking
	Worry

√	SP,ST,LI,SI Fxn
	Loose stool
	Constipation
	Incomplete bowel movements
	Diarrhea
	Blood in stool
	Mucous in stool
	Undigested food in stool
	General sensation of heaviness in the body
	Mental sluggishness
	Mental fogginess
	Swollen hands
	Swollen feet
	Swollen joints
	Chest congestion
	Nausea
	Snoring

√	ST Fxn
	Burning sensation after eating
	Large appetite
	Bad breath
	Mouth(canker) sores
	Bleeding, swollen or painful gums
	Heartburn
	Acid regurgitation
	Ulcer (diagnosed)
	Belching
	Hiccups
	Stomach Pain
	Vomiting
	Sensitive to medications
	Prone to drug's adverse reactions

√	LIV,GB Fxn
	Alternating loose and hard stool
	Chest pain
	Tight sensation in chest
	Bitter taste in mouth
	Anger easily
	Frustration
	Depression
	Irritability
	Frequent inability to adapt to stress
	Skin rashes
	Headaches at the top of the head
	Tingling sensation
	Numbness
	Muscle Spasms
	Muscle twitching
	Muscle cramping
	Seizures
	Convulsions
	Lump in throat
	Neck tension
	Limited range of motion, neck
	Shoulder tension
	Limited range of motion, shoulder
	Drink alcohol
	Recreational drugs
	High pitched ringing in the ears
	Gall stones
	Sexually transmitted disease

√	Eyes (LIV Fxn)
	Itchy
	Bloodshot
	Hot
	Dry
	Watery
	Gritty
	Blurred vision
	Decreased night vision
	Near-sighted
	Far-sighted

√	Libido
	Normal
	High
	Low

√	KI,UB Fxn
	Frequent cavities
	Easily broken bones
	Sore knees
	Weak knees
	Cold sensation in the knees
	Low back pain
	Poor memory
	Excessive hair loss
	Low-pitched ringing in the ears
	Kidney stones
	Bladder infections
	Frequent night time urination
	Lack of bladder control
	Fear
	Easily startled

√	Urination
	Normal color
	Dark yellow
	Clear
	Reddish
	Cloudy
	Scanty
	Profuse
	Strong odor
	Burning
	Painful
	Difficult
	Urgent
	Frequent

√	Overall Temperature (KI Fxn)
	Cold Hands
	Cold Feet
	Sweaty Hands
	Sweaty Feet
	Hot body temperature (sensation)
	Cold body temperature (sensation)
	Afternoon flushes
	Night sweats
	Heat in the hands, feet and chest

√	Women Only
	Regular cycle? ___Y ___N
	Date of last period:_____
	Infertility? ___Y ___N
	Number of children:_____
	Age of first menstruation:_____
	Average # of days of flow:_____
	Average # of days of cycle:_____
	Pregnant? ___Y ___N
	Number of pregnancies:_____
	Number of miscarriages:_____
	Number of abortions:_____
	Age of menopause:_____
	Vaginal discharge: ___Severe ___Moderate ___Slight ___Normal
	Menstrual bleeding: ___Severe ___Moderate ___Slight ___Normal ___Clots __Spotting
	Color of menses:_____
	Irregular menstruation
	Vaginal itching/burning
	Uterine fibroids
	Birth control use; what type:_____
	Do you experience any of the following PMS symptoms:
	Nausea
	Headaches
	Migraines
	Anxiety
	Food cravings
	Irritability
	Breast swelling
	Breast tenderness
	Depression
	Bloating
	Vomiting
	Dull pain, where?_____
	Sharp pain, where?_____
	Pain before period
	Pain during period
	Pain after period

√	Men Only
	Swollen Testes
	Testicular Pain
	Impotence
	Premature Ejaculation
	Feeling of cold or numb in testicles

Women Only

☐ Not Applicable

Please fill in the following menstrual chart:

☐ I no longer have periods

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other:							
History of fertility problems? Please provide details.							

PLEASE COMPLETE IF YOU ARE SEEKING TREATMENT FOR PAIN:

☐ No pain

Please describe your pain level (0 no pain at all to 10 being the worst):

0.....2.....3.....4.....5.....6.....7.....8.....9.....10

Do any of the following lesson the pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other:_____

Do any of the following worsen the pain?

☐ Pressure ☐ Cold ☐ Heath ☐ Exercise ☐ Other:_____

Location of pain: _____

How long have you had pain? _____years _____months _____days

How often are you experiencing pain: _____

What makes the pain worse:_____

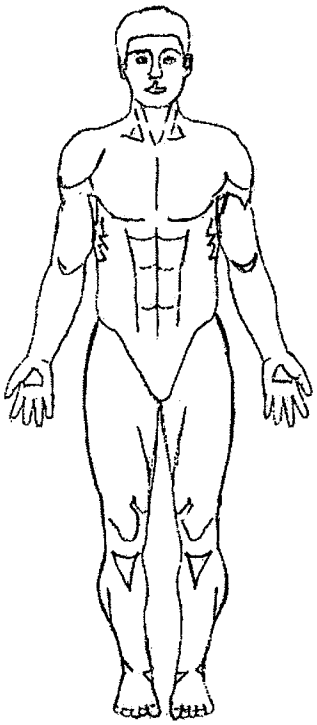
Pain character: ☐ Dull ☐ Sharp ☐ Cramping ☐ Burning ☐ Radiating ☐ Ache ☐ Moves ☐ Numb ☐ Tingling

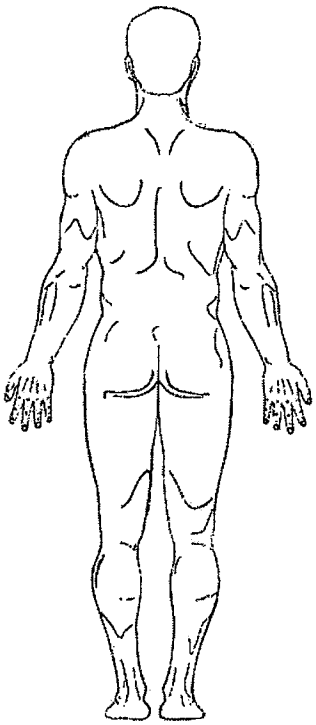
When did pain begin: _____

Was pain caused by an injury: ☐ Yes:_____ ☐ No

Prior treatment: ☐ Medication ☐ Blocks/Injections ☐ Surgery ☐ PT ☐ Chiropractor ☐ Massage ☐ Other:_____

Using the letters at the bottom of the page to describe your pain, indicate directly on the figures the area(s) where you are experiencing pain.

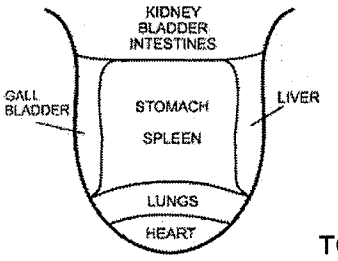




D- Dull	**S- Sharp**	**C – Cramping**	**B – Burning**
R – Radiating	**M – Moves About**	**N – Numbness**	**T – Tingling**
X – Scars from injury or surgery	**A – Ache**	**O – Rashes, Skin Disorders**	**Other:**

****For Practitioner Only****

TCM Tongue Dx:



TCM Tongue Characteristics:_____

TCM Pulse Dx:

Left Side

	Cun	Guan	Qi
Floating			
Mid			
Deep			

Right Side

	Cun	Guan	Qi
Floating			
Mid			
Deep			

TCM Pulse Characteristics:_____

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Traditional Chinese Herbal Therapy Information

Chinese herbal medicine is a major part of Traditional Chinese Medicine. It has been used for centuries in China, where herbs are considered fundamental therapy for many acute and chronic conditions. Chinese herbs can treat a variety of disorders, but they are not a substitute for conventional medical treatment and diagnoses.

I understand that different disorders may require different length of the treatment that may range from few days to a few years. I am aware that it may take a few weeks to notice subtle changes and up to 3 months for the herbal formula to reach its therapeutic potential. It is also important to note that because everyone responds to treatment differently, Traditional Chinese Herbalist cannot guarantee the outcome of the treatment.

I understand that the herbs and nutritional supplements (which are from plant, animal, or mineral sources) that have been recommended are traditionally considered safe but some allergic reactions or other side effects (i.e. nausea, gas, stomach ache, vomiting, headache, diarrhea, and rashes) may occur.

I understand that it is important to provide complete information about all medications and nutritional supplements that I am taking in order to avoid any possible interactions with Chinese herbs.

I confirm that counseling and treatment instructions have been provided to me, including but not limited to the need for herbal therapy, patient instructions on how to take the herbal therapy, explanation of possible contraindications and adverse reactions.

I have been instructed on sources of care in case of an adverse reaction. I have been instructed to inform my health care providers (Physicians, pharmacists, etc.) of the herbal therapy that has been provided to me.

I, the undersigned, have read and understand the above statements and have had the opportunity to ask questions regarding my treatment.

_____ _____

Signature of Patient Date

_____ _____

Signature of Practitioner Date