Brilliant Health Medicine, LLC
At Wholesome Family Medicine
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Welcome!
Initial Intake Form
Please fill out as completely as you can
Send forms to fax: 541-851-9322, email to frontdesk@wholesomefamilymedicine.com or drop them by our clinic before your appointment time.
Thank you and we can't wait to help you!

Name:____________________________________Preferred Name (if any)________________

Age:______ DOB: _____________________ Gender:__________________

Occupation: ____

Address:____

Email Address:____

Emergency Contact/Relation:____

Primary Physician Name + phone: ____

Have you received Acupuncture + Chinese Herbs Before? Y N

How did you hear about us?

What are your expectations or hopes with receiving Acupuncture and Oriental Medicine?

Primary Issue you are hoping to treat:

Secondary Issue:

Past History:

When did your primary complaint start, and how long have you had it?

What kinds of treatments/therapies/surgeries have you had for it?

Medications for it? Did they help?

Any medication allergies? Reaction? ____

Current Medications:

____

____

____

Current Supplements and Vitamins:

____

____

____

Current therapies:

____

____

History of Surgeries, Hospitalizations:

____

____

____

Review of Systems

1. TEMPERATURE
    a. Do you usually run warm or cool? Feet, hands, low back, abdomen, etc. ________
    b. Does time of day affect this? _________
    c. Numbness or tingling anywhere? ___________________________________
2. PERSPIRATION
    a. Do you perspire? ______
    b. Do you feel your perspiration is normal? Excessive or not enough? ____________
    c. Any odors with perspiration? _____________
    d. Do you have night sweats? __________
    e. Do you sweat easily or spontaneously like when going up the stairs? __________
3. APPETITE
    a. How is your appetite? ____________
        i. Do you eat regular meals? ___________________
        ii. Any food allergies or intolerances? What kind of reaction?

            ____
    b. Any changes in appetite recently? ______________
    c. Any cravings for certain foods? ________________
    d. Weight gain or weight loss?__________________
    e. How is your thirst? _____________________
    f. Prefer hot or cold drinks? _________________
    g. Any feeling of fullness after a meal? Bloating or discomfort? ___________________
    h. Acid reflux or pain? ________________
        i. If so, where? _________________
    i. Tiredness or sleepiness after a meal? _________________
    j. Any unusual tastes in your mouth? (metallic, bitter, sour) ____________________
4. EARS, EYES, NOSE, THROAT, LUNGS, HEART
    a. Dry eyes? Floaters? _____________________
    b. Blurry vision, decreased vision? Eye pain? __________________

c. Contacts or glasses? ___________________

d. Do you wake up with stuffed nose or phlegm in nose? _________________

   i. If so, what color is it? _______________

   ii. Thick or thin discharge? _______________

e. Do you have seasonal allergies? Symptoms? ____________________________

f. Ear infections or earaches? ___________________________

g. Deafness, or Tinnitus? (High or low pitched and time of day?)

____

h. Do you experience a lump, or phlegm in throat? ________________________

i. Acid reflux, trouble swallowing? ______________________

j. Do you have any lung issues? ____

k. Do you cough up phlegm? _______________

   i. If so, what color? Dry phlegm that you can't cough out? Or easy to expectorate? How often, seasonal, with illness?

   ____

l. History of asthma or any other respiratory disease? ______________________

m. Fullness in chest? ____________

n. Shortness of breath or breathlessness? __________________

o. Heart palpitations? If so, what time of day? __________________

p. Chest pain or oppression? Radiating pain? _____________________

5. DEFECATION AND URINATION

a. Constipation or diarrhea? ______________________

b. How many times per day do you have a BM? ____________________

c. What is the consistency of your stool: loose, diarrhea, formed and easy to pass (the golden banana), hard or dry, difficult to pass, small hard pieces?

____

d. Any pain or difficulty? ________________________

e. Do you feel BM is complete or incomplete? _____________________

f. Any blood or straining? ________________________

i. If yes, is blood bright red or dark/tarry? ___________________________

g. Color of BM: White, tan, terra-cotta, dark brown, tarry/black? _______________

h. Any undigested food, or mucus in stool? ________________________________

i. Urination- scanty or profuse? ____________________________

i. Difficulty with stream, pain, or dribbling? History of UTIs?

____

ii. Water per day in oz/cups? _____________________________________

j. Color of urine clear, yellow dark or cloudy? ______________________________

6. PAIN (Head, Body, Chest, Abdomen, Eyes, Ears)

a. Where is your pain?

____

b. Is it fixed, or does it migrate? ______________________________

c. Worse or better with pressure? ____________________________

d. Worse or better with heat? _________________________

e. Worse or better with cold? __________________________

f. Does it come and go? _____________________________

g. Any headaches? ___________________________________

i. If so, Top of head, back of head, sides of head, forehead, eyes, or whole head? ______________________________________

ii. Kind of pain: heavy, throbbing, sharp, dull? __________________________

h. Vertigo or dizziness? What time of day? _______________________________

i. Swelling/ Edema. What part of your body? _____________________________

7. SLEEP

a. Do you sleep well? __________________________

b. How many hours? _____________________

c. What time do you usually go to bed/wake up? ____________________________

d. Do you have trouble falling asleep? ____________________________

e. Do you have trouble STAYING asleep? ____________________________

f. Any trouble getting out of bed in the morning? ________________________

g. Any recurring dreams or nightmares?

____

8. REPRODUCTIVE - Woman
   a. Is your period the same time each month? __________________
   b. How far apart is your cycle, i.e. 28 days? ____________________
   c. Is your flow heavy or light? ________________________________
   d. What color is it? ____
   e. Any clots? How big, Dark or light colored? _______________________
   f. Vaginal discharge now or in the past? What color? Does it have an odor? Light or heavy? ____
   g. PMS?
      i. Do you have irritability, distended painful breasts, sadness/crying, anger, emotional mood swings, cravings (what for?)?

         ____

      ii. Do you have menstrual cramps during PMS? Before period? During period? At end or after period?

         ____

      iii. Do you have fatigue? Before, during or after period? _________________
      iv. Do you notice a lowered immune system around monthly menses?

         ____

9. REPRODUCTIVE- Men
   a. Do you feel that you have a high/normal/low libido? ___________________
   b. Any erectile dysfunction? ____________________
      i. If yes, do you get spontaneous morning erections? _______________
10. EMOTIONS
    a. Predominant emotion? ______________________________________
    b. Do you feel good about your emotional /mental health? ___________
    c. Do you feel you have enough support/support system? _____________

d. Have you had any therapy? Did it help or not?

   ____

e. Do you ever/have you ever had thoughts of suicide or hurting yourself?

   ____

f. Have you ever been the victim of abuse, or in an abusive relationship of any kind: physical, emotional, financial, verbal? __________________________________

g. Have you ever experienced a heart shock (a traumatic experience or profound loss)? When? Details as you wish to share.

   ____

11. Energy Level each day? ____
12. Stress Levels? ___________________________________
    a. Hobbies/activities you enjoy to relieve stress? _____________________________
13. Exposure to EMF (electromagnetic fields- close cell phone tower, smart meter, etc?)

    ____
14. Sunlight you receive each day? ____
15. Use of stimulants, caffeine, drugs, alcohol? ________________________________
16. Smoking yes or no, cigarettes, marijuana etc? _____________________________
17. Any other thing you think we should know?