Yan Guo L.Ac.
600 Jefferson Plaza #350, Rockville, MD 20852

Patient Intake Information Form

IDENTIFICATION

Name____ Sex ◯M ◯F Date_____________

Address_________________________________City_____________State__________Zip___________

Preferred Telephone____________________________Email__________________________________

Date of Birth__________________ ◯Single ◯Married ◯Partnered ◯Widowed ◯Separated/Divorced

Occupation_________________________________Height______________Weight_________________

Emergency contact_________________________Relationship___________Phone__________________

Name of physician*___________________________________Phone___________________

Name of counselor/psychologist*_________________________Phone___________________

Name of gynecologist*__________________________________Phone___________________

*No contact will be made without your permission.

Special problems or symptoms

Any allergies/sensitivities____

Any bleeding disorders____

Any infectious disease____

FAMILY HISTORY

Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an “X” or the date in the appropriate box or boxes.

	Self	Mother	Father	Sibling	Spouse/ partner	Children
Adopted						
Good Health						
Diabetes						
Thyroid disorder						
High blood pressure/heart disease/stroke						
Blood disorders/anemia						
Alcohol or other drug use						
Depression or mental illness						
Hepatitis/other liver disorder						
Musculoskeletal disorder						
HIV/AIDS						
Deceased(age)						

PERSONAL LIFESTYLE HABITS

For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs per day)________Coffee/Tea (Cups per day)_________Alcohol (drinks per week)____

Drug use (recreational)__________________Soda (regular or diet)_________________

Exercise ◯Yes ◯No How often?________________ What kind of exercise?__________________

MEDICAL if you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please all of them below: (do not include normal pregnancies).

YEAR	OPERATION/ILLNESS	HOSPITAL OR TREATMENT LOCATION

MEDICINES Please list all medications, vitamins and/or food supplements you are currently taking:

Medications__________________ Dosage________________ For what condition_____________

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Medications__________________ Dosage________________ For what condition_____________

Vitamins_____________________ Dosage________________ For what condition______________

Vitamins_____________________ Dosage________________ For what condition______________

CURRENT AND PAST CONDITIONS/SYMPTOMS/TRAUMAS

If you are currently experiencing any of the following, please mark it with a “C”. if you have experienced any of the following in the past, please mark it with a “P”. Mark “P-C” if you have experienced the condition both in the past and currently.

General

_______ Insomnia
_______ Dreams/nightmares
_______ Fatigue
_______ Poor memory
_______ Strongly like cold drinks
_______ Strongly like hot drinks
_______ Recent weight loss/gain
_______ Cold hands & feet
_______ Chills
_______ Fever
_______ Bad breath
_______ Other (describe) _______

Head & Neck

_______ Headaches
_______ Migraines
_______ Stiff neck
_______ Dizziness
_______ Fainting
_______ Swollen glands
_______ Other (describe) ______________

Ears

_______ Ringing
_______ Hearing loss
_______ Hearing aids
_______ Infections
_______ Earache
_______ Vertigo
_______ Other (describe) ________________

Eyes

_______ Glasses/contact lenses
_______ Blurred vision
_______ Poor night vision
_______ Spots or floaters
_______ Eye inflammation
_______ Double vision
_______ Glaucoma
_______ Cataracts
_______ "Lazy" eye
_______ Other (describe)
_______ ________________
_______ How often checked? _______

Nose, Throat & Mouth

_______ Sinus infection
_______ Hay fever/allergies
_______ Frequent sore throat
_______ Difficulty swallowing
_______ Mount & tongue ulcers
_______ Frequent colds
_______ Nosebleed
_______ Dry nose
_______ Nasal congesting
_______ Loss of voice
_______ Thirst
_______ Excessive phlegm
_______ TMJ
_______ Facial pain
_______ Gum problems
_______ Dry mouth
_______ Other (describe) _______
_______ Dental problems? Last visit _______

Skin

_______ Hives
_______ Rashes
_______ Eczema/psoriasis
_______ Night sweating
_______ Excess sweating
_______ Dry skin
_______ Easily bruised
_______ Changes in moles, lumps
_______ Itching
_______ Other (describe) ___________________

Respiratory

_______ Difficulty breathing
_______ Difficulty breathing when reclining
_______ Wheezing
_______ Asthma
_______ Chronic cough
_______ Wet cough
_______ Dry cough
_______ Coughing up phlegm
_______ Coughing up blood
_______ Shortness of breath
_______ Tight chest
_______ Pneumonia
_______ Other (describe) _____________________

Cardiovascular

_______ High blood pressure
_______ Low blood pressure
_______ Chest pain or tightness
_______ Palpitation
_______ Rapid heart beat
_______ Irregular heart beat
_______ Poor circulation
_______ Swollen ankles
_______ Phlebitis
_______ Anemia
_______ History of heart disease
_______ Heart murmur
_______ Night sweats
_______ Tendency to be cold
_______ Tendency to be warm
_______ Other (describe) _______

Gastrointestinal

_______ Nausea
_______ Indigestion
_______ Stomach pain
_______ Diarrhea
_______ Constipation
_______ Poor appetite
_______ Excessive hunger
_______ Vomiting
_______ Gas
_______ Hiccups
_______ Acid regurgitation
_______ Bloating
_______ Laxative use
_______ Blood stool
_______ Other (describe) _______

Musculoskeletal

_______ Joint pain/swelling
_______ Sore muscles
_______ Weak muscles
_______ Difficulty walking
_______ Pain (Describe) ________________ ________________ ________________
_______ Limited range of motion
_______ Other (describe) ________________

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Neurological

______ Seizures
______ Tremors
______ Numbness or tingling
______ Pain (describe)
______ Paralysis
______ Poor coordination
______ Other (describe)
____

Mental/Emotional

______ Depression
______ Mood swings
______ Irritability
______ Difficulty relaxing
______ Loneliness
______ Sensitive
______ Shyness
______ Frequent Crying
______ Worries frequently
______ Compulsive behaviors
______ Difficulty focusing
______ Hopeless outlook
______ Suicidal thoughts
______ Lose temper
______ Frustration
______ Other (describe)
____

Urinary

______ Pain on urination
______ Frequent urination
______ Urgent urination
______ Blood in urine
______ Incontinence
______ Incomplete urination
______ Bedwetting
______ Wake to urinate
______ History of UTI
______ Kidney (specify)
____
____
______ Other (describe)
____

Male Genital

_______ Impotence
_______ Premature ejaculation
_______ Nocturnal emission
_______ Pain/itching of genitalia
_______ Lumps in testicles
_______ Increased libido
_______ Decreased libido
_______ Breast checked
_______ Other (describe)
____

Gynecology (Women Only)

_______ Currently pregnant
_______ # of Pregnancies
_______ # of Live births
_______ # of Miscarriages
_______ # of Abortions
_______ Menopause
_______ Irregular periods
_______ Menstrual cramps
_______ Excessive blood flow
_______ Menstrual blood clots
_______ Breast tenderness
_______ Abnormal pap smear
_______ Vaginal infections
_______ Vaginal pain/itching
_______ Uterine fibroids
_______ Endometriosis
_______ Breast lumps, cysts
_______ Increased libido
_______ Decreased libido
_______ Other (describe)
____

Infection Screening (circle self and/or partner)

_______ HIV risks: self or partner
_______ TB: self or household
_______ Hepatitis risk: self or partner
_______ History of sexually transmitted disease: self or partner (specify)
____
_______ Other (describe)
____

Trauma (list)

____
____
____
____
____

Other information

____
____
____
____
____

Fees

Late Cancellation (Cancellation less than 24-hr notice)	$25.00
Return Check Fee	$25.00
No Show	$25.00

____
Patient Signature

____
Date