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## Patient Intake Form

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Last name: \_\_\_\_\_ First name: \_\_\_\_\_  
Address: \_\_\_\_\_ City/Postal Code: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Children: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Family Physician: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone : \_\_\_\_\_

**Who may we thank for referring you to this clinic:** \_\_\_\_\_

The following questions will help us in determining your treatment plan:

Have you received Traditional Chinese Medicine treatments in the past?    Yes    No

If so, what type of treatments have you received?    Acupuncture    Herbology    Tui Na

Have you been diagnosed with any type of illness by your family doctor or other specialist of Western medicine? If yes please specify: \_\_\_\_\_

Do you have heart disease?    Yes    No    Do you have a pacemaker?    Yes    No

Do you have any allergies? If yes, please specify \_\_\_\_\_

Do you take some medication? If yes please specify \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

## Patient Clinical Form

**Chief Complaint:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Chief complaint history:** How, when and where did this condition start?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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What types of treatments have you tried, if any? \_\_\_\_\_

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What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Please list any other health problems you would like to address in order of importance: \_\_\_\_\_

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**Medical History:** Diseases, Allergies, Surgeries, Accidents/ include years/

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**Family Medical History (Mother, Father, Siblings):**

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**Current medications, supplements and vitamins:**

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**Do you currently have or have you ever had any of the following? Please circle:**

- Anemia   Epilepsy   Fibromyalgia   Arthritis   Diabetes   Multiple Sclerosis  
Schizophrenia   Drug Problem   Digestive Disorders   Bulimia   High cholesterol  
Anorexia   Tuberculosis   Cancer   Hepatitis   HIV   Snoring   Seizures  
High Blood Pressure   Kidney Disease   Osteoporosis   Asthma   Stroke  
Ulcers   Thyroid disease   Kidney Stones   Gall Stones   Alcoholism   AIDS  
Bipolar disorders   Depression   Mania   Mood swings   Irritability   High blood pressure  
Frozen shoulder   Carpal tunnel syndrome   Bleeding disorder

**Lifestyle and Nutrition:**

Do you follow a special diet? Yes   No   If yes, how would you describe the diet?

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What do you eat on a “typical” day?

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Do you crave any particular foods? \_\_\_\_\_

Exercise Yes No How often \_\_\_\_\_ Type \_\_\_\_\_

Sleep: Hours per night \_\_\_\_\_ Rested in the morning? Yes No

Trouble falling asleep? Yes No Trouble staying asleep? Yes No

Work: Enjoy work? Yes No Hours per week working \_\_\_\_\_

Hobbies: \_\_\_\_\_

**Please check all that apply:**

	Yes	No	Quantity		Yes	No	Quantity
Coffee :				Water :			
Tobacco :				Recreational Drugs :			
Alcohol :				Soda pop :			
Cigarettes :				Tea :			

**General Symptoms (please check all that apply):**

0 - never	1 - rarely	2 - occasionally	3 - frequently	4 - always
0 1 2 3 4	poor appetite		0 1 2 3 4	constant hunger
0 1 2 3 4	loose stools		0 1 2 3 4	heartburn/acid reflux
0 1 2 3 4	gas/abdominal bloating		0 1 2 3 4	mouth sores
0 1 2 3 4	fatigue after eating		0 1 2 3 4	belching or vomiting
0 1 2 3 4	hemorrhoids		0 1 2 3 4	gums bleeding
0 1 2 3 4	bruise easily		0 1 2 3 4	thirst
0 1 2 3 4	anemia		0 1 2 3 4	bad breath
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0 1 2 3 4	abnormal sweating		0 1 2 3 4	fatigue
0 1 2 3 4	allergies		0 1 2 3 4	catch colds easily
0 1 2 3 4	asthma		0 1 2 3 4	tired after little exertion
0 1 2 3 4	shortness of breath		0 1 2 3 4	general weakness
0 1 2 3 4	cough		0 1 2 3 4	nasal discharge
0 1 2 3 4	dry nose/mouth/skin/throat		0 1 2 3 4	sinus infection
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0 1 2 3 4	sore, cold or weak knees		0 1 2 3 4	feel cold often
0 1 2 3 4	low back pain		0 1 2 3 4	swollen ankles
0 1 2 3 4	muscle spasm, twitching, cramps		0 1 2 3 4	joint pain

0 1 2 3 4 frequent urination  
0 1 2 3 4 urinary incontinence  
0 1 2 3 4 ear/hearing problems  
0 1 2 3 4 early morning diarrhea

0 1 2 3 4 poor memory  
0 1 2 3 4 hair loss  
0 1 2 3 4 infertility

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0 1 2 3 4 irritable  
0 1 2 3 4 ligament/tendon issues  
0 1 2 3 4 tight feeling in chest  
0 1 2 3 4 alternating diarrhea/constipation  
0 1 2 3 4 sigh frequently  
0 1 2 3 4 neck/shoulder stiffness

0 1 2 3 4 muscle spasms/twitches  
0 1 2 3 4 numb extremities  
0 1 2 3 4 dry irritated eyes  
0 1 2 3 4 ear ringing  
0 1 2 3 4 easy to be anger  
0 1 2 3 4 red eyes

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0 1 2 3 4 feel heart beating  
0 1 2 3 4 insomnia  
0 1 2 3 4 sores on tip of tongue  
0 1 2 3 4 anxiety

0 1 2 3 4 chest pain  
0 1 2 3 4 disturbing dreams  
0 1 2 3 4 restlessness  
0 1 2 3 4 palpitations

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0 1 2 3 4 dizzy upon standing  
0 1 2 3 4 see floaters in eyes  
0 1 2 3 4 heat in palms or soles  
0 1 2 3 4 afternoon fever  
0 1 2 3 4 night sweats  
0 1 2 3 4 frequently flushed face

0 1 2 3 4 feeling of heaviness  
0 1 2 3 4 nausea  
0 1 2 3 4 foggy thinking  
0 1 2 3 4 enlarged lymph glands  
0 1 2 3 4 cloudy urine

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**Energy level:** 1 2 3 4 5 6 7 8 9 10

Notes: \_\_\_\_\_

**Urination:**

Burning      Urgent      Scanty      Difficult      Profuse      Dribbling      Clear  
Deep yellow      Hematuria      Nocturia      Frequency/Volume \_\_\_\_\_

**Bowel Movements:**

Frequency per day \_\_\_\_\_

Constipation    Loose stools    Diarrhea    Undigested food    Early morning diarrhea  
 Consistency (circle):    Well-formed    Hard    Loose    Alternates between formed and loose  
 Do you ever notice any undigested food, blood or mucous? \_\_\_\_\_  
 Are you Thirsty?    Yes    No    If so, do you prefer warm or cold drinks? \_\_\_\_\_  
 Upon waking, do you have a Bitter taste in your mouth? \_\_\_\_\_  
 Do you find that you like particularly Hot or Cold? \_\_\_\_\_  
 How is your Energy in general? \_\_\_\_\_  
 Do you often get Headaches or Migraines?    Yes    No  
 How do you feel emotionally right now? \_\_\_\_\_  
 Sweating:  
 Spontaneous    Night sweating    Profuse cold    Odor: \_\_\_\_\_  
 Sex drive:    Low    High    Medium

**Pain :**

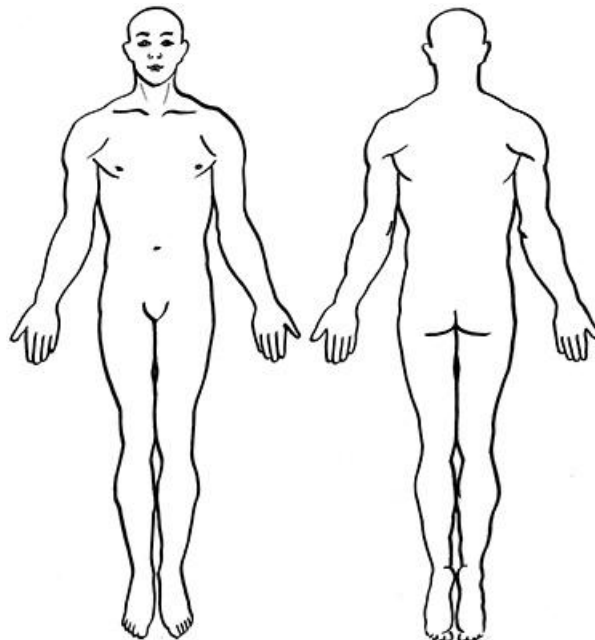
Headache    Chest    Upper abdominal    Lower abdominal    Lumbago  
 General body ache    Acute    Chronic    Persistent    Lingering  
 Relieved by Heat / Cold / Pressure / Massage    Aggravated by Heat / Cold / Pressure / Massage

Are you experiencing pain or discomfort in any area of your body?    Yes    No

If yes, please indicate the location of the pain by using the symbols that best describes your feeling:

XXX - sharp stabbing pain    OOO - pins/needles    NNN - numbness    PPP - dull pain

Use the following illustration to indicate painful or distressed areas:



**For Women Only:**

Are you currently pregnant? Yes No      Are you on the birth control pill? Yes No

Indicate the number of occurrences:

Pregnancies\_\_\_\_\_ Live births\_\_\_\_\_ Miscarriages\_\_\_\_\_ Abortions\_\_\_\_\_ D&C\_\_\_\_\_

How old were you when you had your first period? \_\_\_\_\_

Have you experienced menopause? (if applicable) Yes No      When? \_\_\_\_\_

If you are experiencing menopausal symptoms, please describe: \_\_\_\_\_

Do you have a vaginal discharge? Yes No Please describe the color and smell \_\_\_\_\_

Is your period regular? Yes No When was the first day of your last period? \_\_\_\_\_

Average number of days of flow: \_\_\_\_\_ Flow is: Light Normal Heavy

Color is: Pale Normal Dark Bright Red Brown Purple

Blood clots: Yes No

Do you get pain or cramps? Yes No      Severe: Yes No

Nature of pain (circle):

Sharp Dull Constant Intermittent Burning Aching

Do you experience any of the following before or during your menstrual period?

Edema Breast tenderness/swelling Depression Irritability Migraines

Insomnia Diarrhea Constipation Nausea Hot flashes Night sweating

Headache Fatigue Difficulty with orgasm PMS Pain with intercourse

Vaginal discharge

Do you have a history of the following:

Amenorrhea Breast implants Yeast infection Endometriosis Hysterectomy Infertility Ovarian cyst

Polycystic ovaries Pelvic inflammatory disease(PID) Uterine fibroids

When did you have your last Pap smear? \_\_\_\_\_ Last Mammogram \_\_\_\_\_

Any history of abnormal tests: Yes No

**For Men Only:**

Do you have any bothersome urinary symptoms? Yes No

Date of your last prostate Check up: \_\_\_\_\_ Results: \_\_\_\_\_

General health symptoms:

Groin pain Decreased libido Pain or swelling of testicles Impotence Increased libido

Painful urination Difficult urination Frequent need to urinate at night Dribbling urination

Incontinence Premature ejaculation Nocturnal emissions Difficulty with orgasm

## For the Practitioner use only:

- 1.Pain 2.Food/taste 3.Stools/urine 4.Thirst/drink 5.Energy level  
6.Head/face/body 7.Chest/abdomen 8.Limbs 9.Sleep 10.Sweating 11.Ears/eyes  
12.Feeling of cold/heat/fever 13.Emotional symptoms 14.Sexual symptoms  
15.Women's symptoms 16.Children's symptoms

### Tongue diagnosis:

**Spirit:** Yes No

**Body Shape:**

Thin Swollen Stiff Flaccid Long Short Cracked Loose Deviated Moving  
Numb Toot-marked Ulcerated Sore-covered Sublingual vein congestion

Notes: \_\_\_\_\_

**Color:**

Pale Normal Red Dark red Purple Blue Purple spots

Notes: \_\_\_\_\_

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**Coating(Fur):**

White Yellow Gray Black

Thin Thick Greasy Dry Slippery No coating Moist Normal Peeled Mirror

Notes: \_\_\_\_\_

### Pulse diagnosis:

Pulse per minute rate: \_\_\_\_\_

**Left side:**

Cun Heart  
Guan Liver/Gall Bladder  
Chi Kidney

**Right side:**

Lung  
Spleen/Stomach  
Kidney

Floating Sinking Deep Rapid Slow Thin Big Empty Full Slippery Thready  
Wiry Choppy Tight Knotted Short Long Moderate Flooding Hidden Hollow  
Scattered Intermittent Irregular Regularly irregular

Notes: \_\_\_\_\_

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TCM Diagnosis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treatment Plan: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Acupuncture Treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Treatments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Practitioner Signature:

Date: