Power of Qi Medical Intake Form

Note: *Information provided on this form is confidential*

It is very important the information given is complete and accurate to assist you properly in your healing process.

Please PRINT Today's Date/_____/
How did you hear about us?
□ friend □ relative □ website □ healthcare referral
Name Date of Birth /_____/ Age:_____
Sex: Male □ Female □
Address _____City_____State_____ZIP_____

Telephone (home) _____ (work) _____

Email _____
Occupation_____
Emergency Contact Person /
Relationship _____ Tel: _____
Physician Physician's phone #

What do want treated with Yi Jia Gong?
_____

How long have you had this condition?_____
The onset was sudden □ gradual □
Symptoms relieved by Symptoms worsened by

What medical diagnosis have you received for this condition

What other treatments have you received for this condition?

What medications are you taking?

For what condition(s)?

Is this your first experience in Oriental Medicine and Yi Jia Gong?

How do you feel about Yi Jia Gong?

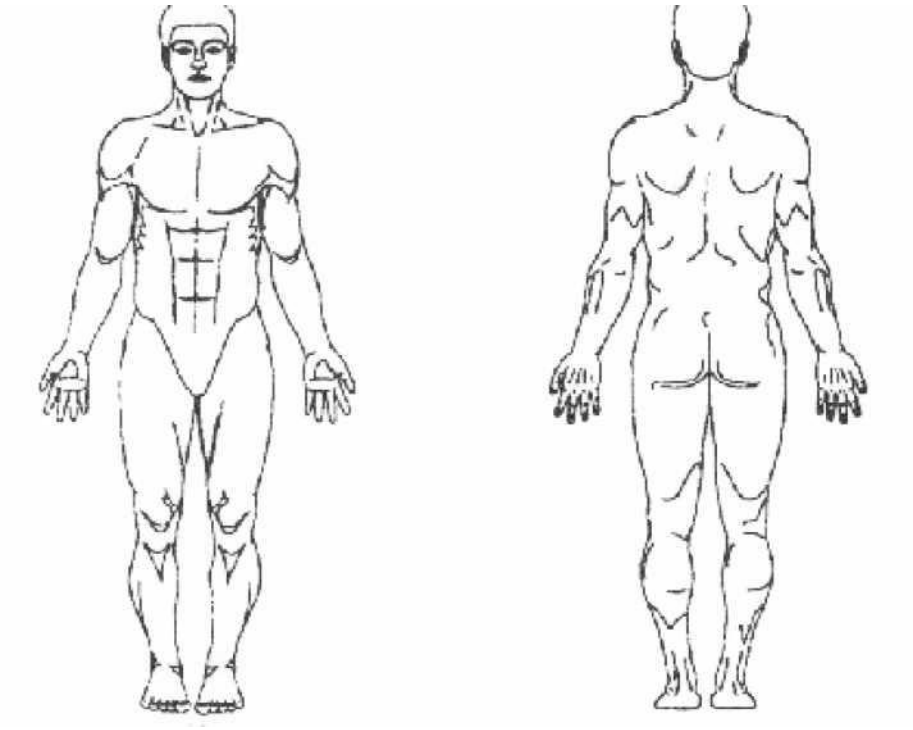
Are you currently pregnant? Yes □ No □
Are you presently trying to get pregnant? Yes □ No □

On the following drawings, shade in the areas where you feel should be addressed.

Past Medical History:

Have you had any of this condition(s)? Check all that apply:

- □ AIDS/HIV
- □ Alcoholism
- □ Allergies (food, latex)
- □ Asthma
- □ Birth Trauma
- □ Cancer
- □ Diabetes
- □ Drug Addictions
- □ Emphysema
- □ Fibromyalgia
- □ Heart Disease
- □ Hepatitis A/B/C
- □ Herpes
- □ Joint Replacements
- □ Lyme's Disease
- □ Lymph Nodes removed
- □ Multiple Sclerosis
- □ Implants (Breast) etc.
- □ Pacemaker
- □ Polio
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Seasonal Allergies
- □ Seizures
- □ Sinus Infections
- □ Tuberculosis
- □ Operations _____
- □ Other _____



Family Medical History: (Please list ar
disease, respiratory conditions, blood p
disorders, arthritis)

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

Exercise & Energy:

How is your energy?_____

What time of day is your energy: Highest?

Lowest?_____

Do you fatigue easily? _____

What kind of exercise do you do?

_____

How often do you
exercise? _____

Emotions & Sleep:
How do you feel emotionally? _____

Do you have (check all that apply): Panic attacks □ Depression □ Anxiety □ Bad temper □ Nervousness □ Fear attacks □ Poor memory □ Difficult concentration □

Are you in a relationship? Yes □ No □
How do you feel about your relationship?_____

How do you hold stress?_____

How do you relax? _____

How do you feel about your work? _____

How long do you normally sleep? Hours per night_____

I have difficulties with (check all that apply): Falling asleep □ Staying asleep □ Dream-disturbed sleep □ Waking up at about am/pm and not being able to fall asleep again □

Gastrointestinal:
I have (check all that apply): Belching □ Nausea □ Vomiting □ Vomiting of blood □ Ulcers □ Bloating □ Acid regurgitation □ Heartburn □ Hernia □ Indigestion □ Severe stomach pain □

Bowel movements: How often? Time(s)/day_____
I have (check all that apply): Irregular □ Constipation □ Diarrhea □ Gas □ Burning sensation □ Hemorrhoids □
Undigested food in stool □ Loose stool □ Hard stool □ Blood in stool □ Itchiness □ Painful bowel movements □

Urinary:
Urination: How often? Times per day__ Color: Pale/yellow □ □ Dark yellow/orange □
I have or had (check all that apply): Trouble starting stream □ Frequent urination □ Incontinence □ Pain □ Burning □ Dribbling when sneezing □ Blood in urine □ Kidney stones □ Urinary tract infections □ Other_

Women:
At what age did you start menstruating? Number of days between cycles:
Number of days of flow: Color:

I have or had (check all that apply): Irregular menstruation □ Heavy flow □ Light flow □ No flow □ Clots □
Vaginal itching/burning □ Spotting between periods □ Discomfort/pain before period □
Discomfort/pain during period □ Other
Any vaginal discharge? No □ Yes □ Color

Men:
I have (check all that apply): Prostatitis □ Impotence □ Penis blood/mucous discharge □
Other: _____

Muscles, Joints & Bones:
Do you have pain or tightness? No □ Yes □
Where?_____
The pain is (check all that apply): Sharp □ Dull □ Aching □ Numb □ Superficial Pain □ Deep Pain □ Burning □ Tingling □ Shooting □ Pain worse/better with heat □ Pain worse/better with cold □
Pain worse/better with pressure □ Pain worse in am/pm □
I have (check all that apply): Swollen joints □ Arthritis/joint pain □ Tendonitis □ Bone pain □ Muscle cramping □ Muscle pain □ Repetitive Strain Injury □ Fractured Bone(s) □
Other _____

Eyes, Ears, Nose, Throat, & Head:
Do you smoke? No □ Yes □per day, for years
I have (check all that apply): Frequent colds □ Chronic runny nose □ Frequent sore throat □ Chronic cough □ Coughing blood □ Cough up mucous □ Pain inhaling □ Shortness of breath on exertion/at rest □ Asthma □
Nose bleeds □ Painful/red eyes □ Poor vision □ See spots/floaters □ Dizziness □ Cold sores □ Bleeding gums □ Dry mouth □ Ear pain □ Ringing in ears □ Clogged/popping in ears □ Frequent headaches/migraines □ describe:_____

Cardiovascular:
I have (check all that apply): Chest pain □ Palpitation □ Varicose veins □ Phlebitis □ Cold hands and feet □ Irregular heartbeat □ Poor circulation □
Other: _____

Skin & Hair:
I have or often have (check all that apply): Dry skin □ Skin rashes □ Itching □ Acne □ Eczema □ Hives □
Hair loss □ Premature graying □ Other:_____ _____
Other: _____

Power of Qi Patient Information Sheet

Yi Jia Gong is NOT a substitute for conventional medical diagnosis and treatment.

There is no guarantee that medical qigong will help any condition. Certain medications and social habits may decrease the beneficial effects of medical qigong. These include the use and abuse of alcohol, tobacco, steroids, painkillers, narcotics, stimulants, antidepressants, psycho pharmaceuticals and illegal drugs.

I, certify that I have read and understood (Print Name)

the statements above. I also certify that I have informed Ping Tao, OMD of all known physical, mental, and medical conditions, and medications, and I will keep him updated on any changes.

Signature:_____ Date:_____

I understand that situations arise in which you must cancel your appointment. Office appointments which are cancelled with less than 24 hours notification may be subject to a $**50.00** cancellation fee. Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as **NO SHOW**. Patients who cancel (2) or more times may be dismissed from the practice thus they will be denied any future appointments. The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.
I understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with my approval.
I firmly believe that good physician/patient relationship is based upon understanding and good communication.
Please sign that you have read, understand, and agree to this Cancellation and No-show Policy.

_____Patient Name (Please Print)

_____Signature of Patient or Patient Representative

Date _____