TAOIST INSTITUTE OF TCM
Patient Intake Form

Name _____ **Date** _____

Date of Birth_____ **Age**_____**Male/ Female**(circle) **Marital status**_____

Address_____

City_____ **State**_____ **Zip**_____

Phone_____ **Cell**_____ **Email** _____

Occupation_____ **Work Phone**_____

Referred by: _____

Health concerns in order of importance:

1._____**2.**_____**3.**_____

Describe onset, quality, site, time

DO YOU USE: _____ HERBS _____ HOMEOPATHICS _____ALCOHOL _____ TOBACCO

HAVE YOU USED ACUPUNCTURE BEFORE? YES _____ NO _____ TUI NA? YES _____ NO _____

ARE YOU SEEING YOUR PHYSICIAN FOR THIS PROBLEM? YES _____ NO _____

ARE YOU SEEING: CHIROPRACTOR_____ PHYSICAL THERAPIST _____ PSYCHIATRIST_____

ARE YOU ON A SPECIAL DIET? YES _____ NO _____ VEGETARIAN/VEGAN YES _____NO _____

SIGNIFICANT HEALTH HISTORY-Including surgery, past accidents/injuries, family history, and diagnoses:

_____

_____

_____

_____

ALLERGIES- medication, food, environmental:

_____

_____

_____

NAMES OF ALL DRUGS AND MEDICINES YOU ARE NOW TAKING:

_____

_____

_____

MINERALS, VITAMINS, HERBAL, HOMEOPATHIC SUPPLEMENTS:

_____

_____

_____

EMERGENCY CONTACT:_____**PHONE**_____

Ming Wu 45 South Main St. Suite 100 West Hartford CT wuhealing@yahoo.com 978-790-8888

_ Do you feel afraid/fearful?	_Do you have unresolved grief/sadness?	_Are you anxious or do you excite easily?	_Do you worry/overthink?	_Are you Angry/irritable?
_Difficult urination	_Shortness of Breath	_ Heart palpitations	_Heartburn	_Headaches Time of day? Sharp Dull
_Burning on urination	_Allergies	_Dizziness	_Nausea	_Do you Feel stuck in life?
_Night time urination	_Hay fever	_Fainting	_Vomiting	_Frustrated
_Loss of control of urine	_Nasal discomfort	_Anxiety	_Diarrhea	_Pain in body, Where-
_Blood in urine	_Nose bleeds	_Phobias	_Belching/Flatulence	_Duration
_Dark urine	_Nasal discharge	_Nervousness	_Bloating	_Scale of 1-10-
_Frequent urination more than 10 times/day?	_Have five or more colds/ flu per year	_Stroke	_Fatigue All day Specific time	_Hormone Imbalance
_Auto-immune diagnosis	_Cough	_Hot weather intolerance	_Special food intolerance	Many fluctuations in cycles of life
_Hair loss	_Wheezing	_Easily startled	-Post nasal drip	_Joint pain
_Premature gray hair	_Chest pains	_High blood pressure	-Constipation	_Tendons
_Chronic illness	_Sputum	_Low blood pressure	_Muscle aches	_Ligaments
_Premature graying	_Skin problems Dry skin	_Do you not have Passion for life or Feel Purposeful?	_Strong Appetite	_Tremors
_Swollen feet/ankles	_Nail problems	_Tongue issues	_Poor appetite	_Muscle weakness
_Fatigue	_Increased thirst	_Joylessness	_Weight gain	_Seizures/convulsions
_ Poor memory/ fog	_Dryness	_Depression	_Weight loss	_Jaundice
_ Hot flashes 1-10 After 3pm?	_Throat discomfort	_Inappropriate actions	_Abdominal pain	_Eye trouble Blurred vision Eye twitching
_Do you not feel supported in life	_ Excess sweating Daytime?	_Do you feel out of balance?	_Swollen glands	_Spots in the visual field
_Reproductive issues	_Fever/chills	_Heart disease	_Bruise or bleed easily	_Arthritis
_Aversion to cold	_Itching	**For Men only**	_Heavy limbs	**_For Women only**
_Feel cold internally	_Rashes	_Weak urine stream _Prostate trouble _Discharge from penis _Painful or swollen testes	_Are you hungry in the AM?	_Menstrual duration 4-5days amount consistent -28-30days
_Feel cold extremities	_Hives	**Sleep**	_Phlegm	_Vaginal discharge
_Backache	_Post Nasal Drip	How long	_Mouth problems	_PMS/Painful
_Knee pain		Trouble Falling asleep		-Breast or lump discharge
_Thyroid issues		Insomnia Wake up when?		_Date of last period
_Leg pain		Night terrors		# of pregnancies
_Ringing in the ear		Warm or Cold		# of miscarriages
_Ear Trouble		What time awaken		# of abortions
_ Night sweats		Restful		Birth control

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Appointment Cancellations: We understand that circumstances occasionally arise that will change your plans. You may cancel at no charge if you call **at least 24 hrs.** before your appointment. If you do not cancel or fail to come for your appointment, a fee of $50.00 will be charged. If you make up your apt. within a week your fee will be waived.

Disclaimer: This modality known as "Qi Gong Tui Na Therapy, Quantum Energy Medicine" is an ongoing study, being followed by the Taoist Institute of TCM. The practice of energy therapy has never been adequately researched and/or tested in the United States by modern scientific methods. As such, no guarantees or promises as to results and/or to the effectiveness of this modality are offered or implied. This modality is considered to be experimental and in no way should take the place of traditional medical consultation or care.

I have read and understand these guidelines and agree to the terms therein. I give permission to receive email and phone call or text from Wu Healing Center.

_____

(**PRINT** name of patient)

SIGNATURE: _____ DATE: _____

~~(Patient, Guardian*, or Authorized Representative*).~~