1/51 Darling St Balmain East NSW 2041 ph: 9555 8806
email: reception@darlinghealth.com.au

Traditional Chinese Medicine New Patient Intake Form

Date:____/____/____

Personal Information

Name_____
Address _____
Suburb _____
State _____ Postcode _____
Home phone _____
Work phone _____
Mobile _____
Email _____
Birth date _____ Age _____

Number of children _____Ages_____
Marital status _____
Occupation _____
Referred by _____
Physician name_____
Physician's phone _____
May I contact? □ Yes □ No
Emergency contact name_____
Relationship _____ Phone _____

Main Concerns

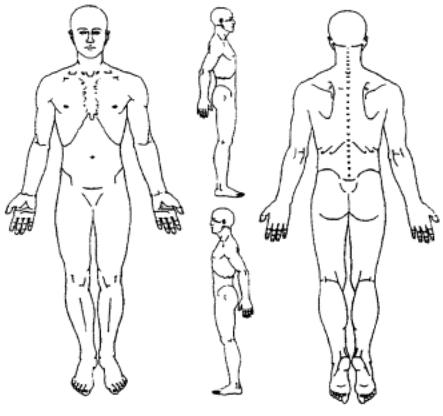
Please list your main concerns and reasons for this appointment (symptoms, diagnosis, duration etc.)

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

Have you seen any other doctors for this condition? If yes, please list doctor, prior interventions, and treatments _____
_____
_____
_____

What makes your chief condition worse? (stress, fatigue, hunger, food, weather, etc.)
_____
_____

What makes your chief condition better? (rest, movement, heat, cold, eating, etc.)_____
_____
_____



Please mark areas of discomfort

Please mark the severity of your chief concern today.
No problem_____ Worst imaginable
1 2 3 4 5 6 7 8 9 10

1/51 Darling St Balmain East NSW 2041 ph: 9555 8806
email: reception@darlinghealth.com.au

Please mark the greatest degree of severity of your chief concern that you have ever experienced.

No problem _____ Worst imaginable

1 2 3 4 5 6 7 8 9 10

Please list all current Medications / Vitamins / Herbs

Name Dosage Duration Reason

_____

_____

_____

_____

Personal Medical History

Please mark all that apply and explain as necessary

- ☐ Allergies_____
- ☐ Asthma _____
- ☐ Cancer_____
- ☐ Diabetes _____
- ☐ Heart disease _____
- ☐ Hepatitis_____
- ☐ High blood pressure _____
- ☐ HIV/AIDS_____
- ☐ Seizures _____
- ☐ Stroke_____
- ☐ Thyroid disease_____
- ☐ Other _____

Post Hospitalisations / Illnesses / Accidents (please list and date) _____

_____

Please date and describe significant traumas (physical or emotional) _____

_____

List all known allergies (food, chemicals, drugs, seasonal, insects, etc.) _____

_____

Have you undergone a course of antibiotics lately? _____

Have you been under the care of a licensed health care professional in the past year? _____

If so, for what reasons?_____

Family Medical History

Please mark which apply, elaborate as appropriate and indicate which family member.

- ☐ Allergies_____
- ☐ Asthma _____
- ☐ Cancer_____
- ☐ Diabetes _____
- ☐ Drug/alcohol abuse _____
- ☐ Heart disease _____
- ☐ High blood pressure _____
- ☐ Mental disorder _____
- ☐ Seizures _____
- ☐ Stroke_____
- ☐ Thyroid disease_____
- ☐ Other _____

1/51 Darling St Balmain East NSW 2041 ph: 9555 8806
email: reception@darlinghealth.com.au

Review of Symptoms

GENERAL

Past Current

- ☐ ☐ Frequent colds/infections
- ☐ ☐ Chills
- ☐ ☐ Fevers
- ☐ ☐ Fatigue
- ☐ ☐ Sudden energy drops
  Time of day _____

Past Current

- ☐ ☐ Night sweats
- ☐ ☐ Poor sleeping
- ☐ ☐ Localised weakness
- ☐ ☐ Bleed/bruise easily
- ☐ ☐ Sweats easily

Past Current

- ☐ ☐ Muscle weakness / fatigue
- ☐ ☐ Poor balance
- ☐ ☐ Tremors
- ☐ ☐ Dental/gum problems
- ☐ ☐ Strong thirst (hot/cold drink)

Past Current

- ☐ ☐ Poor appetite
- ☐ ☐ Cravings
- ☐ ☐ Sudden change in weight
- ☐ ☐ Peculiar tastes/smell
  Bitter/sweet/salty?

SKIN AND HAIR

- ☐ ☐ Rashes
- ☐ ☐ Eczema / Psoriasis
- ☐ ☐ Skin discoloration
- ☐ ☐ Dry skin
- ☐ ☐ Ulceration
- ☐ ☐ Acne
- ☐ ☐ Face flushing
- ☐ ☐ Changes in skin /hair
- ☐ ☐ Hives/Allergic Dermatitis
- ☐ ☐ Loss of hair
- ☐ ☐ Dandruff
- ☐ ☐ Itching
- ☐ ☐ Recent moles
- ☐ ☐ Warts
- ☐ ☐ Weak or ridged nails
- ☐ ☐ Fungal infection

HEAD, EYES, EARS, NOSE AND THROAT

- ☐ ☐ Eye strain
- ☐ ☐ Colour blindness
- ☐ ☐ Eye pain / sore eyes
- ☐ ☐ Dry eyes
- ☐ ☐ Glasses/contacts
- ☐ ☐ Excessive tearing
- ☐ ☐ Poor or blurred vision
- ☐ ☐ Poor night vision
- ☐ ☐ Spots in front of eyes
- ☐ ☐ Cataracts
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Recurrent sore throat/colds
- ☐ ☐ Sores on lips/tongue
- ☐ ☐ Grinding teeth
- ☐ ☐ Jaw clicks / locks
- ☐ ☐ Earaches
- ☐ ☐ Poor hearing
- ☐ ☐ Ringing in ears
- ☐ ☐ Nose bleeds
- ☐ ☐ Sinus problems
- ☐ ☐ Dizziness
- ☐ ☐ Facial pain
- ☐ ☐ Headaches
  Where_____
  When _____
- ☐ ☐ Migraines
  Where _____
  When _____

CARDIOVASCULAR

- ☐ ☐ Chest pain or pressure
- ☐ ☐ Irregular heart beat
- ☐ ☐ Shortness of breath
- ☐ ☐ Palpitations at rest
- ☐ ☐ Low blood pressure
- ☐ ☐ High blood pressure
- ☐ ☐ Edema / swollen ankles
- ☐ ☐ Varicose / Spider Veins
- ☐ ☐ Cold hands / feet
- ☐ ☐ Anemia
- ☐ ☐ Blood clots
- ☐ ☐ Puffy eyes
- ☐ ☐ Fainting spells
- ☐ ☐ Dizziness / vertigo
- ☐ ☐ Other_____

RESPIRATORY

- ☐ ☐ Cough / Wheezing
- ☐ ☐ Coughing blood
- ☐ ☐ Difficulty inhaling
- ☐ ☐ Pain with deep inhalation
- ☐ ☐ Tight sensation in chest
- ☐ ☐ Difficulty breathing lying down
- ☐ ☐ Asthma
- ☐ ☐ Production of phlegm
  Colour_____
- ☐ ☐ Bronchitis
- ☐ ☐ Pneumonia
- ☐ ☐ Other_____

GASTROINTESTINAL

- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Belching
- ☐ ☐ Gas / flatulence
- ☐ ☐ Indigestion
- ☐ ☐ Bloating
- ☐ ☐ Acid reflux / GERD
- ☐ ☐ Bad breath
- ☐ ☐ Excessive appetite
- ☐ ☐ Changes in appetite
- ☐ ☐ Hunger but no desire to eat
- ☐ ☐ Chronic laxative use
- ☐ ☐ Anorexia nervosa
- ☐ ☐ Bulimia
- ☐ ☐ Diarrhea
- ☐ ☐ Black stools
- ☐ ☐ Loose stools
- ☐ ☐ Constipation (< 1 b.m./day)
- ☐ ☐ and dry stools
- ☐ ☐ not daily
- ☐ ☐ with difficulty
- ☐ ☐ Alternating constipation and diarrhea
- ☐ ☐ Blood in stool
- ☐ ☐ Hemorrhoids
- ☐ ☐ Hernia
- ☐ ☐ Rectal pain/ prolapse
- ☐ ☐ Abdominal pain
- ☐ ☐ Other _____

1/51 Darling St Balmain East NSW 2041 ph: 9555 8806
email: reception@darlinghealth.com.au

GENITO-URINARY

Past	Current	
☐	☐	Pain on urination
☐	☐	Frequent urination
☐	☐	Urgent urination
☐	☐	Unable to hold urine
☐	☐	Scanty flow
☐	☐	Copious flow
☐	☐	Dribbling after urination

Past	Current	
☐	☐	Blood in urine
☐	☐	Burning urination
☐	☐	Urinary Tract Infection
☐	☐	Kidney stones
☐	☐	Night urination

How often?_____

MALE REPRODUCTIVE

Past	Current	
☐	☐	Impotence
☐	☐	Premature ejaculation
☐	☐	Nocturnal emission
☐	☐	Pain in testicles
☐	☐	Low sperm count/motility
☐	☐	Erection difficulty

Past	Current	
☐	☐	Prostatitis
☐	☐	Herpes
☐	☐	Sores on genitals
☐	☐	Infections
☐	☐	Decreased libido
☐	☐	Excessive libido

FEMALE REPRODUCTIVE / GYNECOLOGICAL

☐ ☐ Premenstrual irritability
☐ ☐ Irregular menses
☐ ☐ Painful menses
☐ ☐ Heavy/prolonged bleeding
☐ ☐ Missed menses
☐ ☐ Spotting/abnormal bleeding
☐ ☐ Clots in menstrual blood
Color of blood_____
☐ ☐ Vaginal discharge
☐ ☐ Vaginal dryness
☐ ☐ Genital sores
☐ ☐ Difficult / painful intercourse

☐ ☐ Ovarian cysts
☐ ☐ Uterine fibroids
☐ ☐ Endometriosis
☐ ☐ Polycystic Ovarian Disease
☐ ☐ Breast lumps
☐ ☐ Breast swelling or redness
☐ ☐ Nipple discharge
☐ ☐ Abnormal Pap smear
☐ ☐ Infertility
☐ ☐ Other _____

Do you practice birth control?
_____
If so, list type and for how long?
_____
_____

Age of first menses _____
Duration of menses _____
First day of last menses _____
Number of days in cycle _____

Are you pregnant now? _____
Is it possible you're pregnant now? _____
Are you trying to get pregnant? _____
Number of pregnancies _____
Number of Ectopic pregnancies_____
Number of live births_____
Number of premature births _____
Number of abortions_____
Age of menopause _____
Date of last PAP _____

NERVOUS SYSTEM

☐ ☐ Paralysis or seizures
☐ ☐ Lack of coordination
☐ ☐ Loss of balance

☐ ☐ Vertigo / Dizziness
☐ ☐ Loss of taste/smell/touch

☐ ☐ Tingling sensations/numbness
☐ ☐ Tremors
Where? _____

☐ ☐ Stroke
☐ ☐ Concussion
☐ ☐ Other _____

MUSCULOSKELETAL

☐ ☐ Back pain
Where?_____
☐ ☐ Neck pain
☐ ☐ Shoulder pain
☐ ☐ Knee pain

☐ ☐ Hip pain
☐ ☐ Hand / wrist pain
☐ ☐ Foot / ankle pain
☐ ☐ Joint / bone problems
☐ ☐ Osteoporosis

☐ ☐ Sprains / strains
☐ ☐ Muscle pain/weakness
☐ ☐ Numbness
☐ ☐ Sciatica
☐ ☐ Herniated disc

☐ ☐ Carpal tunnel
☐ ☐ Lower body weak/aches
☐ ☐ Other _____

EMOTIONAL

☐ ☐ Nervousness
☐ ☐ Often stressed
☐ ☐ Easily angered
☐ ☐ Aggressive behaviour

☐ ☐ Difficulty concentrating
☐ ☐ Poor memory
☐ ☐ Over thinking

☐ ☐ Manic-Depression
☐ ☐ Depression
☐ ☐ ADD / ADHD

☐ ☐ Anxiety
☐ ☐ Panic attacks
☐ ☐ Other _____

SLEEP

☐ ☐ Difficulty falling asleep
☐ ☐ Wake up easily during the night
Times per night? _____
At a particular time?_____

☐ ☐ Wake up too early in the am
What time? _____
☐ ☐ Nightmares
☐ ☐ Vivid dreams

☐ ☐ Grinding teeth
☐ ☐ Talking in sleep
☐ ☐ Snoring

1/51 Darling St Balmain East NSW 2041 ph: 9555 8806
email: reception@darlinghealth.com.au

Lifestyle / Self Care

Do you allow time to relax? Yes ☐ No ☐ If yes, how? _____

_____

Do you exercise regularly? Yes ☐ No ☐

Length of activity_____ Days per week_____

Types(s) of exercise _____

How many hours per week do you work?_____

What are the major stressors in your life? _____

Please rate the following areas:

	great		good		ok		poor		bad
Family	5		4		3		2		1
Partner	5		4		3		2		1
Libido	5		4		3		2		1
Self	5		4		3		2		1
Work	5		4		3		2		1
Exercise	5		4		3		2		1
Spirituality	5		4		3		2		1

Do you use the following?

Tobacco	frequently ☐	occasionally ☐	never ☐	Number of cigarettes per day ____ Age started _____
Alcohol	frequently ☐	occasionally ☐	never ☐	Number of drinks per week _____ Type of drinks _____
Caffeine	frequently ☐	occasionally ☐	never ☐	Number of cups per day _____ Type of drinks _____
Recreational drugs	frequently ☐	occasionally ☐	never ☐	Number of times per month _____ Type of drug _____

Do you have any current or past problems with addiction or substance abuse? Yes ☐ No ☐

Substance_____ Amount_____ When did you quit? _____

Please mark those that you use:

☐ Pacemaker	☐ Contact Lenses	☐ Hearing Aid	☐ Artificial Limb
☐ Birth Control IUD	☐ Eyeglasses	☐ Dentures	☐ Brace (neck, arm, back)

DIET

Please list some of your favourite foods _____

How many meals do you eat per day? _____ When is your biggest meal? _____

Do you eat when you are worried or rushed? Yes ☐ No ☐ Do you frequently eat in between meals? Yes ☐ No ☐

Do you eat when you are not hungry? Yes ☐ No ☐ Do you eat until you feel full? Yes ☐ No ☐

How much liquid do you drink per day? _____ cups What types (water, soft drink, beer)? _____

Do you eat raw fruits and vegetables at least twice per day? Yes ☐ No ☐ Meat products? Yes ☐ No ☐

Do you eat dairy products? Yes ☐ No ☐ Soy products? Yes ☐ No ☐

"Typical Breakfast_____

_____

Lunch _____

_____

Dinner _____

_____

Additional Comments

_____

_____

_____

1/51 Darling St Balmain East NSW 2041 ph: 9555 8806
email: reception@darlinghealth.com.au

Patient Information and Consent Form

Please read this information carefully, and ask your practitioner if there is anything that you do not understand. While acupuncture, Chinese Medicine and other treatments provided by this clinic have proven to be highly effective in correcting conditions and maintaining overall wellbeing, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

What is acupuncture?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body. Single-use, sterile, disposable needles are used in the clinic.

Is acupuncture safe?

Acupuncture is generally very safe. Serious side effects are very rare – less than one per 10,000 treatments.

What are the possible side effects of acupuncture?

- drowsiness occurs after treatment in a small number of patients, and, if affected, you are advised not to drive
- minor bleeding or bruising occurs after acupuncture in about 3% of treatments
- pain during treatment occurs in about 1% of treatments
- symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign
- fainting can occur in certain patients, particularly at the first treatment.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?

- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy. Please always follow your practitioner's prescription.

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- if you have ever experienced a fit, faint or funny turn
- if you have a pacemaker or any other electrical implants
- if you are pregnant
- if you have a bleeding disorder
- if you are taking anti-coagulants (blood thinners) or any other medication
- if you have damaged heart valves or have any other particular risk of infection.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time. I wish to rely on my practitioner to exercise judgment during the course of treatment, which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Appointment Policy

Welcome to Darling St Health Centre. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy. Many of our clients are pleased to find out that we are usually on time. This is because a treatment room has been reserved for you. Occasionally, there is a problem with patient's time and, with that in mind, if you are going to be more than 15 minutes late, please call to confirm availability. A 24-hour notice for cancelled or rescheduled appointments is necessary in order to avoid the cancellation fee. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

1/51 Darling St Balmain East NSW 2041 ph: 9555 8806
email: reception@darlinghealth.com.au

Privacy Policy

The information received and collected about our clients/patients from their visit to Darling St Health Centre is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Darling St Health Centre, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional (also, Darling St Health Centre will not give, share, sell, or transfer any personal information to a third party unless required by law). The client/patient information will be stored both in digital and hard copy format on Darling St Health Centre premises. On occasion, Darling St Health Centre may use client/patient information to conduct clinical studies to help us improve upon services provided.

_____

Print name in full (Print name of Representative if represented by another)

_____

Signature (Signature of Representative if represented by another)

_____

Date