4 Winds Medicine

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Traditional Chinese Medicine Intake Form

Patient Information

- Name: _____
- Age: _____ Sex: _____ Date of Birth: _____
- Occupation: _____
- Phone: _____
- Email: _____
- Emergency Contact (Name/Phone): _____

Chief Complaint

- Main Reason for Visit:

- Duration: _____
- Severity: ☐ Mild ☐ Moderate ☐ Severe
- Aggravating Factors: _____
- Relieving Factors: _____
- Previous Treatments:
  ☐ Acupuncture ☐ Herbal Medicine ☐ Medications ☐ Other: _____

History of Present Illness

- Related diagnosis (Western/TCM): _____
- Past injuries/accidents: ☐ Yes ☐ No
  If yes: _____
- Surgeries: ☐ Yes ☐ No
  If yes: _____

Medical History

- Major illnesses (check all that apply):
  ☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Heart Disease ☐ Asthma ☐ Autoimmune Disease ☐ Digestive Disorders ☐ Mental Health Conditions ☐ Other: _____
- Allergies: _____
- Current Medications/Supplements: _____

Family History (check all that apply)

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Mental Illness ☐ Other: _____

Lifestyle

- Diet (describe typical meals): _____
- Appetite: ☐ Normal ☐ Low ☐ High
- Cravings: _____
- Exercise: ☐ None ☐ Light ☐ Moderate ☐ Intense
  Type/Frequency: _____
- Sleep:
  Quality: ☐ Good ☐ Fair ☐ Poor

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Vivid dreams

- Substance Use:
  ☐ Tobacco ☐ Alcohol ☐ Caffeine ☐ Recreational Drugs
- Stress Level: ☐ Low ☐ Moderate ☐ High
- Social Support: ☐ Strong ☐ Some ☐ Limited

Emotional Factors

- General emotional state: _____
- Recent or chronic stressors: _____
- Emotions you experience often (check all that apply):
  ☐ Anxiety ☐ Sadness/Grief ☐ Anger/Irritability ☐ Worry/Overthinking ☐ Fear/Insecurity ☐ Mood Swings ☐ Numbness/Lack of Emotion
- Do emotions feel stuck or excessive? ☐ Yes ☐ No
- How well do you express emotions? ☐ Freely ☐ With difficulty ☐ Rarely
- History of trauma or loss? ☐ Yes ☐ No
  If yes: _____
- Coping strategies: _____
- Receiving professional mental health care? ☐ Yes ☐ No

Energy & Vitality

- Overall energy level (1–10): _____
- Fatigue: ☐ None ☐ Mild ☐ Moderate ☐ Severe
  Worse at: ☐ Morning ☐ Afternoon ☐ Evening

Digestion

- Appetite: ☐ Normal ☐ Low ☐ Excessive
- Taste changes: ☐ Yes ☐ No
- Cravings: _____
- Nausea/Vomiting: ☐ Yes ☐ No
- Bloating/Gas: ☐ Yes ☐ No
- Heartburn: ☐ Yes ☐ No
- Bowel movements:
  Frequency: _____ Consistency: ☐ Normal ☐ Loose ☐ Hard
  ☐ Diarrhea ☐ Constipation ☐ Alternating

Urination

- Frequency: ☐ Normal ☐ Increased ☐ Decreased
- Urgency: ☐ Yes ☐ No
- Night urination: ☐ Yes ☐ No Times/night: _____
- Pain/difficulty: ☐ Yes ☐ No
- Color: ☐ Pale ☐ Dark ☐ Cloudy ☐ Normal

Thirst & Fluids

- Thirst level: ☐ Normal ☐ Increased ☐ Decreased
- Preference: ☐ Hot drinks ☐ Cold drinks ☐ No preference
- Dry mouth: ☐ Yes ☐ No

Body Temperature

- Cold sensitivity: ☐ Yes ☐ No
- Heat sensitivity: ☐ Yes ☐ No
- Hot flashes: ☐ Yes ☐ No
- Night sweats: ☐ Yes ☐ No
- Spontaneous sweating: ☐ Yes ☐ No

Pain

- Pain location(s): _____
- Type: ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Aching
- Frequency: ☐ Constant ☐ Intermittent
- Better with: _____
- Worse with: _____

Head & Sense Organs

- Headache: ☐ Yes ☐ No Location/type: _____
- Dizziness/Vertigo: ☐ Yes ☐ No
- Vision changes: ☐ Yes ☐ No
- Eye issues: ☐ Dry ☐ Pain ☐ Red ☐ Watery
- Hearing issues: ☐ Yes ☐ No ☐ Ringing ☐ Loss

- Nasal issues: ☐ Congestion ☐ Bleeding ☐ Loss of smell
- Throat issues: ☐ Dry ☐ Sore ☐ Frequent clearing
- Taste changes: ☐ Yes ☐ No
- Teeth/gum issues: ☐ Yes ☐ No

Respiratory

- Shortness of breath: ☐ Yes ☐ No
- Cough: ☐ Dry ☐ Productive
  Phlegm color/consistency: _____
- Asthma/Wheezing: ☐ Yes ☐ No

Cardiovascular

- Palpitations: ☐ Yes ☐ No
- Chest tightness/pain: ☐ Yes ☐ No
- Known BP issues: ☐ High ☐ Low ☐ Normal

Musculoskeletal

- Joint pain/stiffness: ☐ Yes ☐ No
- Muscle tension: ☐ Yes ☐ No
- Weakness: ☐ Yes ☐ No

Skin & Hair

- Rashes: ☐ Yes ☐ No
- Itching: ☐ Yes ☐ No
- Dryness: ☐ Yes ☐ No
- Acne / Eczema / Psoriasis: ☐ Yes ☐ No
- Hair loss/changes: ☐ Yes ☐ No

Gynecological / Obstetric (if applicable)

- Age at first period: _____
- Cycle regularity: ☐ Regular ☐ Irregular
- Cycle length (days): _____
- Flow: ☐ Heavy ☐ Light ☐ Clots
- PMS symptoms: ☐ Yes ☐ No
- Menopause/Perimenopause: ☐ Yes ☐ No
  Symptoms: _____
- Pregnancies: _____ Miscarriages: _____ Births: _____
- Birth control use: ☐ Yes ☐ No Type: _____

Sexual Health

- Libido: ☐ Normal ☐ Low ☐ High
- Satisfaction: ☐ Satisfied ☐ Unsatisfied
- Issues with function/arousal: ☐ Yes ☐ No

Additional TCM Diagnostic Notes (Practitioner Use)

- Tongue observation: _____
- Pulse diagnosis: _____
- Abdominal palpation: _____

Patient Goals

- What would you like to achieve with treatment?

  _____
- What does “wellness” look like to you?

  _____

Additional Notes

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