# Dantian Health

## Confidential initial intake form

This intake form is designed to accumulate essential information about your current and past medical history. Your answers to the questions on this form will assist your practitioner in understanding the the complete picture of your health in order to determine the best treatment strategy for you. Should you have any difficulty or concerns answering any of the questions on this form, they can be discussed further at your initial consultation.

Name | Date of birth

Address

Phone | Email

Occupation

Emergency contact | Phone

How did you find out about Dantian Health

Do you have health fund coverage for acupuncture / Chinese Medicine? ○ Yes ○ No — If yes, what is the name of your health fund

Have you had a Chinese Medicine treatment before ○ Yes ○ No — If yes, when was your last treatment

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Please fill out the following as detailed and thoroughly as possible:

Reason for seeking treatment

Secondary Health Concerns

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Current Medical Diagnosis

Current Medications / Herbs / Vitamins

Childhood Illnesses

Major Illnesses (adulthood)

Past Injuries / Trauma

Allergies

Family Health History

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Please indicate which (if any) of the following conditions apply to you:

**Musculoskeletal**

- ☐ Headache
- ☐ Migraine
- ☐ Back pain
- ☐ Neck pain
- ☐ Knee pain
- ☐ Abdominal Pain
- ☐ Shoulder pain
- ☐ Muscle weakness
- ☐ Muscle spasms
- ☐ Sciatica
- ☐ Numbness / tingling
- ☐ Swelling
- ☐ Other

**Respiratory Complaints**

- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Nasal Congestion
- ☐ Phlegm
- ☐ Wheezing
- ☐ Other

**Temperature**

- ☐ Hot
- ☐ Cold
- ☐ Cold hands / feet
- ☐ Sensitive to wind
- ☐ Temperature dysregulation
- ☐ Afternoon fever
- ☐ Other

**Skin Conditions**

- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Rashes
- ☐ Fungal Infections
- ☐ Warts
- ☐ Dry skin
- ☐ Hair loss
- ☐ Brittle nails
- ☐ Other

**Sweating**

- ☐ Sweat spontaneously
- ☐ Sweat easily
- ☐ Rarely sweat
- ☐ Night sweating
- ☐ Sticky sweat
- ☐ Yellow Sweat
- ☐ Other

**Vision**

- ☐ Poor vision
- ☐ Floaters
- ☐ Red eyes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other

**Hearing**

- ☐ Deafness
- ☐ Tinnitus
- ☐ Ear pain
- ☐ Blocked ears
- ☐ Other

**Digestive**

- ☐ High Appetite
- ☐ Low Appetite
- ☐ Bloating
- ☐ Bad breath
- ☐ Indigestion
- ☐ Reflux
- ☐ Nausea
- ☐ Belching
- ☐ Other

**Dietary Restrictions**

- ☐ Vegetarian
- ☐ Vegan
- ☐ Gluten intolerant
- ☐ Food allergies
- ☐ Other

**Bowel Movements**

- ☐ Constipation - difficult
- ☐ Constipation - infrequent
- ☐ Diarrhoea
- ☐ Pain
- ☐ Flatulence
- ☐ Haemorrhoids
- ☐ Other

**Consistency**

- ☐ Formed
- ☐ Hard
- ☐ Loose
- ☐ Alternates

**Thirst level**

- ○ High
- ○ Low

Alcohol intake / week

Coffee intake / day

**Urination**

- ☐ Difficulty
- ☐ Pain
- ☐ Nocturnal
- ☐ Urgency
- ☐ Dribbling
- ☐ Cloudy
- ☐ Bleeding
- ☐ Scanty
- ☐ UTIs
- ☐ Other

Urination Frequency / day

**Sleep**

- ☐ Insomnia
- ☐ Waking at night
- ☐ Vivid dreaming
- ☐ Trouble falling asleep
- ☐ Difficulty waking
- ☐ Other

**Energy Levels**

- ☐ Lethargy
- ☐ Easily fatigued
- ☐ Poor memory
- ☐ Difficult concentrating
- ☐ Afternoon crash
- ☐ Other

**Mental / emotional**

- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Panic attacks
- ☐ Restlessness
- ☐ Frustration
- ☐ Fear
- ☐ Worry
- ☐ Grief
- ☐ Withdrawn
- ☐ Other

**Cardiovascular**

- ☐ Palpitations
- ☐ Poor circulation
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Anemia
- ☐ Dizziness
- ☐ Irregular heartbeat
- ☐ Rapid heartbeat
- ☐ Other

**Mens Health**

- ☐ Erectile dysfunction
- ☐ Low libido
- ☐ Low sperm count
- ☐ Prostate issues
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Other

**Womens Health**

- ☐ PMS
- ☐ Subfertility
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Other

**Menses**

- ☐ Heavy bleeding
- ☐ Light bleeding
- ☐ Clots
- ☐ Pain
- ☐ Discharge
- ☐ Other

**Colour is**

- ☐ Pale
- ☐ Red
- ☐ Brown
- ☐ Dark
- ☐ Bright

Length of cycle

Duration of cycle

Age of first period

# Children

# Miscarriage

# Abortion

**Are you pregnant?**

- ○ Yes
- ○ No

Birth control pills

- ○ Yes
- ○ No

**Menopausal**

- ○ Yes
- ○ No

Age of onset

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|---|---|
| Other relevant health information | |

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Please read the following and sign below to indicate you have read and understood everything listed below

All medical records with Dantian Health are kept private and confidential and may be stored in hard copy or electronic form. . At any time you may request to view your records.
Dantian Health may use your details provided to contact you regarding appointments and follow ups to treatment, please advise if this is not suitable for you.
I understand that Chinese Medicine can be helpful in managing many conditions, and that some minor side effects may occur, including (but not limited to) minor bruising / bleeding, drowsiness and short term flare up of symptoms (if any of the previous occurs, please discuss with your practitioner).
By signing below I hereby consent to treatment, which may include acupuncture, herbal medicine, massage, cupping, Gua Sha, moxibustion or other therapies as deemed appropriate by my practitioner. I understand that all procedures will be discussed beforehand, and that I have the right to withdraw my consent to any or all parts of treatment at any time. I acknowledge full responsibility for payment of services, and that a 24 hour cancellation policy is in place.
I acknowledge that the above medical history provided is true to the best of my knowledge and awareness.

| | |
|---|---|
| Name (please print) | |
| Signature | |
| Date | |

Please print this completed intake form and bring along to your initial consultation with Dantian Health. If you do not have access to a printer this form can be emailed to Dantian Health.