

Chinese Medicine and Massage Therapy

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Amherst, MA 01002
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www.amherstchinesemedicine.com

your email _____

1) Name _____ M F Birthday ___/___/___ Age _____

Address _____ Phone _____

City _____ State _____ Zip _____

2) How were you referred to this office ___ friends/family ___ yellow pages _____ other

Name of primary care provider _____

Have your complaints previously been given a particular medical diagnosis?

Are you currently taking any prescribed medications/supplements?

Present complaint: symptoms, when and how the problem started, anything that makes the symptoms worse or better?

Please check any of the following that applies to you

DIABETES__HEPATITIS a, b, C__ HYPERTENSION __ PREGNANCY __ CHEMO__
RAD__SEIZURE__PACEMAKER__HIV

Describe your

Energy level _____

Time of the day you feel best/worst _____

History of your particular emotional episodes _____

Hobbies/interests _____

What are you commonly experienced emotions

Anger Frustration Worry Sadness Fear Excitement Joy

What emotion do you have a difficult time to expressing

Anger Frustration Worry Sadness Fear Excitement Joy

What would you like us to focus on today

1) _____

2) _____

3) _____

History of your major illness

Life style/daily consumption

Cigarettes _____ Alcohol _____

Coffee/tea/soft drink _____

Dairy: milk, cheese, yogurt, butter, ice cream, etc. _____

Meat/fish/poultry _____

Bread/grains _____

Cooked vegetables _____

Raw fruit/vegetables _____

Specific food/flavor cravings _____

Daily exercise

Typical menu:

Breakfast_____

Lunch_____

Dinner_____

Snack_____

Which of these affect you adversely?

Cold heat damp dry windy humidity foggy

Which of these make you feel better?

Cold heat damp dry windy humidity foggy

Family medical history

Father_____ Mother_____

Grandparents_____ Siblings_____

Women

Age when the first periods began_____ Last PAP_____ Results_____

Length of the cycle_____days Duration of flows_____ Is your cycle regular_____

Any spotting_____ Pain_____ PMS_____ Vaginal discharge_____

Birth control history_____

Obstetric history_____

Menopause_____ STD_____

Men

STD_____ History of prostate conditions, impotence, etc._____

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