**Patient Intake Form**

*Please complete this form with as much detail as possible. Your information will be kept confidential.*

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**Personal Information**

* **Full Name:**
* **Date of Birth:**
* **Gender:**
* **Occupation:**
* **Contact Number:**
* **Email Address:**

**Primary Health Concerns**

* **Main reason for visit:**
* **Duration of condition:**
* **Previous treatments (type and outcome):**

**Medical History**

* **Current health conditions (diagnosed):**
* **Past surgeries (type and date):**
* **Allergies (food, medication, environment):**
* **Medications & supplements (name, dosage, purpose):**

**Lifestyle & Daily Habits**

* **Diet (e.g., vegetarian, balanced, high-protein):**
* **Sleep (average hours and quality):**
* **Exercise (type, frequency):**
* **Energy levels (e.g., consistent, low, fluctuating):**
* **Stress (rate 1–10):**
* **Emotional state (e.g., anxiety, irritability, calm):**

**Symptom Checklist**

**Please tick any that apply. If none applies, please specify.**

* **Head & Eyes:**
☐ Headaches
☐ Dizziness
☐ Blurred vision
☐ Eye dryness

Others:

* **Respiratory & Cardiovascular:**
☐ Shortness of breath
☐ Chest tightness
☐ Persistent cough

Others:

* **Digestive:**
☐ Appetite changes
☐ Acid reflux
☐ Gas/bloating
☐ Constipation

Others:

* **Urinary & Reproductive:**
☐ Urinary discomfort
☐ Menstrual issues (for females)
☐ Sexual health concerns

Others:

* **Musculoskeletal:**
☐ Joint pain
☐ Muscle cramps
☐ Back pain

Others:

* **Skin & Hair:**
☐ Dry skin
☐ Eczema
☐ Hair loss

Others:

* **General:**
☐ Fatigue
☐ Fever or chills
☐ Day/night sweats

Others:

**Additional Information for Women**

* **Menstrual cycle length:**
* **Cycle symptoms (e.g., bloating, cramps):**
* **Pregnancy history (number and any complications):**
* **Menopausal symptoms (if applicable):**

**Traditional Chinese Medicine (TCM) Specific Questions**

* **Body temperature preferences (do you feel warmer or cooler than others?):**
* **Sweating (frequency, night sweats):**
* **Thirst and preferred drink temperature:**
* **Digestion & bowel movements (frequency and consistency):**
* **Sleep quality (difficulty falling or staying asleep):**
* **Pain (location, type, frequency):**
* **Emotional state (overall mood and mental health):**

**Consent**

I confirm that the information provided is accurate to the best of my knowledge. I understand this information is essential for my health assessment and will remain confidential.

**Signature:**

**Date:**

*Please bring this completed form to your appointment or send it to us via email beforehand. Thank you.*