Name:_____ **Date:**_____

Traditional Chinese Medicine Questionaire

This check list is based on oriental observation which evaluates energy (chi).
Each answer you provide helps us see how this energy flows for you.
Some questions are asked a second time. Please answer even if repeated.

Skin:

Please check off anything of the following that apply to you. Write location in the description column.

Condition	Describe	Office Use Only
Blemishes		Lo Li Clear
Rashes		Lo Li Clear
Brown spots		Lo Li Clear
Freckles		Lo Li Clear
Have your brown spots of freckles increased?		Lo Li Clear
Skin growth/tags		Lo Li Clear
Spider veins		Li/He, Ht/He
Vericose veins		Li
Brown/Black spots		LiLo Met, Hi Rad
Brown/Green spots		Low Li
Brown or green color		Low Li
Red spots		Ht/He, Acid, Hi BP
Red color to skin		Ht/He, Acid, Hi BP
Yellow spots		Low Sp
Yellow color to skin		Low Sp
Are you on hormone therapy?		Lines/Wet
Plump skin/swelling		Wet
Do you smoke?		Lines/age/yang
Large pores		He
Dry/Flaky patches		He
Allergy reaction on skin?		He
Rashes		He
Eczema		Cleanse Bl
Pimples		Ht
Long term pimples		Co
Acne scars		He, Const
Are you constipated?		He
Are you pale?		Lo Ht, Bl

Skin Color:

What is your general skin tone? The best place to check for your tone is the under side of your arm.

Condition	Describe	Office Use Only
Gray tone or color		Ki, Bl, Sp, Hormones
Red tone or color		Ht, Circ, Br
Pink color		Ht, Circ, Br
White tone or color		Lu
Yellow		Sp, St, Lymph
Green tone or color		Liv, Nerve

Emotions:

Condition	Describe	Office Use Only
Mood swings		Ht
Anxiety/Stress		Ht
Depression		Lo Ht
Phobias		Tr Ht

Teeth/Lips/Mouth:

Condition	Describe	Office Use Only
Yellow teeth		Lo, Ki, Co
Yellow spots on teeth		Lo, Ki, Co
White teeth		Excess Ki, He
White spots on teeth		Excess Ki, He
Gray teeth		Low Ki
Gray spots on teeth		Low Ki
Gum disease/bleeding gums		St
Red lips		He
Pale lips		Co
Cracked lips/dry lips		He

Tongue:

Condition	Describe	Office Use Only
Do you have a coating on the tongue?	Yes _____ No _____	
If so, what color & location? Circle: Yellow, white		Int, St
Dry tongue		Sp, He
Tenderness of tongue		Sp, He
Lack of saliva		Sp, He
Increase of saliva		Wet
Do you cough up sputum?		Wet
If so, what color? Circle: Red, white, yellow clear		

Eyes:

Condition	Describe	Office Use Only
Dark circles under eyes		KI
Spots before eyes		Li
Dry eyes		Li cong, He
Conjunctivitis/Pink eye		Li cong, He
Spots in the white of the eye	Color: Red, blue, brown	Lo Lu, He
Puffy lids		Sp
Puffy under lid		Lo St
Eye twitching		Sp, St
Eye dryness		Sp, St

Pulse:

Any problems with heart rate or pulse? Yes_____ No_____
If so, describe _____

Have you had an EKG? Yes_____ No_____
If so, what were the results? _____

Any problems with blood pressure? Yes_____ No_____
If so, describe _____

CONSTITUTIONAL TEST PAGE 1

A constitutional assesment gives the practitioner an idea of your complete physical and emotional picture combined.
Please check what closest fits your physical and emotional features. Go with your first instinct.
Some questions are asked a second time. Please answer even if repeated. Don't spend a lot of time thinking about this.

COLUMN A

_____ Changeable moods
_____ Female
_____ Child
_____ Blonde
_____ Blue eyed
_____ Soft/mild personality
_____ Easily influenced
_____ Flexible
_____ Sympathetic
_____ Shy
_____ Cries easily
_____ Likes to please others
_____ Likes hugs
_____ Needs reassurance
_____ Hormonal disturbances
_____ Needs attention
_____ Won't hold back emotions in front of others
_____ Dependent on others
_____ Easily dominated
_____ Loving
_____ Fidgety
_____ Body type: Chubby
_____ Deeply emotional
_____ With respiratory infections
_____ Has yellow discharge
_____ Have changeable physical symptoms
_____ Bowel movements change
_____ Periods change from month to month

IF CHILD:
_____ Clings to moms often
_____ Easily bullied
_____ Needs moms kisses

COLUMN B

_____ Aggressive
_____ Cleanly
_____ Competitive
_____ Can't stand traffic
_____ Ambitious
_____ Impatient
_____ Corporate worker
_____ Bad temper, given to outbursts
_____ Likes to work
_____ Works more than 40 hours/week
_____ Doesn't like slowness
_____ Needs stimulation
_____ Can overdo it
_____ Gets low energy from doing too much
_____ Stomach problems
_____ Spices irritate stomach
_____ Alcohol problem
_____ Drug problem
_____ Feels cold often
_____ Thin body
_____ Short body stature
_____ Difficulty in marriages
_____ Need heat
_____ Crave spicy foods
_____ Difficulty sleeping because thinking about work
_____ Tense
_____ Irritable
_____ Fussy
_____ Intolerant
_____ Unable to take criticism

PULS.

NUX

CONSTITUTIONAL TEST PAGE 2

COLUMN C

_____ Retain pain, sorrow and grief
_____ Difficult to forgive
_____ Difficult to forget
_____ Very sensitive
_____ Serious
_____ Thinks of past often
_____ Reserved
_____ Doesn't like others sympathy
_____ Doesn't like to ask for help
_____ Grief in the past is difficult to talk about
_____ Sad but can't cry
_____ Migraine headaches
_____ Dignified
_____ High blood pressure
_____ Cold sores
_____ Swelling
_____ Responsible
_____ Grief feelings held in
_____ Build psychological walls
_____ Appears hardened to others
_____ Difficulty sleeping due to past memories
_____ Independent
_____ Unpredictable
_____ Suffers in silence
_____ Sensitive
_____ May laugh when solemnity is indicated
_____ Depressed
_____ Awkward
_____ Gets into passion about trifles

COLUMN D

_____ Brown discolorations on body
_____ Thin body stature
_____ Enjoys career
_____ Doesn't want children
_____ Loner
_____ Wants to escape home
_____ Sarcastic
_____ Indifferent to sex
_____ Infertility problems
_____ Has difficulty showing love to family members
_____ Female
_____ Weeping spells
_____ Unemotional
_____ Easily offended
_____ Dislikes being alone
_____ Sad
_____ Anxious in evening
_____ Aversion to occupation
_____ Aversion to family
_____ Irritable
_____ Chills easily
_____ Faints easily
_____ Brunette
_____ Pulsating headache
_____ Appears detached to others

IF FEMALE:
_____ Small breasted
_____Dark blood with period
_____Strong PMS symptoms

NAT. MUR.

SEPIA

CONSTITUTIONAL TEST PAGE 3

COLUMN E

_____ Tall
_____ Thin
_____ Anxious, nervous
_____ Proper
_____ Aristocratic
_____ Fear of things going wrong
_____ Panic attacks
_____ Very fastidious (neat & clean)
_____ Restless
_____ Insomnia
_____ Wakes between 12am & 2am
_____ Feels chilly often
_____ Fear of death
_____ Fear of cancer
_____ Wants control
_____ Becomes tired from restlessness
_____ Needs heat
_____ Fear of robbers
_____ Needs details
_____ Compulsive
_____ Obsessive
_____ Dwells on trivial things
_____ High strung
_____ Feeling of hopelessness
_____ Fussy
_____ Fastidious
_____ Oversensitive
_____ Fear of hurting someone

COLUMN F

_____ Insecure
_____ Introverted
_____ Male
_____ Fearful of other people
_____ Low self esteem
_____ Low self confidence
_____ Lack of discipline
_____ Crave sweets
_____ Eats sweets to the point of getting sick
_____ Permissive
_____ Difficulty with strong relationships
_____ Feels as if not good enough for another person
_____ Gas & belching frequently
_____ Right-sided headache
_____ Problems with ovaries
_____ Early gray hair
_____ Early wrinkles
_____ Distended abdomen
_____ Tall
_____ Thin
_____ Delicate features in face
_____ Problems in school as a child
_____ Bossy as a child
_____ Angry as a child
_____ Fear of failing
_____ Conscientious
_____ Meticiulous
_____ Fear of future
_____ Dislikes public appearances
_____ Self-conscious

AR. ALB. LY.

COLUMN G

_____ Cleanly
_____ Clammy skin, moist skin
_____ Pale skin
_____ Low activity level
_____ Cautious
_____ Feel tired with work
_____ Craves eggs
_____ Bone problems
_____ Perspiration on head
_____ Feel overburdened
_____ Spiritual
_____ Depressed
_____ Feels as if can't get well
As a child:
_____ Low activity
_____ Content to watch surroundings
_____ Fearful
_____ Trouble teething
_____ Obstinate
_____ Hardworking
_____ Worry about money
_____ Becomes overwhelmed
_____ Fearful of mice
_____ Fearful of heights
_____ Worry about health
_____ Chubby
_____ Obese
_____ Hand gestures limp
_____ Stubborn
_____ Withdrawn
_____ Supersensitive

COLUMN H

_____ Tall
_____ Thin
_____ Red haired
_____ Long fingers
_____ Bubbly personality
_____ Fun
_____ Artistic
_____ Sympathetic
_____ Anxiety problems
_____ Loves company
_____ Gullible
_____ Suggestible
_____ Wants closeness to others
_____ Clairvoyant
_____ Loves chocolate
_____ Needs cold drinks
_____ Gets pneumonia easily
_____ Fearful of dark
_____ Fearful of death
_____ Fearful of water
_____ Fearful of lightening
_____ Have very wide boundaries
_____ Intelligent
_____ Cooperative
_____ Desires affection
_____ Returns affection
_____ Easily exhausted
_____ Becomes apathetic or irritable with exhaustion
_____ Outbursts of emotion
_____ Remorseful

CAL. CARB.

PHOS.

Medical Information – *Please list all medications and supplements and their intended use*

Medications	*Intended Use*	***Supplements***	*Intended Use*

Family History- *Please list any and all diseases / conditions that run in your family:*_____

_____

_____

Please check any and all that apply, Circle if it has occurred within the last 6 months:

- ☐ Fainting
- ☐ Excessive PMS
- ☐ Low Blood Sugar
- ☐ Chest Pain
- ☐ Diarrhea
- ☐ Neck Pain
- ☐ Cramping in: _____
- ☐ Colitis
- ☐ Sinus Trouble
- ☐ Sciatic Pain
- ☐ High Blood Pressure
- ☐ Heart Palpitations
- ☐ Tension in Neck / Shoulders
- ☐ Headaches
- ☐ Too Much / Too Little Sleep
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Difficulty Concentrating
- ☐ Alcohol Use – Frequency:_____/wk
- ☐ Limited Use of Limbs / Paralysis
- ☐ Lower Back Pain
- ☐ Skin Eruptions
- ☐ Swollen Ankles
- ☐ Sore Throat / Cough
- ☐ Weakness in: _____
- ☐ Spinal Problems
- ☐ Heartburn
- ☐ Rectal Pain
- ☐ Numbness
- ☐ Cold Hands / Feet
- ☐ Poor Appetite
- ☐ Breathing Difficulty
- ☐ Fatigue
- ☐ Relationship Changes
- ☐ Health Complications
- ☐ Occupational Complications
- ☐ Thoughts of Suicide
- ☐ Non Rx Drug Use – Frequency:_____/wk
- ☐ Constipation
- ☐ Frequent Colds
- ☐ Genital Trouble
- ☐ Blood Clots
- ☐ Chills / Fever
- ☐ Poor Coordination
- ☐ Osteoporosis
- ☐ Kidney Stones
- ☐ Cancerous Growth
- ☐ Dizziness
- ☐ Abnormal Thyroid
- ☐ Cystic Tumors
- ☐ Abdominal Pain
- ☐ Ulcers
- ☐ Muscle Stiffness
- ☐ Anxiousness
- ☐ Irritability
- ☐ Nausea
- ☐ Other_____

COLUMN I

_____ Critical
_____ Stick feet out of covers at night
_____ Doesn't like baths
_____ Suffers from throat pain frequently
_____ Slouched as a teen or adult
_____ Quick tempered
_____ Easily offended
_____ Sensitive to smells
_____ Aversion to water
_____ Worries about self
_____ Takes offense easily
_____ Quick tempered
_____ Flashes of brilliance
_____ Intellectual
_____ Deep thinker
_____ Absent minded
_____ Education is important
_____ Self confident
_____ Male
_____ Idealistic
_____ Bad temper
_____ Looks are unimportant
_____ Eczema rashes
_____ Loves spicy foods
_____ Disgestive problems
_____ Becomes hot easily
_____ Hypoglycemic
_____ Gets headache at 11am
_____ Alcohol problem
_____ Lazy

SULPH.

Have you ever consulted with any of the following:

☐ Iridologist	☐ Chiropractor	☐ Reflexologist	☐ Massage Therapist
☐ Medical Doctor	☐ Nutritionist	☐ Life / Wellness Coach	☐ Psychiatrist

Any Other Specialists

_____

How did you hear about us? Check all that apply:

- ☐ Friend
- ☐ Driving By
- ☐ Practitioner of Thrive
- ☐ Internet
- ☐ Newspaper
- ☐ Independent Magazine
- ☐ Natural Awakenings
- ☐ PA Family
- ☐ Television
- ☐ Billboard
- ☐ FAX
- ☐ Radio
- ☐ From local shop/bulletin board
- ☐ Other_____

What topics are you most interested in learning more about?

Holistic Medicine	Detoxification	Massage
Nutrition	Aromatherapy	Juicing
Weight Loss	Homeopathy	Meditation
Supplements	Life Coaching	Iridology
Raw Foods	Reflexology	Tai Chi
Yoga	Psychotherapy	Qi Gong
Shiatsu	Traditional Chinese Medicine	Feng Shui

I verify that, to my knowledge, all of the information listed above is accurate.

Signature:_____ ***Date:***_____

647 N. Wyoming Ave, Kingston, PA
570.283.0111

Client Initial Intake Form

Basic Information

Name:_____ Birthdate:_____ Gender: ☐Male ☐Female

Address:_____ City:_____ State:_____ Zip Code:_____

Phone Number: *Home* (____)_____ *Cell* (____)_____ *Work* (____)_____

Occupation:_____ Referred By:_____

Marital Status:_____ Number of Children:_____ Primary care Physician:_____

Email Address:_____ Best Way to Contact: ☐Mail ☐Phone ☐Email

Emergency Contact Information

Name:_____ Phone: (____)_____ Relationship:_____

Complaint *(Please list major symptoms and concerns)*:_____

_____

_____

Brief Medical History *(Please list any and all medical conditions, treatments, past surgeries, etc)*

_____

_____

ALLERGIES:_____

Have you taken Anti-Biotics in the past six months? Yes No