Chinese Medicine and Massage Therapy
29 Pray St.
Amherst, MA 01002
413-549-9944
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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