Natural Golden Energy Intake Form

General Information

Today's Date: _____

Name _____ Date of Birth _____ Age_____

Address _____

City _____ State _____Zip _____ □Male □Female Veteran? Yes/No

Best Contact Phone _____ Second Contact Phone _____

Email _____ Referred By _____

Height _____ Weight_____ Marital Status _____

Occupation_____ Employer _____

Family Physician _____ Contact # _____

Emergency Contact Name _____Phone # _____

Emergency Contact Relationship to you _____

Have you had: □Acupuncture □Moxa □Chinese Herbal Medicine □Cupping □Gua Sha

Are you involved with other therapies? Yes/No Who and for what?

_____

_____

Primary reason for visit today? _____

What was the initial cause?_____

When did it begin? _____ Onset: Sudden/Gradual

How does this interfere with daily activities?

□Standing □Sitting □Walking □Bending □Emotional □Recreation □Work □Sleeping

□Social Life □Relationships □Other _____

What therapies have you tried?_____

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Do you sleep well? Yes/No Wake up rested: Yes/No Hours/night _____

Energy high point of the day: _____Energy low point of the day: _____

□Occupational hazards □Tobacco Type & Frequency _____

□Stress □Alcohol Type & Frequency _____

□Marijuana □Drugs Type & Frequency _____

□Exercise Type & Frequency _____

Are you interested in:

□Pain relief □Performance Care □Maintenance Care □Stress Relief

□Preventative Care □Holistic Health □Nutrition □Herbal Therapy

□Other _____

General

Do you tend to feel more hot or cold?_____ All over body or more where?_____

□Chills/Fever □Cold hands/feet □Lack of strength □Fatigue

□Night sweats □Prefer hot/cold drinks □Poor/heavy appetite □Poor circulation

□Recent weight loss/gain

Medical History

Illnesses _____

Surgeries _____

Traumas _____

Head, Ears, Eyes, Nose, Throat

□Bad Breath □Sinus pain □Dry mouth/throat □Eye pain/strain/floaters

□Ear pain □Migraine □Headache □Grinding teeth/TMJ

□Itchy/red eyes □Sore throat □Blurry vision □Phlegm

□Mouth/lip sores □Nasal congestion/drip □Nosebleeds □Seasonal Allergies

□Dizziness/vertigo □Swollen glands □Teeth/gum issues □Thyroid high/low

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Musculoskeletal

□Body heaviness □Joint pain □Muscle cramps/pain
□Neck/shoulder pain □Numbness □Upper/Lower back pain

Heart & Lungs

□Asthma/wheezing □Blood clots □Bruise easily
□Fainting □Chest pain/pressure □Cough
□Coughing blood □Difficulty breathing □High/low blood pressure
□Heart palpitations □Shortness of breath □Irregular heartbeat

Gastrointestinal

□Abdominal pain/distention □Bloody/dark stool □Acid reflux □Constipation
□Diarrhea/cramping/urgency □Gas/belching □Hemorrhoids □High/low appetite
□Indigestion □Laxative use □Nausea/vomiting □Weight loss/gain
□Peculiar taste in mouth- Bitter/Metallic/Sour/Other:_____

Skin/Hair/Nails

□Acne □Dandruff □Dry/itchy skin □Eczema
□Fungal infection □Hair loss □Dry Hair □Hives
□Poor circulation □Psoriasis □Profusely sweat □Easily Sweat
□Difficult to sweat □Rash □Ulcerations □Dry/brittle nails

Genitourinary

□Kidney stones □Impotence/ED □Low/high libido □Nocturnal emission
□Pain □Premature ejaculation □Blood in urine □Frequent urination
□Incomplete urination □Difficult urination □UTI frequency □Urinary urgency
□Unable to hold urine □Wake to urinate □ Prostate Issues □Unprotected sex
□Multiple partners □STD: _____

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Neuropsychological

□Abuse survivor □Anxiety □Confusion/Brain fog

□Concentration issues □Depression □Difficulty falling/staying asleep

□Irritability □Frustration □Anger

□Rage □Grief □Panic/Fear/Panic attack

□Poor memory □Seizures □Seeing therapist

□Thoughts of hurting self or others □Euphoria □Indecisiveness

□Worry/Over-thinking/Rumination □Blaming □Judgmental

□Doubtful □Overwhelmed □Mood swings

□Bipolar □Other diagnosis or challenge_____

OBGYN

□Heavy Bleeding □Irregular cycle □Painful periods

□Discharge □Blood clots □Breast lump/pain

□ other: _____

Days between periods _____ Period Length _____

PMS Symptoms _____

Menopause Symptoms _____

#Pregnancies _____ #Live Births _____ Date of last period _____

Allergies/Current Medications/Supplements

□Allergies to food or medication: _____

_____

□Current Medications: _____

_____

_____

□Supplements/Herbs: _____

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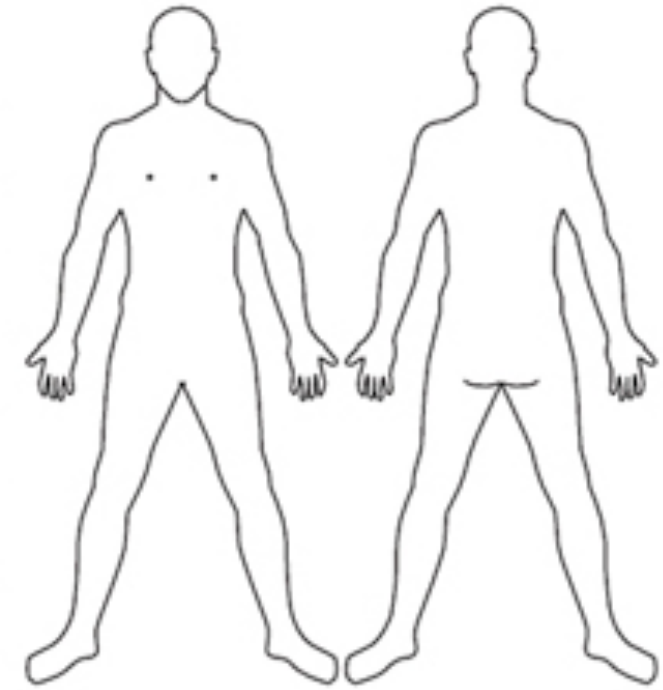
Pain

Mark areas of pain, tension, tightness, discomfort



Pain intensity levels (indicate which best describes)
□None □Moderate □Severe □Excruciating

Quality
□Dull □Ache-y □Sharp □Radiating

□Other: _____ pain scale/range: (1-10)_____/10

Pain Frequency
□25% of time □50% of time □75% of time □100% of time

Sleep Disturbance
□None □Mild □Severe □Cannot sleep

Work Impact
□None □25% □50% □Cannot work

Walking
□Any distance □<1/2 mile □Cannot walk

Sitting
□No pain □Some pain □Cannot sit