Cleveland Clinic
Wellness

# Tanya I. Edwards MD Center for Integrative Medicine
# Traditional Chinese Herbal Therapy Intake Form

Name ______________________________ CLINIC # ____________________
Last, First Middle

Date of Birth: ____________________ Gender: ☐M ☐F

Your e-mail: ______________________________

Personal Physician: ____________________ Address: ____________________

Emergency Contact: ____________________ Phone: ____________________

How did you hear about Traditional Chinese Herbal Therapy?

☐Physician: ______________ ☐ Friend: ______________ ☐ Pamphlet ☐ Seminar ☐ Other: __________

## Purpose for Visit

**Main issue(s)**, in order of significance to you:

| | | | | | |
|---|---|---|---|---|---|
| 1. | ☐ Severe | ☐ Moderate | ☐ Slight | ☐ Normal | ______________ |
| 2. | ☐ Severe | ☐ Moderate | ☐ Slight | ☐ Normal | ______________ |
| 3. | ☐ Severe | ☐ Moderate | ☐ Slight | ☐ Normal | ______________ |
| 4. | ☐ Severe | ☐ Moderate | ☐ Slight | ☐ Normal | ______________ |

How do these conditions impair your daily activities? ______________________________

Other treatments you have used: ______________________________

How long have you had these symptoms? ______________________________

What makes your symptoms better? ____________________ Worse? ____________________

Have you received a medical diagnosis? ☐ Yes ☐ No If yes, what is it? ____________________

**Current Medications:** ______________________________

**Food Allergies** ☐ Yes ☐ No If yes, circle all that apply: Soy, Gluten, Wheat, Tree Nuts, Citrus, Sesame, Latex, Other_

______________________________

**Medication Allergies:** ______________________________

**Please check all that apply:** ☐ Pregnant ☐ Pacemaker ☐ Lymphedema ☐ Infection of skin; location: __________

## Patient Medical History

How was your childhood health? ______________________________
Hospital visits/stays: ______________________________
Immunizations: ______________________________
Surgeries: ______________________________

**EMOTIONS & SLEEP:**

How do you feel emotionally?________________________________________

Are you: ☐ Married/Stable Relationship ☐ Single ☐ Widowed How do you feel about your relationship?__________

How do you hold your stress?________________________________________

How do you relax?____________________________________________

How would you rate your stress level? (0 little or no stress to 10 high stress):________

How long do you normally sleep? ______ Hours a night Do you feel rested upon waking? ____________

**Do you have any of the following (please check all those that apply):**

| √ | **Overall Temperature (KI Fxn)** |
|---|---|
| | Cold Hands |
| | Cold Feet |
| | Sweaty Hands |
| | Sweaty Feet<br>Hot body temperature (sensation) |
| | Cold body temperature (sensation) |
| | Afternoon flushes |
| | Night sweats |
| | Heat in the hands, feet and chest |
| | Hot flashes any time of the day |
| | Thirsty |
| | Perspire easily |
| | Lack of perspiration |
| | Take water to bed |
| | Difficulty keeping eyes open in the daytime |

| √ | **Overall Energy (LU,KI Fxn)** |
|---|---|
| | Shortness of breath |
| | Difficulty keeping eyes open in the daytime |
| | General Weakness |
| | Easily catch colds |
| | Feel worse after exercise |

| √ | **Blood (LIV,SP,HT Fxn)** |
|---|---|
| | Dizziness |
| | See floating black spots |

| √ | **HT Fxn** |
|---|---|
| | Palpitations |
| | Anxiety |
| | Sores on the tip of the tongue |
| | Restlessness |
| | Mental confusion |
| | Chest pain traveling to shoulder |
| | Frequent dreams |
| | Wake unrefreshed |
| | Drink coffee (#of cups per day:__) |

| √ | **LU Fxn** |
|---|---|
| | Nasal discharge (Color:________) |
| | Cough |
| | Nose bleeds |
| | Sinus congestion |
| | Dry mouth |
| | Dry throat |
| | Dry nose |
| | Dry skin |
| | Allergies (to what?__________) |
| | Alternating fevers and chills |
| | Sneezing |
| | Headache (location:_________) |
| | Overall achy feeling in the body |
| | Stiff neck |
| | Stiff shoulders |
| | Sore throat |
| | Difficulty breathing |
| | Smoke cigarettes (#per day:___) |
| | Sadness |
| | Melancholy |

| √ | **SP Fxn** |
|---|---|
| | Low appetite |
| | Abrupt weight gain |
| | Abrupt weight loss |
| | Abdominal bloating |
| | Abdominal gas |
| | Gurgling noise in the stomach |
| | Fatigue after eating |
| | Prolapsed organs (organ:_______) |
| | Easily bruised |
| | Hemorrhoids |
| | Pensive/Reflective/Day dreaming |
| | Over thinking |
| | Worry |

| √ | **SP,ST,LI,SI Fxn** |
|---|---|
| | Loose stool |
| | Constipation |
| | Incomplete bowel movements |
| | Diarrhea |
| | Blood in stool |
| | Mucous in stool |
| | Undigested food in stool |
| | General sensation of heaviness in the body |
| | Mental sluggishness |
| | Mental fogginess |
| | Swollen hands |
| | Swollen feet |
| | Swollen joints |
| | Chest congestion |
| | Nausea |
| | Snoring |

| √ | **ST Fxn** |
|---|---|
| | Burning sensation after eating |
| | Large appetite |
| | Bad breath |
| | Mouth(canker) sores |
| | Bleeding, swollen or painful gums |
| | Heartburn |
| | Acid regurgitation |
| | Ulcer (diagnosed) |
| | Belching |
| | Hiccups |
| | Stomach Pain |
| | Vomiting |
| | Sensitive to medications |
| | Prone to drug's adverse reactions |

| √ | LIV,GB Fxn |
|---|---|
| | Alternating loose and hard stool |
| | Chest pain |
| | Tight sensation in chest |
| | Bitter taste in mouth |
| | Anger easily |
| | Frustration |
| | Depression |
| | Irritability |
| | Frequent inability to adapt to stress |
| | Skin rashes |
| | Headaches at the top of the head |
| | Tingling sensation |
| | Numbness |
| | Muscle Spasms |
| | Muscle twitching |
| | Muscle cramping |
| | Seizures |
| | Convulsions |
| | Lump in throat |
| | Neck tension |
| | Limited range of motion, neck |
| | Shoulder tension |
| | Limited range of motion, shoulder |
| | Drink alcohol |
| | Recreational drugs |
| | High pitched ringing in the ears |
| | Gall stones |
| | Sexually transmitted disease |

| √ | Eyes (LIV Fxn) |
|---|---|
| | Itchy |
| | Bloodshot |
| | Hot |
| | Dry |
| | Watery |
| | Gritty |
| | Blurred vision |
| | Decreased night vision |
| | Near-sighted |
| | Far-sighted |

| √ | Libido |
|---|---|
| | Normal |
| | High |
| | Low |

| √ | KI,UB Fxn |
|---|---|
| | Frequent cavities |
| | Easily broken bones |
| | Sore knees |
| | Weak knees |
| | Cold sensation in the knees |
| | Low back pain |
| | Poor memory |
| | Excessive hair loss |
| | Low-pitched ringing in the ears |
| | Kidney stones |
| | Bladder infections |
| | Frequent night time urination |
| | Lack of bladder control |
| | Fear |
| | Easily startled |

| √ | Urination |
|---|---|
| | Normal color |
| | Dark yellow |
| | Clear |
| | Reddish |
| | Cloudy |
| | Scanty |
| | Profuse |
| | Strong odor |
| | Burning |
| | Painful |
| | Difficult |
| | Urgent |
| | Frequent |

| √ | Overall Temperature (KI Fxn) |
|---|---|
| | Cold Hands |
| | Cold Feet |
| | Sweaty Hands |
| | Sweaty Feet |
| | Hot body temperature (sensation) |
| | Cold body temperature (sensation) |
| | Afternoon flushes |
| | Night sweats |
| | Heat in the hands, feet and chest |

| √ | Women Only |
|---|---|
| | Regular cycle? ___Y ___N |
| | Date of last period:_________ |
| | Infertility? ___Y ___N |
| | Number of children:_______ |
| | Age of first menstruation:______ |
| | Average # of days of flow:______ |
| | Average # of days of cycle:______ |
| | Pregnant? ___Y ___N |
| | Number of pregnancies:______ |
| | Number of miscarriages:______ |
| | Number of abortions:______ |
| | Age of menopause:_______ |
| | Vaginal discharge: ___Severe ___Moderate ___Slight ___Normal |
| | Menstrual bleeding: ___Severe ___Moderate ___Slight ___Normal ___Clots __Spotting |
| | Color of menses:_______ |
| | Irregular menstruation |
| | Vaginal itching/burning |
| | Uterine fibroids |
| | Birth control use; what type:_____________ |
| | *Do you experience any of the following PMS symptoms:* |
| | Nausea |
| | Headaches |
| | Migraines |
| | Anxiety |
| | Food cravings |
| | Irritability |
| | Breast swelling |
| | Breast tenderness |
| | Depression |
| | Bloating |
| | Vomiting |
| | Dull pain, where?_________ |
| | Sharp pain, where?_________ |
| | Pain before period |
| | Pain during period |
| | Pain after period |

| √ | Men Only |
|---|---|
| | Swollen Testes |
| | Testicular Pain |
| | Impotence |
| | Premature Ejaculation |
| | Feeling of cold or numb in testicles |

**Women Only**

☐ Not Applicable

Please fill in the following menstrual chart:

☐ I no longer have periods

| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| Color (normal, bright red, pale, brown, rust, dark, purple, other) | | | | | | | |
| Amount of flow (normal, heavy, light) | | | | | | | |
| Pain/cramps (location, dull, sharp, other) | | | | | | | |
| Clots (large, small, black, purple, red, other) | | | | | | | |
| Vomiting (check if yes) | | | | | | | |
| Nausea (check if yes) | | | | | | | |
| Other: | | | | | | | |
| History of fertility problems? Please provide details. | | | | | | | |

## PLEASE COMPLETE IF YOU ARE SEEKING TREATMENT FOR PAIN:

☐ No pain

Please describe your pain level (0 no pain at all to 10 being the worst):

0......2......3......4......5......6......7......8......9......10

Do any of the following lesson the pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other:______________________

Do any of the following worsen the pain?

☐ Pressure ☐ Cold ☐ Heath ☐ Exercise ☐ Other:______________________

Location of pain: ______________________________________

How long have you had pain? ________years ________months ________days

How often are you experiencing pain: ______________________________

What makes the pain worse:______________________________

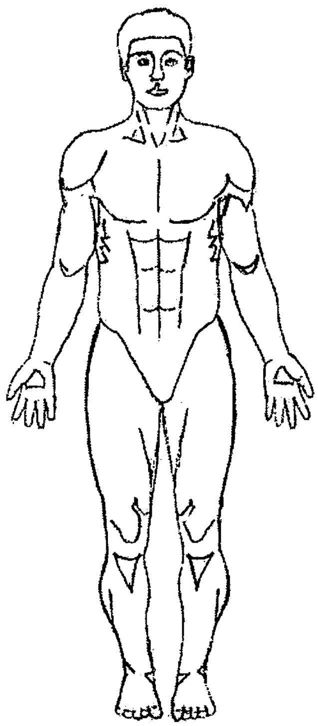
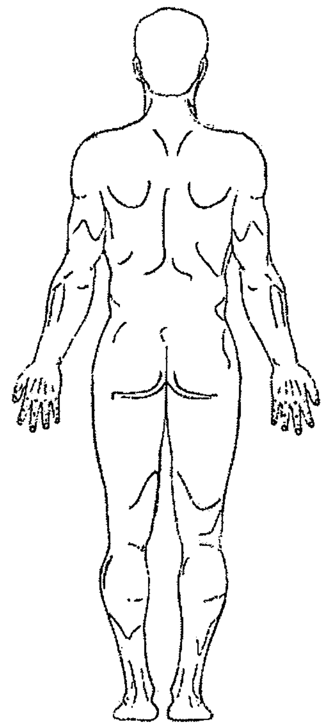
Pain character: ☐ Dull ☐ Sharp ☐ Cramping ☐ Burning ☐ Radiating ☐ Ache ☐ Moves ☐ Numb ☐Tingling

When did pain begin: ______________________________

Was pain caused by an injury: ☐ Yes:______________________ ☐ No

Prior treatment: ☐ Medication ☐ Blocks/Injections ☐ Surgery ☐ PT ☐ Chiropractor ☐ Massage ☐ Other:__________

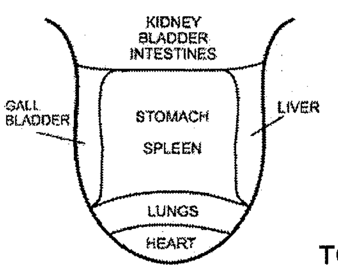
Using the letters at the bottom of the page to describe your pain, indicate directly on the figures the area(s) where you are experiencing pain.

| | | | |
|---|---|---|---|
| **D- Dull** | **S- Sharp** | **C – Cramping** | **B – Burning** |
| **R – Radiating** | **M – Moves About** | **N – Numbness** | **T – Tingling** |
| **X – Scars from injury or surgery** | **A – Ache** | **O – Rashes, Skin Disorders** | **Other:** |

****For Practitioner Only****

***<u>TCM Tongue Dx:</u>***




TCM Tongue Characteristics:________________________________________

***<u>TCM Pulse Dx:</u>***

**Left Side**

| | Cun | Guan | Qi |
|---|---|---|---|
| Floating | | | |
| Mid | | | |
| Deep | | | |

**Right Side**

| | Cun | Guan | Qi |
|---|---|---|---|
| Floating | | | |
| Mid | | | |
| Deep | | | |

TCM Pulse Characteristics:________________________________________

# Cleveland Clinic Tanya I. Edwards MD Center for Integrative Medicine

## Traditional Chinese Herbal Therapy Information

Chinese herbal medicine is a major part of Traditional Chinese Medicine. It has been used for centuries in China, where herbs are considered fundamental therapy for many acute and chronic conditions. Chinese herbs can treat a variety of disorders, <u>but they are not a substitute for conventional medical treatment and diagnoses.</u>

I understand that different disorders may require different length of the treatment that may range from few days to a few years. I am aware that it may take a few weeks to notice subtle changes and up to 3 months for the herbal formula to reach its therapeutic potential. It is also important to note that because everyone responds to treatment differently, Traditional Chinese Herbalist cannot guarantee the outcome of the treatment.

I understand that the herbs and nutritional supplements (which are from plant, animal, or mineral sources) that have been recommended are traditionally considered safe but some allergic reactions or other side effects (i.e. nausea, gas, stomach ache, vomiting, headache, diarrhea, and rashes) may occur.

I understand that it is important to provide complete information about all medications and nutritional supplements that I am taking in order to avoid any possible interactions with Chinese herbs.

I confirm that counseling and treatment instructions have been provided to me, including but not limited to the need for herbal therapy, patient instructions on how to take the herbal therapy, explanation of possible contraindications and adverse reactions.

I have been instructed on sources of care in case of an adverse reaction. I have been instructed to inform my health care providers (Physicians, pharmacists, etc.) of the herbal therapy that has been provided to me.

I, the undersigned, have read and understand the above statements and have had the opportunity to ask questions regarding my treatment.

______________________________ ______________________________

Signature of Patient Date

______________________________ ______________________________

Signature of Practitioner Date