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INSTITUT FÜR CHINESISCHE MEDIZIN

To better assist you in your treatment, we will need some information on your health. All details of your current health and health history will be interwoven, to create a picture of your state of health and an individualized Chinese medical diagnosis. Please take a few minutes to fill out this questionnaire. It is an important tool for health support and prevention. The information will be looked over and discussed at your first interview with your therapist.

☑ CHECK ONLY WHEN ANSWER IS YES

✓☐ CHECK WHEN THERE ARE ANY UNCERTAINTIES

HEALTH ISSUES IN YOUR FAMILY

	Yourself	*Your child*	*Your mother*	*Your father*	*Your sister*	*Your brother*
Death		☐	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐	☐	☐
Psychiatric Issues	☐	☐	☐	☐	☐	☐
Tumor / Carcinoma	☐	☐	☐	☐	☐	☐
Blood Disorder	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Rheumatism/ Athritis	☐	☐	☐	☐	☐	☐
Hypertension/ Heart	☐	☐	☐	☐	☐	☐
Allergies / Skin	☐	☐	☐	☐	☐	☐
Asthma / Lung	☐	☐	☐	☐	☐	☐
Kidney/ Bladder	☐	☐	☐	☐	☐	☐
Digestive	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Epilepsy / Neurological	☐	☐	☐	☐	☐	☐
Alcohol / Substance Abuse	☐	☐	☐	☐	☐	☐

CHILDHOOD DISEASES THAT YOU HAVE HAD / check a plus sign by immunizations (+ ☐):

☐ Measles
☐ Mumps
☐ Polio
☐ Chicken Pox / Varicella

☐ Whooping Cough
☐ Diphtherie
☐ Scarlet Fever
☐ German Measles/ Rubella

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ISSUES WITH:

- ☐ Pneumonia
- ☐ Skin
- ☐ Tuberculosis
- ☐ Pancreas
- ☐ Spleen
- ☐ Liver
- ☐ Malaria
- ☐ Thrombosis
- ☐ Thyroid
- ☐ Stomach
- ☐ Intestinal/ Hemorrhoids
- ☐ Neuralgia
- ☐ Disc Herniation
- ☐ Stroke
- ☐ Genitals/ STD
- ☐ Eyes/ Ears

OTHER DISEASES?

WERE YOU EVER HOSPITALIZED ? WHY, WHEN & LENGTH OF STAY ?

- ☐ Do you have a skin rash / numbness or tingling
- ☐ Do you get bruised easily
- ☐ Do you bleed easily from injury and are you unable to stop the bleeding
- ☐ Do you have prominent scars (with numbness, pain, burning, itching)
- ☐ Are you prone to fainting/ dizziness from standing-up too quickly
- ☐ Do you have tremoring of hands/ whole body
- ☐ Has your handwriting changed in the past few weeks
- ☐ Do you have issues with concentration/ memory
- ☐ Do you have difficulties with decisions
- ☐ Do you often feel alone/ depressed/ cry a lot
- ☐ Do you have difficulties to relax / worry a lot
- ☐ Do you have nightmares/ fear
- ☐ Are you easily angered/ irritated
- ☐ Do you have problems in the family or at work / sexual dysfunction
- ☐ Have you ever tried/ thought of suicide
- ☐ Have you ever sought psychiatric help
- ☐ Have you lost/ gained more than 6 kg in the past 6 months
- ☐ Do you often feel cold/ hot
- ☐ Do you have no appetite/ are always hungry
- ☐ Are you often thirsty/ not thirsty
- ☐ Do you have swollen glands in your armpit / inguinal curve
- ☐ Are you fatigued/ tired
- ☐ Do you play sports/ exercise more than 3 times a week
- ☐ Do you drink more than 6 cups of coffee / Cola / black tea/ green tea a day
- ☐ Do you smoke, if so, how many per day
- ☐ Do you consume Alcohol / Marijuana daily
- ☐ Do you regularly take sleep medication/ pain medication/ tranquilizers

- ☐ Do you use Heroin / Cocaine / LSD / Ecstasy

- ☐ Do you experience discomfort in the abdomen/ heartburn/ acid reflux
- ☐ Do you have abdominal bloating after meals/ excessive belching
- ☐ Are you prone to nausea/ vomiting
- ☐ Have you ever vomitted blood
- ☐ Do you experience difficulties/ pain when swallowing
- ☐ Do you experience constipation more than 2 times a week
- ☐ Do you often have loose stools/ diarrhea
- ☐ Do you have black/ blood in your stools
- ☐ Do you have pain by defecation/ bleeding from the rectum
- ☐ Do you regularly wake-up at night to urinate
- ☐ Do you urinate more than 6 times a day
- ☐ Do you experience incontinence
- ☐ Do you experience burning with urination
- ☐ Is your urine brownish/ bloody
- ☐ Do you experience difficulty in starting urination /urinary urgency
- ☐ Do you experience headache once or more times a week
- ☐ Do you wear glasses/ contact lenses/ have blurred vision
- ☐ Do you sometimes see double
- ☐ Do you often have tearing/ dry eyes
- ☐ Do you have difficulties with hearing
- ☐ Do you have ear pain/ discharge from your ear
- ☐ Do you have intermittent/ permanent tinnitus
- ☐ Do you have teeth problems/ sensitive/ painful tongue
- ☐ Do you have receeding/ swollen gums
- ☐ Has your sense of taste/ smell changed in the last few months
- ☐ Do you have a runny/ blocked nose without a cold
- ☐ Do you experience unexplained sneezing attacks/ nosebleeds
- ☐ Do you get colds/ influenza often
- ☐ Do you have hoarseness/ sore throat without a cold
- ☐ Do you have enlarged tonsils
- ☐ Do you experience coughing fits
- ☐ Are you often breathless/ need a few pillows to lay down
- ☐ Do you have sputum/ cough with bloody sputum
- ☐ Do you wake-up in the night breathless/ coughing
- ☐ Do you sweat a lot/ have nightsweating
- ☐ Do you have a high blood pressure/ dizziness
- ☐ Do you experience heart palpitations
- ☐ Do you experience pain/ tension in the chest
- ☐ Are you ankles/ feet swollen
- ☐ Do you experience cramping in the legs at night/ while walking

FEMALE:

- ☐ Are you in menopause
- ☐ Have you had a hysterectomy
- ☐ Have you experienced bleeding after intercourse
- ☐ Do you bleed between menstrual periods
- ☐ Do you experience vaginal itching/ excessive vaginal discharge
- ☐ Do you check your breasts every month
- ☐ Have you observed lumps your breasts / experienced pain in your breasts

When was your last PAP-Test/ Smear:
How often have you been pregnant:
How many children have you given birth to:

MALE:

- ☐ Do you experience slow / weak urine stream
- ☐ Do you experience burning / discharge from your penis
- ☐ Have you observed lumps in/ swelling of your scrotum
- ☐ Do you experience testical pain

When was your last prostate screening:

PRESCRIBED MEDICATION:

COUNTRIES YOU HAVE VISITED IN THE LAST YEAR:

OTHER THERAPIES THAT YOU ARE CURRENTLY RECEIVING:

WHAT WOULD YOU LIKE TO TREAT WITH CHINESE MEDICINE:

WHO IS YOUR DOCTOR(GENERAL PRACTITIONER), WHICH OTHER DOCTORS ARE YOU BEING TREATED BY?