FAMILY CLINIC OF NATURAL MEDICINE

3205 East Washington Avenue Madison, WI 53704 608.222.2700 www.familynaturalmedicine.com info@familynaturalmedicine.com

Are you presently taking any of the following medications? Or you may provide us a list of medications you are currently using during your visit.

Medications	No	Yes	Dosage and Frequency
Analgesics (Aspirin, Ibuprofen, Naproxen, Sodium, etc.	☐	☐	
Cardiovascular Agents (Digoxin, Lanoxin, Captopril, etc.)	☐	☐	
Laxatives	☐	☐	
Antacids (Bicarbonate of Soda, Calcium Carbonate, etc.)	☐	☐	
Sedative, Antianxiety, Antipsychotic drugs (Lithium, Thioridazine, Chlorpromazine, Prozac, etc.)	☐	☐	
Anti-Inflammatories (Predinisone, other corticosteroids, NSAIDs, etc.)	☐	☐	
Diuretics (Lasix)	☐	☐	
Antibiotics	☐	☐	
Elixirs containing sorbitol (Theophylline, Acetaminophen, etc.)	☐	☐	
Insulin or Diabetic Pills	☐	☐	
Sleeping Pills	☐	☐	
Thyroid Medication	☐	☐	
Blood-thinning Pills	☐	☐	
Seizure Medication	☐	☐	
Weight Reducing Pills	☐	☐	
Birth Control Pills	☐	☐	
Hormones	☐	☐	
Blood Pressure Pills	☐	☐	

List any other including over-the-counter medications you currently take/use:

Please list any herbal, or other natural supplements, vitamins and minerals you are taking:

Allergies: (List allergen name and the type of reaction, write n/a if none)

Medication (s):		Reaction:	
Food/Insects/Others:		Reaction:	

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Chinese Medicine Consultation Review

What are your current complaints?

#1		How long?	
#2		How long?	
#3		How long?	
#4		How long?	

Please check the appropriate descriptions and fill in the necessary information:

Emotions: ☐depressed ☐sad ☐panic attack ☐anger ☐anxiety

Energy: ☐low ☐exhausted ☐hyperactive

Sleep Pattern: ☐have difficulty falling asleep ☐wake up _____ times per night

☐wake up too early ☐cannot go back to sleep after waking up

Menstrual Cycle (Female patient only):

average days of the cycle _____ days of menstruation period _____

☐clots ☐menstrual pain COLOR: ☐pale red ☐bright red ☐dark red

EMOTION AROUND MENSTRUAL PERIOD: ☐depression ☐irritability ☐anger ☐crying

☐anxiety others _____

Emotions occur: ☐before period ☐during period ☐after period

Temperature: ☐fever ☐cold hands ☐cold feet ☐hot flash

Sweating: ☐too little ☐too much ☐night sweats

Sensitivity and Allergy: ☐cold ☐hot ☐dampness ☐food ☐dust ☐hay

☐pollen others _____

Appetite and Digestion: ☐poor appetite ☐rapid hungering ☐craving ☐nausea

☐bloating ☐gas

Bowel Movement: ☐constipation ☐diarrhea ☐loose ☐watery ☐incomplete defecation

☐hard and dry ☐strong smell ☐with mucus ☐with blood

time of day when BM occurs _____

Body Weight: ☐overweight ☐underweight How may pounds would you like to gain/lose? _____

Liquid Intake: ☐dry mouth ☐thirsty ☐drink a lot of water

☐not thirsty, but drink a lot of water anyway

Urination: ☐frequent ☐urgent ☐burning ☐painful ☐cloudy ☐dark color ☐foul smell

☐retention ☐bloody number of times per day _____ number of times per night _____

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For patient with any pain and related condition(s), please check the appropriate boxes below and mark on the figure.

Location	Level (1-10)	Dura-tion	Constant/ intermittent	Stabbing	Heavy	Sore	Dull	Burning	Numb/ Tingling
Headache			☐	☐	☐	☐	☐	☐	☐
Jaw			☐	☐	☐	☐	☐	☐	☐
Upper back			☐	☐	☐	☐	☐	☐	☐
Middle back			☐	☐	☐	☐	☐	☐	☐
Lower back			☐	☐	☐	☐	☐	☐	☐
Chest			☐	☐	☐	☐	☐	☐	☐
Neck			☐	☐	☐	☐	☐	☐	☐
Shoulders			☐	☐	☐	☐	☐	☐	☐
Upper Arm			☐	☐	☐	☐	☐	☐	☐
Elbows			☐	☐	☐	☐	☐	☐	☐
Forearm			☐	☐	☐	☐	☐	☐	☐
Wrist			☐	☐	☐	☐	☐	☐	☐
Hands			☐	☐	☐	☐	☐	☐	☐
Buttocks			☐	☐	☐	☐	☐	☐	☐
Thighs			☐	☐	☐	☐	☐	☐	☐
Knees			☐	☐	☐	☐	☐	☐	☐
Legs			☐	☐	☐	☐	☐	☐	☐
Ankles			☐	☐	☐	☐	☐	☐	☐
Foot			☐	☐	☐	☐	☐	☐	☐