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Traditional Chinese Medicine For Modern Health

ASTHMA INTAKE FORM

FIRST NAME _____ **LAST** _____ **DATE OF BIRTH** _____

Address _____

Postal/Zip Code _____

Phone Home _____ **Cell** _____

Emergency Contact _____

E-Mail Address _____ **Occupation** _____

How did you hear about us? Safeway, shared Vision (Vancouver Woman) _____

Family Physician: _____

NAME _____ **PHONE** _____

Height: _____ Weight: _____

How long have you had Asthma? _____

When and how was your Asthma diagnosed? _____

What seemed to be the initial cause of your Asthma? _____

Asthma Symptoms (Please check any of the following symptoms you currently have, or have had in the past)

Wheezing	Cough	Shortness of breath
Sneezing	Chest tightness	Low immunity
Snoring	Throat clearing	Swollen glands
Itchy eyes/nose	Runny nose	Low energy
Nasal congestion	Trouble lying down	Sweating
Fever	Nasal polyps	Other (please specify)

How many days per week/month do you have symptoms during the day? _____

How many days per week/month do you have symptoms during the night? _____

Have You Taken Chinese Herbal Medicines? _____ / _____

YES NO

MEDICAL HISTORY

How often do you suffer from an acute attack or exacerbation of your symptoms? _____

Have you ever been hospitalized or needed emergency care for your Asthma, if so, how often? _____

Is it getting worse? Yes: No:

What makes it better? _____

How frequently are you absent from work/school due to your Asthma? _____

Asthma Triggers

(Please indicate which are triggers with a check mark)

Dust	Mold	Pets
Pollution	Food	Food additives
Exercise	Laughter	Stress
Workplace/ School	Menstruation	Pollen
Colds/ Viral Infect.	Fumes	Fragrances
Change in temp.	Smoke	Other (specify)

Other current treatments _____

Family Medical History

Allergic Rhinitis? Yes No

Asthma? Yes No

Stress Eczema? Yes No

Food Allergies: Yes No

Other? _____

Diphtheria	Rubella
Tetanus	Chicken pox
Pertussis	Mumps
Polio	Measles
	Other? _____

Please indicate if there was any side effect from any of the above immunizations _____

Past Medical History

(Please check any of the following conditions you currently have, or have had in the past)

Jaundice	Allergies	Tonsillitis
Born Premature	Impetigo	Bedwetting
Low birth weight	Fever	Eczema
Hay fever	Measles	ADHD
Pneumonia	Canker sores	Cold sores
Strep throat	Colic	Whooping cough
Oral thrush	Hives	Ear infections
Acid reflux	RSV/Bronchitis	Sinusitis
Bronchitis	Nosebleed	Arthritis
Parents smoke	Conjunctivitis	Other (specify)

Surgeries (please list) _____

Major trauma? (Car accident / fall/ etc.) _____

Asthma Medication

Are you currently taking any of the following Asthma medications (please include frequency, form of administration and dosage)?

- Bronchodilators** [quick acting/rescue medication]
- Please circle your current medication: Airet®, Proventil®, Ventolin®, levalbuterol (Xopenex®), Tornalate® (bitolterol), Maxair® (pirbuterol), and Brethaire® (terbutaline).

Dosage/frequency:

Inhaled steroids

- please circle your current medication: Beclovent®, Qvar®, Vanceril® (beclomethasone), Pulmicort® Turbohaler (budesonide), Aerobid® (flunisolide), Flovent® (fluticasone), Pulmicort® Respules and Azmacort® (triamcinolone)

- Dosage/frequency:

Long-acting beta-agonists

- please circle your current medication: Serevent® (salmeterol) and Foradil® (formoterol).

- Dosage/frequency:

**Theophylline**

- please circle your current medication: Aerolate®, Choledyl®, Elixophyllin®, Quibron®, Slo-bid®, Theochron®, T-Phyl®, and Uniphyll®.

- Dosage/frequency:

Besides Asthma medications are you currently on any prescribed medicine? Yes No

Are you currently taking any non-prescribed medicine (for i.e. herbs, vitamins, supplements etc.)?

Yes No

Have you taken antibiotics before?



Yes



No

Number of times

Have you been prescribed antibiotics before? Yes No

Excluding the above listed medicine, have you taken any other medicine in the past?

DIET (please complete the sample menu according to an average day)

Morning

Noon

Evening

Snacks (when and what)

Do you eat or drink the following (if so how often)?

- | | |
|---|---|
| <input type="checkbox"/> Juice | <input type="checkbox"/> Milk |
| <input type="checkbox"/> Ice Cream | <input type="checkbox"/> Cheese |
| <input type="checkbox"/> Peanut Butter | <input type="checkbox"/> Breads |
| <input type="checkbox"/> Raw Vegetables | <input type="checkbox"/> Sweets and Sugar |

Habits:

Cigarettes –

Alcohol –

Soft drinks –

Coffee –

Tea –

Please describe or elaborate on the following questions:

Pain –

Appetite –

Thirsty –

Energy – 1 2 3 4 5 6 7 8 9 10

Sleep –

Abnormal Sweating –

Skin and hair problems –

Abnormal Swelling -

Bowel Movement – Loose? Formed? Alternating?

Other digestive problems -

Urination –

Mood –

Headaches -

Menstruation –

PMS (Premenstrual Symptoms)

How often?

How long?

Symptoms during menstruation?

Pregnancies?

Births?

Occupational Stress (Chemical, Physical, Psychological):

Exercise:

Please read the following information carefully, and ask your practitioner if there is anything that you do not understand.

I acknowledge the results vary by individual and that six months is one course of treatment. Some cases may require more than one treatment. Optimal results are achieved only if the program requirements are strictly adhered to.

Minor side effects from the herbs can occur, please inform your practitioner of any changes you experience.

I agree to have my personal information shared between practitioners for professional purposes, including research studies _____ / _____
YES NO

I, the undersigned, consent to receive treatment offered at Qi Integrated Health; I also acknowledge full responsibility for payment of services.

I, the undersigned, certify that all of the above medical history provided is true to the best of my knowledge, and I have not knowingly omitted information.

Cancellation Policy: Cancellations are accepted up to 48 hours before scheduled date of appointment. Missed appointments are charged one half of the cost of the appointment.

Name (Please Print) Signature

Name Parent Consent (Under 18 Yrs) Signature

DATE SIGNED: _____ / _____ / _____
DAY MONTH YEAR

CONFIDENTIAL