IACM
The Israeli Association of Chinese Medicine
איגוד הרפואה הסינית בישראל

Date:____________

Preliminary Questionnaire for the Treatment of Chinese Medicine

Full Name:_______________ **Date of Birth:________________** **Sex: M / F/ other**

ID number:_______________ **Address:____________________** **Health Insurance Fund: __________**

Phone number:____________ **Marital Status: __________________**

Weight: _________ **Height: __________**

1	**Have you had or been advised to have surgery?**	**Yes**	**No**
2	**Have you undergone medical tests such as: ECG, various imaging tests (CT/MRI etc), coating tests, computed tomography,urine tests, and fecal occult blood test? Detail cause, date and abnormal results____**	**Yes**	**No**
3	**Have you had any tests to detect cancerous growth, such as: radioactive examination, CT scan, oncographic test, X-ray, organ demonstration using isotopes and a biopsy?**	**Yes**	**No**
4	**Have you received radiation, chemical or radioactive treatments?**	**Yes**	**No**
5	**Have any tumors been excised?**	**Yes**	**No**
6	**Have you ever had a bone density test?**	**Yes**	**No**
7	**Do you smoke? If so how many cigarettes per day X how many years?** ____ **If you have smoked in the past, when did you stop? How many cigarettes per day X years did you smoke?** ____		
8	**Are you sick with any disease, or do you know that you have any health disorder? _______________________________________**	**Yes**	**No**
9	**Have you received or are you currently receiving any treatment or medication?**	**Yes**	**No**
Did the patient have any diseases or signs of illness listed below?			
10	**Nervous and brain diseases: paralysis, movement and / or sensory disturbances, dizziness, fainting, chronic headaches, epilepsy, mental disorders, psychological and / or psychiatric treatment, suicide attempts.**	**Yes**	**No**
11	**Cardiovascular disease: heart attack, infarction, thrombosis, angina pectoris, chest pain or pressure, shortness of breath, heart failure, suffocation, arrhythmias, accelerated heartbeat,**	**Yes**	**No**

	circulatory disorders in the legs with edema or pain, hypertension Blood, dilated veins.		
12	**<u>Arthritis and bone diseases</u>: arthritis, rheumatism, arthritis, back pain, neck pain, sciatica, osteoporosis.**	**Yes**	**No**
13	**<u>Eye, ear and throat diseases</u>: visual disturbances, hearing loss, sinusitis.** **Do you wear glasses? ___________**	**Yes**	**No**
14	**<u>For women only</u>: Are you currently pregnant? ____ If so, in what week? ____**		

1. **Do you suffer from the following problems?**

Do you have diabetes?	**Yes**	**No**	**Do you have high blood pressure?**	**Yes**	**No**
Do you have migraines?	**Yes**	**No**	**Do you consume drugs / alcohol?**	**Yes**	**No**
Do you suffer from hair loss? dandruff?	**Yes**	**No**	**Do you suffer from sexually transmitted diseases?**	**Yes**	**No**
Do you suffer from abdominal pain?	**Yes**	**No**	**Women Only: Are you a carrier of the papilloma virus?**	**Yes**	**No**

2. **Does one of your family members (parents, grandparents, siblings) suffer from one or more of the problems mentioned above? (Yes No)? If so, from which? ____**
3. **Do you take medications / herbs / supplements regularly? (Yes / No)**

   If so, please write in details:____
4. **Have you ever taken steroids / blood thinners of any kind? (Yes No)**
5. **Do you suffer from any allergies or sensitivities (such as to metals)?__________________**
6. **Do you know of a health condition that you are not explicitly asked about, which is important for the therapist to know about?**
7. **Do you know of a health condition that you are not explicitly asked about, which is important for the therapist to know about? _______________________________________**
8. **Have you received complementary medicine treatment in the past? (Yes / No)**

I am aware that I am being treated in Chinese medicine [Shiatsu Tuina Acupuncture Herbal Nutrition] by a therapist who is not a MD licensed physician. I am also aware that the treatment I receive in this context does not cancel or replace any other medical treatment.

I am aware that any change to the recommendations given to me by a doctor will be made in coordination with him, including taking medication, follow-up tests or any other recommendation.

Name and signature _______________________ Date: ______________________