Pre-Treatment Questionnaire – Chinese Medicine

Part A: Personal Information

Date: _____
Full Name: _____
Date of Birth: _____
Gender: M / F
ID Number: _____
Address: _____
HMO: _____
Phone: _____
Marital Status: _____

Part B: Patient's Health Condition

Weight: _____ **Height:** _____

1. Have you had or been advised to have surgery? ☐ Yes ☐ No
2. Have you undergone medical tests such as ECG, X-rays, CT scans, catheterization, tomography, blood tests, urine tests, or occult blood tests? If yes, please specify reason, date, and abnormal results: ☐ Yes ☐ No
3. Have you undergone any cancer screening such as radioactive tests, CT, oncographic tests, X-rays, isotope imaging, or biopsy? ☐ Yes ☐ No
4. Have you received radiation, chemotherapy, or radioactive treatments? ☐ Yes ☐ No
5. Have tumors been surgically removed? ☐ Yes ☐ No
6. Have you ever had a bone density test? ☐ Yes ☐ No
7. Do you smoke? ___ How many cigarettes per day? ___ For how many years? ___
   If you smoked in the past, when did you quit? ___ How many per day? ___
8. Do you suffer from any illness or known health condition? ☐ Yes ☐ No
9. Have you received or are currently receiving any treatment or medications? ☐ Yes ☐ No

Have you experienced any of the following conditions?

10. Nervous system and brain: paralysis, motor/sensory issues, dizziness, fainting, chronic headaches, epilepsy, mental disorders, psychological/psychiatric care, suicide attempts.
    ☐ Yes ☐ No

11. Cardiovascular: heart attack, infarction, thrombosis, angina pectoris, chest pain/pressure, shortness of breath, heart failure, suffocation, arrhythmias, palpitations, poor leg circulation with swelling/pain, hypertension, varicose veins.
    ☐ Yes ☐ No

12. Joints and bones: arthritis, rheumatism, back pain, neck pain, sciatica, osteoporosis.
    ☐ Yes ☐ No

13. Eyes, ears, throat: vision issues, hearing loss, sinusitis.
    Do you wear glasses? ___ If yes, what is the prescription? ___
    ☐ Yes ☐ No

14. For women only: Are you currently pregnant? ___ If yes, which week? ___

Part C: Medical History

Do you suffer from the following?

- Diabetes: ☐ Yes ☐ No
- Hypertension: ☐ Yes ☐ No
- Migraines: ☐ Yes ☐ No
- Drug/alcohol use: ☐ Yes ☐ No
- Hair loss / dandruff: ☐ Yes ☐ No
- Sexually transmitted diseases: ☐ Yes ☐ No
- Bloating / abdominal pain: ☐ Yes ☐ No
- HPV (women only): ☐ Yes ☐ No

Do any family members (parents, grandparents, siblings) suffer from any of the above?

☐ Yes ☐ No. If yes, specify: _____

Do you regularly take any medications, herbs, or supplements? ☐ Yes ☐ No

If yes, which? _____

Have you taken or are you currently taking steroids or any type of blood thinners?

☐ Yes ☐ No

Do you suffer from allergies or sensitivities (e.g., metals)?

_____

Are you aware of any other health condition not specifically mentioned here, which your practitioner should know about?

_____

Have you previously received complementary/alternative medicine treatment? ☐ Yes ☐ No

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Part D: Patient Declaration

I acknowledge that I am receiving treatment in Chinese Medicine (Shiatsu / Tuina / Acupuncture / Herbs / Nutrition) by a practitioner who is not a licensed M.D. I understand that this treatment does not replace any conventional medical care.

I understand that any changes to recommendations given by a physician, including medication, follow-up tests, or other instructions, will be made only in consultation with them.

Name and Signature: _____ **Date:** _____