



TCM Consultation

THINK theCare For Your Health

Name: _____

Date: _____

History and Health Information:

Please complete the following information pertaining to your health history and sign below. All information will be kept confidential and will not be released without a signed and written letter from the patient.

1. Are you under the care of a physician? Yes/No Age: _____ Sex: M/F
 If yes, for what reason? _____ Smoking: Yes/No
 Physician's Name and Contact: _____ Alcohol Use: Yes/No
2. Do you have any allergies? Yes/No If yes, please list: _____
3. Are you taking medication/supplements? Yes/No If yes, please list: _____
4. If female, are you pregnant? Yes/No If yes, what is your expected delivery date? _____
5. Please list the 3 main concerns that you would like to focus on:
 A. _____ B. _____ C. _____

I come to this clinic for consultation and accept the proposed recommendations and treatment.

Signature: _____

Contact info:

Address: _____

tel: _____ e-mail: _____

For Office Use Only

Examination: _____

Pulse diagnosis: Heart, Small intestine _____ Liver, Gallbladder _____ Kidney, Urinary bladder _____
 Lung, Large intestine _____ Spleen, Stomach _____ Kidney (Mingmen), UB _____

Tongue diagnosis: color _____ shape and size _____ coating _____

Characteristics: Yin and Yang; Exterior and Interior; Cold and Heat; Deficiency and Excess

Notes: _____

