9 PALACES TCM
Traditionelle Chinesische Medizin

Questionnaire

Please complete this questionnaire before the first appointment. The questions relate to your personal details, complaints, circumstances, habits and constitution.

Personal

☐ Mrs. ☐ Mr.

Name	First name
Street No.	Postcode/Place
Email	
Date of birth	Phone
Health insurance	Supplementary insurance ☐ Yes ☐ No

Complaints

Main complaint

____

e.g. headaches, insomnia, emotional problems, fatigue, etc.

Detailed description of the main complaint

____
____
____
____
____

Since when? How did it start? Course, time of day, trigger, aggravating factors (e.g. cold, heat, humidity, stress), improving factors, pain quality (e.g. stinging, pulling, burning),etc.

Previous therapies

____
____
____

Type, duration, success

Medications

____
____
____
____

Have you had surgeries, serious illnesses or accidents?

____
____
____
____

Family history

☐ Circulatory diseases ☐ Stroke ☐ Allergies
☐ Diabetes ☐ Obesity ☐ Nervous diseases
☐ Rheumatic diseases ☐ Epilepsy ☐ Mental diseases
☐ Tumors / carcinomas ☐ Genetic diseases
☐ other/comments

GENERAL, CONSTITUTION

Mental wellbeing

☐ 0 ☐ 20 ☐ 40 ☐ 60 ☐ 80 ☐ 100

0 - bad / 100 - very good

Physical wellbeing

☐ 0 ☐ 20 ☐ 40 ☐ 60 ☐ 80 ☐ 100

0 – bad / 100 - very good

Habits

☐ Cigarettes
How much? _________________________
☐ Marijuana
How much? _________________________
☐ Coffee
How much? _________________________
☐ Alcohol
How much? _________________________
☐ other/comments

Nutritional style

☐ Mixed food ☐ Vegetarianism
☐ Veganism
☐ other/comments

Childhood diseases

☐ Pertussis ☐ Rubella ☐ Polio
☐ Diphtheria ☐ Measles ☐ Scarlet
☐ Chickenpox / varicella ☐ Mumps
☐ other/comments

Viral diseases

☐ HIV ☐ Hepatitis A ☐ Hepatitis B
☐ Hepatitis C ☐ Herpes / herpes zoster
☐ other/comments

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Thirst, Appetite

☐ A lot of thirst	☐ Little thirst	☐ Fancy something cold
☐ Fancy something warm	☐ Carvings	☐ Low appetite
☐ Bloating	☐ Fullness	☐ Reflux
☐ Weight gain	☐ Weight loss	☐ Lost sense of taste
☐ Bitter taste in the mouth		
☐ other/comments		

Excretion

☐ Diarrhea	☐ Constipation	☐ Watery stool
☐ Strong smelling stool	☐ Hard stool	☐ Food residues in the stool
☐ Mucus in the stool	☐ Blood in the stool	☐ Frequent urination
☐ Frequent nocturnal Urinate	☐ Cloudy urine	☐ Blood in the urine
☐ Burning while urinating	☐ Stream slow / weak	☐ Cystitis
☐ other/comments		

Sleep

☐ Difficulty falling asleep	☐ Problems staying asleep	☐ Unwanted waking up
☐ Dream disturbed sleep	☐ Grinding teeth	☐ Restless sleep
☐ Fatigue		
☐ other/comments		

Temperature/sweating

☐ Cold sensations	☐ Heat sensations	☐ Do you prefer cold
☐ Do you prefer warmth	☐ Cold hands	☐ Cold feet
☐ Hot feet/hands	☐ Fever	☐ Hot flashes
☐ Night sweats	☐ Spontaneous sweating	☐ Frequent sweating
☐ other/comments		

Circulation

☐ Palpitations	☐ Angina pectoris	☐ Heart disease
☐ Circulatory collapse	☐ Irregular pulse	☐ Pacemaker
☐ Pressure on the chest	☐ Dizziness	☐ Edema
☐ other/comments		

Vein problems

☐ Thrombosis	☐ Phlebitis	☐ Varicose veins
☐ Swollen legs	☐ Calf cramps	☐ Feeling of heaviness in the Legs
☐ other/comments		

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Respiratory, Eyes + ENT

☐ Visual impairment	☐ Poor eyesight	☐ Eye spots
☐ Eye flicker	☐ Burning eyes	☐ Itchy eyes
☐ Cataract	☐ Glaucoma	☐ Tinnitus
☐ Hearing impairment	☐ Outflow from the ears	☐ Disturbing the sense of smell
☐ Chronically clogged nose / sinuses	☐ Runny nose	☐ Cough with sputum
☐ Cough without sputum	☐ Cough with blood-streaked sputum	☐ Shortness of breath
☐ Asthma	☐ Dental problems	

☐ other/comments

Allergies

☐ Pollen	☐ Dust	☐ Hay fever
☐ Food	☐ Rashes	

☐ other/comments

Skin / Hair

☐ Acne	☐ Neurodermatitis / eczema	☐ Herpes
☐ Psoriasis	☐ Skin cancer	☐ Rosacea
☐ Foot and nail fungus	☐ Increased hair loss	☐ Alopecia

☐ other/comments

Liver problems

☐ Jaundice	☐ Liver cirrhosis	☐ Fatty liver
☐ Hemochromatosis	☐ Biliary colic	☐ Gallstones

☐ other/comments

Kidney problems

☐ Type I diabetes	☐ Type II diabetes	☐ Glomerulonephritis
☐ Vascular nephropathy	☐ Interstitial nephritis	☐ Polycystic kidney disease
☐ Kidney stones		

☐ other/comments

Musculoskeletal system

☐ Neck	☐ Upper back	☐ Lower back
☐ Buttocks	☐ Hip	☐ Knee
☐ Shoulder	☐ Body aches	☐ Sensory disturbances of the arms / legs

☐ Joints (stiffness, deformation, pain, inflammation)
☐ Muscles (weakness, strength, pain, paresthesia, strength, inflammation, tremors)
☐ other/comments

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Headache

- [ ] Migraines without aura
- [ ] Migraine with aura
- [ ] Cluster headaches
- [ ] Tension headaches
- [ ] Temples
- [ ] Vertex
- [ ] Forehead
- [ ] Occipital (back of the head)
- [ ] Pulling
- [ ] Stabbing
- [ ] Diffuse
- [ ] Pulsating
- [ ] Burning
- [ ] Fixed location
- [ ] Wandering
- [ ] Heaviness
- [ ] Bandage sensation
- [ ] other/comments

Women's complaints

- [ ] Pain before the menstruation
- [ ] Pain during the menstruation
- [ ] Little blood
- [ ] Lots of blood
- [ ] Light blood
- [ ] Dark blood
- [ ] Clots in the blood
- [ ] Abnormal cycle
- [ ] Abnormal discharge
- [ ] Premenstrual Complaints PMS
- [ ] Breast tension
- [ ] Knots / pain in the breasts
- [ ] Miscarriages
- [ ] Abortions
- [ ] Menopause
- [ ] Tumors / cysts
- [ ] Stds
- [ ] Disruption of the sexual function
- [ ] other/comments

Prevention

- [ ] Birth control pills
- [ ] Hormone patch
- [ ] Coil
- [ ] Hormone stick
- [ ] other/comments

Male complaints

- [ ] Burning sensation / discharge
- [ ] Testicular pain
- [ ] Prostate enlargement
- [ ] Swelling / nodules on the testicles
- [ ] Urination (stream slow or weak)
- [ ] Prostate cancer
- [ ] Stds
- [ ] Disruption of the sexual function
- [ ] other/comments

Emotions

- [ ] Angry / irritated
- [ ] Restless / nervous
- [ ] Optimistic
- [ ] Sad / depressive
- [ ] Worrying
- [ ] Forgetful
- [ ] Anxious / terrifying
- [ ] Lack of emotion
- [ ] other/comments

Climatic factors

Are you often exposed to or suffer from the following climatic factors?

- [ ] Wind
- [ ] Dampness
- [ ] Heat
- [ ] Cold
- [ ] Dryness

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Do you have blood clotting disorders?
☐ Yes ☐ No
e.g. haemophilia A, haemophilia B or von-Willebrand syndrome (VWS)

Do you take medication to inhibit blood clotting?
☐ Yes ☐ No
z.B. Cumarinderivate, Macumar, Heparine

Do you have a pacemaker?
☐ Yes ☐ No

Do you suffer from hypertension (high blood pressure)?
☐ Yes ☐ No

Do you suffer from hypotension (low blood pressure)?
☐ Yes ☐ No

Do you have severe respiratory or circulatory disorders?
☐ Yes ☐ No

Do you suffer from epilepsy (seizures)?
☐ Yes ☐ No

Do you suffer from osteoporosis?
☐ Yes ☐ No

Do you suffer from tuberculosis?
☐ Yes ☐ No

Do you suffer from a communicable infectious disease?
☐ Yes ☐ No

Are you currently pregnant?
☐ Yes ☐ No

How did you hear about us?
____
Recommendation, internet, Google, advertising etc.

Thank you for your help!

Location, date   Signature

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