9 PALACES TCM
Traditionelle Chinesische Medizin

Patient Form

Please fill out this questionnaire before your first appointment. The questions pertain to your personal information, complaints, living conditions, habits, and constitution.

PERSONAL INFORMATIONS

Name	First Name
Date of Birth	

COMPLAINTS

Main complaint

e.g., headaches, sleep disturbances, emotional problems, fatigue, etc.

Detailed description of the main complaint

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

Previous therapies

Type, duration, success

Current medications

Have you had any surgeries, serious illnesses, or accidents?

General Health and Constitution

Family History

☐ Circulatory diseases	☐ Stroke	☐ Allergies
☐ Diabetes	☐ Obesity	☐ Nervous diseases
☐ Rheumatic diseases	☐ Epilepsy	☐ Psychological disorders
☐ Tumors / Carcinomas	☐ Genetic diseases	
☐ Other / Comments		

Mental well-being

☐ 0 ☐ 20 ☐ 40 ☐ 60 ☐ 80 ☐ 100

0 - poor / 100 - very good

Physical well-being

☐ 0 ☐ 20 ☐ 40 ☐ 60 ☐ 80 ☐ 100

0 - poor / 100 - very good

Habits

☐ Cigarettes	☐ Marijuana
☐ Coffee	☐ Alcohol
☐ Other / Comments	

Dietary

☐ Mixed diet	☐ Vegetarianism	☐ Veganism
☐ Other / Comments		

Childhood Diseases

☐ Whooping cough / Pertussis	☐ Rubella	☐ Polio
☐ Diphtheria	☐ Measles	☐ Scarlet fever
☐ Chickenpox	☐ Mumps	
☐ Other / Comments		

Viral Diseases

☐ HIV	☐ Hepatitis A	☐ Hepatitis B
☐ Hepatitis C	☐ Herpes / Herpes Zoster	
☐ Other / Comments		

Thirst and Appetite

☐ High thirst	☐ Low thirst	☐ Craving for cold
☐ Craving for warm	☐ Binge eating	☐ Loss of appetite
☐ Bloating	☐ Feeling of fullness	☐ Heartburn / Reflux
☐ Significant weight gain	☐ Significant weight loss	☐ Taste disturbance
☐ Bitter mouth taste		
☐ Other / Comments		

Excretion

☐ Diarrhea	☐ Constipation	☐ Watery stool
☐ Strong-smelling stool	☐ Hard stool	☐ Food remnants in stool
☐ Mucus in stool	☐ Blood in stool	☐ Frequent urination
☐ Frequent nocturnal urination	☐ Cloudy urine	☐ Blood in urine
☐ Burning when urinating	☐ Slow/weak stream	☐ Bladder infection
☐ Other / Comments		

Sleep

☐ Problems falling asleep	☐ Problems staying asleep	☐ Unintentional waking
☐ Dreams	☐ Teeth grinding	☐ Restless sleep
☐ Frequent tiredness		
☐ Other / Comments		

Temperature and Sweating

☐ Sensitivity to cold	☐ Sensitivity to heat	☐ Prefer cold
☐ Prefer warmth	☐ Cold hands	☐ Cold feet
☐ Hot feet/hands, especially in the evening	☐ Fever	☐ Hot flashes
☐ Night sweats	☐ Spontaneous sweating	☐ Frequent sweating
☐ Other / Comments		

Circulation

☐ Palpitations	☐ Angina pectoris	☐ Heart diseases
☐ Circulatory collapse	☐ Irregular pulse	☐ Pacemaker / Bypass / Stent
☐ Chest pressure	☐ Dizziness	☐ Edema
☐ Other / Comments		

Vein Complaints

☐ Thrombosis	☐ Vein inflammation	☐ Varicose veins
☐ Leg swelling	☐ Calf cramps	☐ Heaviness in legs
☐ Other / Comments		

Respiratory Tract, Eyes and ENT

☐ Visual disturbances	☐ Weak vision	☐ Visual spots
☐ Flickering eyes	☐ Burning eyes	☐ Itchy eyes
☐ Cataract	☐ Glaucoma	☐ Tinnitus
☐ Hearing loss	☐ Ear discharge	☐ Smell disturbance
☐ Chronic nasal congestion	☐ Runny nose	☐ Cough with phlegm
☐ Cough without phlegm	☐ Bloody cough	☐ Shortness of breath
☐ Asthma	☐ Dental problems	
☐ Other / Comments		

Allergies

☐ Pollen / Hay fever	☐ House dust	☐ Animal hair
☐ Food	☐ Skin rashes	
☐ Other / Comments		

Skin and Hair

☐ Acne	☐ Neurodermatitis / Eczema	☐ Herpes
☐ Psoriasis	☐ Skin cancer	☐ Rosacea
☐ Athlete's foot / Nail fungus	☐ Increased hair loss	☐ Circular hair loss
☐ Other / Comments		

Liver Complaints

☐ Jaundice	☐ Liver cirrhosis	☐ Fatty liver
☐ Iron storage disease / Hemochromatosis	☐ Gallbladder colic	☐ Gallstones
☐ Other / Comments		

Kidney Complaints

☐ Type I Diabetes	☐ Type II Diabetes	☐ Glomerulonephritis
☐ Vascular nephropathy	☐ Interstitial nephritis	☐ Polycystic kidney
☐ Kidney stones		
☐ Other / Comments		

Musculoskeletal System

☐ Neck	☐ Upper back	☐ Lower back / Sacrum
☐ Buttocks	☐ Hip	☐ Knee
☐ Shoulder	☐ Elbow	☐ Limb pain
☐ Sensory disturbance of arms/ legs	☐ Joints (Stiffness, Deformation, Pain, Inflammation)	☐ Muscles (Weakness, Strength, Pain, Paresthesia, Inflammation, Tremors)
☐ Other / Comments		

Headaches

☐ Migraine without aura	☐ Migraine with aura	☐ Cluster headaches
☐ Tension headaches	☐ Temples	☐ Vertex
☐ Forehead	☐ Occipital	☐ Aching
☐ Stabbing	☐ Diffuse	☐ Pulsating
☐ Burning	☐ Fixed location	☐ Wandering
☐ Pressing	☐ Feeling of heaviness	☐ Band-like sensation
☐ Other / Comments		

Women's Complaints

☐ Pain before menstruation	☐ Pain during menstruation	☐ Little blood or absence of menstruation
☐ Heavy bleeding	☐ Bright blood	☐ Dark blood
☐ Blood clots	☐ Irregular cycle	☐ Abnormal discharge
☐ Premenstrual syndrome (PMS)	☐ Breast tension	☐ Lumps/pain in the breast
☐ Miscarriages	☐ Abortions	☐ Menopause
☐ Tumors / Cysts	☐ Sexually transmitted diseases	☐ Sexual dysfunction
☐ Other / Comments		

Contraception

☐ Birth control pill	☐ Hormone patch	☐ IUD
☐ Hormone implant		
☐ Other / Comments		

Men's Complaints

☐ Burning / Discharge	☐ Testicular pain	☐ Enlarged prostate
☐ Swelling / Nodules on testicles	☐ Slow or weak urine stream	☐ Prostate cancer
☐ Sexually transmitted diseases	☐ Sexual dysfunction	
☐ Other / Comments		

Emotions

☐ Angry / Irritable	☐ Restless / Nervous	☐ Cheerful / Optimistic
☐ Sad / Depressed	☐ Worried	☐ Forgetful
☐ Anxious / Startled	☐ Lack of emotions	
☐ Other / Comments		

Klimatische Faktoren

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

☐ Wind / Draught	☐ Humidity	☐ Heat
☐ Cold	☐ Dryness	

Do you have any blood clotting disorders?

☐ Ja ☐ Nein

e.g., Hemophilia A, Hemophilia B, or von Willebrand syndrome (VWS)

Do you take medications to inhibit blood clotting?

☐ Ja ☐ Nein

e.g., coumarin derivatives, macumar, heparins

Do you have a pacemaker?

☐ Ja ☐ Nein

Do you suffer from hypertension (high blood pressure)?

☐ Ja ☐ Nein

Do you suffer from hypotension (low blood pressure)?

☐ Ja ☐ Nein

Do you have any severe respiratory or circulatory disorders?

☐ Ja ☐ Nein

Do you suffer from epilepsy (seizures)?

☐ Ja ☐ Nein

Do you suffer from osteoporosis?

☐ Ja ☐ Nein

Do you suffer from tuberculosis?

☐ Ja ☐ Nein

Do you suffer from a contagious infectious disease?

☐ Ja ☐ Nein

Are you currently pregnant?

☐ Ja ☐ Nein

How did you hear about us?

_____

Recommendation, internet, Google, advertisement, etc.

Thank you for your cooperation!