**New Patient Intake Form**

Name:       Date:

Address:       DOB:

City, State, Zip:       Home phone:

Email:       Cell:

Occupation:       Work phone:

Emergency Contact: (name & phone)

Referred by:      Have you had acupuncture/herbal medicine?

Reason for today's visit:

How long have you had this condition?

What other treatment have you received for this condition?

Please list your family physician & phone number:

Allergies:

Height:       Weight:

**Family History:** (mark all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Arteriosclerosis | Cancer | Hypertension | Asthma |
| Diabetes | Seizures | Alcoholism | Heart Disease |
| Stroke |  |  |  |

**Your Past Medical History:** (mark all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Aids/HIV | Pacemaker | Alcoholism | Rheumatic Fever |
| Cancer | Thyroid Disorders | Diabetes | Tuberculosis |
| Emphysema | Arteriosclerosis | Food allergies | Kidney or Gallstones |
| Multiple Sclerosis | Stroke | Ulcers | Fractures |
| Epilepsy/seizures | Venereal Disease | Heart Disease | Seasonal allergies |
| Hypertension | Hernias | Herpes | Hepatitis |

When was your last physical?

List any major traumas?

Major Surgeries:

Have you had a colonoscopy?  Yes /  No An EGD? (for upper digestive tract)  Yes /  No

Please list your current daily medications / supplements:

**Please describe your average daily menu:**

Breakfast :      Lunch:       Dinner:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Coffee | Tea | Sugar | Artificial sweetener | Chocolate |

**Do you want information on nutritional counseling to create a healthier lifestyle?**

|  |  |  |
| --- | --- | --- |
| Yes | No | Not at this time |

**History of Pain**

|  |  |  |
| --- | --- | --- |
| 0 = none | 5 = moderate | 10= severe |

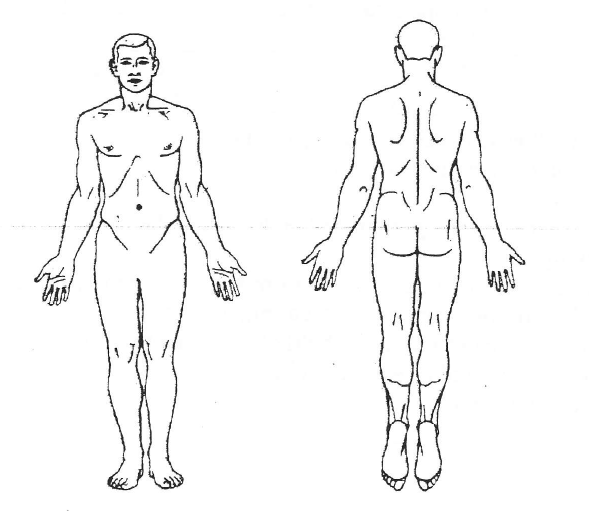
Please rate your pain below using the scale:

1. **1 2 3 4 5 6 7 8 9 10** (circle one number or the range)

**Please describe your pain.** (mark all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Stabbing/sharp | Dull/aching | Numbness/tingling | Throbbing |
| Spasm | Burning | Heaviness | Pulling/tight |
| Fixed Location | Moves around | Pain is constant | Pain comes & goes |
| Worse in morning | Worse end of day | Worse at night | Better w/movement |
| Worse w/movement | Interrupts sleep | Worse sitting | Worse standing |
| Worse lying down | Worse lifting/grasp | Worse w/pressure | Better w/pressure |
| Better w/heat | Better w/cold | Worse walking | Worse driving |

**PLEASE MARK THE LOCATIONS OF YOUR PAIN ON THE MODEL BELOW:**



**Please check all that apply**

**Respiratory**

|  |  |  |  |
| --- | --- | --- | --- |
| Cough | Short of breath | Asthma | Chest tightness |
| Difficult inhale | Difficult exhale | Sneezing | Sinus congestion |
| Nasal congestion | Sore throat | Frequent colds | Loss of voice |
| Weak voice | Hoarse voice | Other |  |

**Dizziness**

|  |  |  |
| --- | --- | --- |
| Standing up | Severe, loss of balance | worse w/fatigue |

**Sweating**

|  |  |  |  |
| --- | --- | --- | --- |
| Spontaneous | Night | Daytime | Hands & feet |
| Only head | Only arms/legs | Only hands | Only feet |

**Head/eyes/ears/throat**

|  |  |  |  |
| --- | --- | --- | --- |
| Headaches | Frontal | Temple | Back of neck |
| Top of head | Whole head | Frequency? | Migraines |
| Bleeding gums | Mouth sores | Tongue sores |  |
| TMJ | Ringing in ears |  |  |

**Gastrointestinal**

|  |  |  |  |
| --- | --- | --- | --- |
| Poor appetite | Gnawing hunger | Stomach rumbling | Indigestion |
| Acid reflux | Nausea/vomiting | Belching | Gas |
| Bloating/distention | Abdominal pain | Stomach pain | Intestinal pain |
| Bad breath | Diarrhea | Constipation | Laxative use |
| Rectal pain | Hemorrhoid | Bitter taste | Always hungry |
| Sticky sweet taste | Other |  |  |

**Bowel Patterns**

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the stool: (mark all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Soft & formed | Loose pieces | Hard dry | Pebbles |
| Alternates | Foul odor | Black, tarry | Blood streaked |
| Stool floats | Other |  |  |

**Urine patterns**

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Urgency | Pain/burning | Scant amount | Too frequent |
| Dribbling | Blood in urine | Yellow | Clear |
| Dark | Cloudy | Incontinent |  |

**Cardiovascular**

|  |  |  |  |
| --- | --- | --- | --- |
| High blood pressure | Low blood pressure | Palpitations | Chest pain |
| Dizziness | Irregular heartbeat | Rapid heart rate | Sweat easily |

**Sleep**

|  |  |  |
| --- | --- | --- |
| Easy to fall asleep | Sleep through night | Difficult to wake up |
| Difficulty falling asleep | Difficult staying asleep | Vivid disturbed dreams |

**Up during the night ?**  Yes /  No

If Yes then:

Frequency:

What wakes you?:

What time?

**Energy level**

|  |  |
| --- | --- |
| 0 = no energy | 10= running a marathon |

Please rate your energy level below using the scale:

**0 1 2 3 4 5 6 7 8 9 10** (circle one number or the range)

|  |  |  |
| --- | --- | --- |
| Fatigue | Fatigue on waking | Body feels heavy |
| Limbs feel heavy | Fatigue, sleepy after eating |  |

**Neuro**

|  |  |  |  |
| --- | --- | --- | --- |
| Tics | Trembling | Poor memory | Fuzzy thinking |
| Indecisive | Nervous | Frequent sighing | Easily startled |
| Depression | Anxiety | Easy anger | Easy irritability |
|  |  |  |  |

**General symptoms**

|  |  |  |
| --- | --- | --- |
| Thirsty all the time | Thirsty but don't drink | Prefer hot drinks only |
| Prefer cold drinks only | Feel too full to drink | Feel weak, lack of strength |
| Feel hot mostly | Feel cold mostly | Cold hands/feet |
| Hot hands/feet | Hot flashes | Feel warm in the evening |
| Bleed, bruise easily | Nosebleeds | Varicose veins |
| Dry skin | Itchy skin | Dry scalp |
| Dry hair | Teeth feel dry | Sticky saliva |
| Dry mouth | Psoriasis | Eczema |
| Acne | Rashes | Lymphatic swellings |
| Nodules, masses | Boils, carbuncles, sores | Hair loss |
| Easily cracked nails | Nail ridges | Facial edema |
| Warm in head/chest/neck | Feet swell | Overall edema |

**Cravings** (mark all that apply)

|  |  |  |
| --- | --- | --- |
| Sweet | Salty | Sour |
| Spicy/hot | Bitter | Chew ice |

**Pain issues** (mark all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Muscle spasms | Numbness/tingling | Head/neck | Upper body |
| Neck tight/tense | Chest | Below the sternum | Along the ribcage |
| Stomach | Abdominal | Groin | Leg/foot/ankle |
| Joint pain | Low back | Knee soreness | Bone pain |

**Social**

|  |  |  |
| --- | --- | --- |
| Single | Partnered | Divorced |
| Abuse survivor | Considered/attempted suicide | Seeing a therapist |

**Your lifestyle:** (mark all that apply)

|  |  |  |
| --- | --- | --- |
| Alcohol | Marijuana | Stress |
| Tobacco | Drugs | Occupational hazards |

Regular exercise:       frequency:

Type       frequency:

**For Men:** (mark all that apply)

|  |  |  |
| --- | --- | --- |
| Impotence | Nocturnal emission | Premature ejaculation |
| Increased libido | Decreased libido | ED |

When was your last prostate exam?

**Gynecology for Women:**

Age menses began:      Length of cycle:       Duration of flow:

# of Pregnancies:       # Live births:       Premature births:

Date last period began:       Date of last PAP:       Age at menopause:

|  |  |  |
| --- | --- | --- |
| Irregular periods | Painful periods | PMS |
| Small clots | Large clots | Hot flash/night sweats |
| Increased libido | Decreased libido | Vaginal discharge |
| Frequent yeast infections |  |  |

When was your last complete pelvic exam?

Other:

**Thank you for completing the questionnaire.**