**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.**