New Patient Intake Form

All answers are confidential. Please print clearly.

Patient Name ____ Date ________________________

Check if this appointment relates to: Workers Compensation ______ Personal Injury ______

Chief Complain(s): Your most important health concerns and goals

____

____

____

Present History: List illness, symptoms and their onset time in chronicle order

____

____

____

____

Medicines & Drugs

Medications/Vitamins/food supplements Recreational drugs Names	Dosage/Day/Week/Month	For what condition

Surgical Operation

Year	Operation/Procedures	Reasons
Scar Location		

Laboratory Test and Imaging: recommend bringing them with you

	Month/Year	Diagnosis	Notes
Blood			
Urine			
Stool			
X-ray			
CT scan			
MRI			
EKG			

Family History: Indicate any situations that your family members have ever had. Place an "X" or date in the box.

	Self (date)	Mother	Father	Sibling	Spouse/partner	Children
Adopted						
Cancer						
Diabetes						
Thyroid disorders						
Kidney disorders						
High blood pressure						
Heart disease						
Stroke						
Bleeding/anemia						
Seizures						
Allergies						
Alcohol or street drug						
Mental illness						
Liver disorders						
AIDS						
Deceased (age)	N/A					

Check those that apply (or happened) to you

	Yes	When	Reasons
Loss of Consciousness			
Electrotherapy			
Pacemaker			
Prosthetic device			
Hearing Aid			
Other in-plant			

Major Life Changes

	Yes	When	Note
Moving away from Home			
Graduation			
Marriage			
Divorce/Separation			(Indicating D or S)
Accident			
Retirement			
Death in Family			

Current and Past History: mark conditions/symptoms you currently have indicating:

P – Past, **C** – Current.

P	C	General	P	C	Nose, Throat and Mouth	P	C	Cardiovascular System
		Insomnia			Sinus infection			High blood pressure
		Dreams / nightmares			Hay fever / allergies			Low blood pressure
		Fatigue			Frequent sore throat			Chest pain / tightness
		Poor memory			Mouth and tongue ulcer			Palpitation
		Recent weight loss/gain			Difficulty swallowing			Rapid heart beat
		Cold hands & feet			Frequent colds			Irregular heart beat
		Hot hands & feet			Nose bleeding			Poor circulation
		Chills			Dry nose			Swollen ankles
		Fever			Nasal congestion			Phlebitis
		Bad breath			Loss of voice			Anemia
		Strongly like cold drinks			Thirst			Heart disease history
		Strongly like hot drinks			Excessive phlegm			Heart murmur
		Other			TMJ			Night sweats
					Facial pain			Tendency to be cold
P	**C**	**Head and Neck**			Gum problems			Tendency to be warm
		Headache			Dry mouth			Thrombosis
		Migraines			Dental problems			Other
		Stiff neck			Other			
		Dizziness				**P**	**C**	**Digestive System**
		Fainting	**P**	**C**	**Skin**			Nausea
		Swollen glands			Hives			Vomiting
		Other			Rashes			Indigestion
					Eczema/psoriasis			Stomachache
P	**C**	**Ears**			Night sweating			Diarrhea
		Ringings			Excess sweating			Constipation
		Hearing loss			Dry skin			Poor appetite
		Hearing aids			Easily bruised			Excessive hunger
		Infections			Changes in moles, lumps			Gas
		Earache			Itching			Hiccups
		Vertigo			Other			Acid regurgitation
		Other						Bloating
			P	**C**	**Respiratory system**			Laxative use
P	**C**	**Eyes**			Difficulty breathing			Bloody stool
		Glasses / contact lenses			Shortness of breathing			Other
		Blurred vision			Wheezing			
		Poor night vision			Asthma	P	C	**Musculoskeletal system**
		Floaters			Chronic cough			Joint pain/ swelling
		Eye inflammation			Wet cough			Sore muscles
		Double vision			Dry cough			Weak muscles
		Glaucoma			Phlegm			Difficulty walking
		Cataracts			Coughing up blood			
		Lazy eye			Tight chest			
		Blood-shot eyes			Pneumonia			
		Spots at white of eyes			Other			
		Nearsighted						
		Farsighted						

Current and Past History: mark conditions/symptoms you currently have indicating:
P – Past, **C** – Current.

P	C	Neurological diseases	P	C	Male genital	P	C	Infection screening
		Seizures			Impotence			Pain & Location
		Tremors			Premature ejaculation			Tuberculosis
		Numbness, tingling			Nocturnal emission			Hepatitis risk
		Spasm, ticks			Pain/itching of genitalia			**Infection screening**
		Paralysis			Lumps in testicles			HIV risk
		Poor coordination			Increased libido			Tuberculosis
		Other			Decreased libido			Hepatitis risk
					Other			Sexually Transmitted Disease
P	**C**	**Mental/Emotional**						Other
		Depression	**P**	**C**	**Gynecology**			
		Mood swings			Pregnant now	**P**	**C**	**Trauma**
		Irritability			# of pregnancies			Car Accidents Year: ______ Year: ______ Year: ______
		Difficulty relaxing			# of live births			
		Loneliness			# of miscarriages			
		Sensitive			# of abortion			
		Shyness			Menopause			
		Frequent crying			Irregular periods			Exposed to extreme hot/cold temperature Y/N
		Worries frequently			Menstrual cramps			
		Compulsive behaviors			Excessive blood flow			
		Difficulty focusing			Menstrual blood clots			Exposure to toxic environment – coal mine, factory, chemical plant, fumes Y/N
		Suicidal Thoughts			Breast tenderness			
		Lose Temper			Abnormal pap smear			
		Frustration			Vaginal infection			Hospital Operation
		Other			Vaginal pain/itching			Scar locations and causes
					Uterine fibroids			
					Endometriosis			
					Breast lumps, cysts			
					Increased libido			
					Decreased libido			
					Other			

Other information

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____

Patient signature ______________________________ Date ______________________

Personal History

Name: ____

Height __________________ Weight _________________ Maximum weight _________________ When? ______________

Nutrition

1. Appetite? Poor ____ good ____ excess ____ comment ____
2. Describe your typical diet & time for meals

   Breakfast ____

   Lunch ____

   Dinner ____

   Snacks ____
3. If skip meals: breakfast? _______ Lunch? _______ Dinner? _______ # of snacks per day _________
4. Do you change your eating habits when you are upset, worried, or sad? Yes _______ No _______
5. Allergies/food sensitivities & what triggers: ____
6. Water in-take per day ______________________oz.

   Usually drink: cold water______ hot water ______ room temperature ______
7. Cigarettes _________packs/day Coffee __________cups/day Tea ___________cups/day
8. Alcohol ___________glass/day Soda ____________cups/day Milk ___________cups/day
9. Recreational drugs? ___________________________, how many times? _________________/day/week/month/year

Bowel and Urination

1. Do you have bowel movement every day? _________How many times per day/week? ___________________________
2. Are your stools formed? __________ Color of stool: Light Tan ______ Brown ______ Dark Brown ______ Black _____
3. Urination frequency during the day __________ times, at night __________ times: what clock time ________________
4. Color of urine: straw______ Orange______ Foamy ______Cloudy ______ 5. Does stress trigger urge to urinate? Y / N
6. Difficulty holding urine? __________ Burning sensation? __________ Itchiness? ___________

Sleep

1. How many hours do you sleep per night? _________, time you go to bed __________, time you get up ___________
2. Difficulty falling asleep? ______, What do you do when that happens? ____
3. Do you have difficulty staying asleep? ______ At what time you wake up? ________ What do you do after waking up?

   ____ Would you be able to go back to sleep after waking up? ___________
4. Factors affecting your sleep ____
5. Do you dream? _______ Is there a particular repetitive theme, what is it? ____
6. Describe your general emotion in your dreams____
7. Do you generally feel rested waking up in the morning? Y/N

Stress

1. Your stress level (please circle): the lowest – 1 2 3 4 5 6 7 8 9 10 – the highest
2. What are associated with your stress? (describe) family issues ____

   work issues _______________________________health _________________________others ______________________

3. What help or aggravate your stress? ____
4. Describe your supporting system (family, friends, religion, spirituality, community, club, pets) ______________________

   ____

Energy

1. Evaluate your energy level (please circle): the lowest – 1 2 3 4 5 6 7 8 9 10 – the highest
2. At what time of day you have the best energy? ______________________, at its worst? ___________________________
3. What season do you like most? _______________________________, least? _____________________________________
4. Do you usually feel hot? ______ have Night Sweat? ______ What occasions trigger? _________________________________
   You feel hot on Cheeks? ________ Palms? ________ Foot Soles? ________ Both Palm and Sole ________Chest? ________
5. Do you usually feel cold _______ Where do you feel cold? ____
6. Do you have a strong desire for cold drink? ____________________ or for hot/warm drink? _______________________
7. How do you describe your sexual drive? Great ______ Good ______ Fair______ Poor ______ Bad ______ (not prying)

Exercise

1. What type/How often? ____
2. Interests/Hobbies you have ____

Pain

1. Where do you have the pain? ____
2. How does your pain feel like? sharp _____ dull _____ distension _____ hollow _____ heavy _____ cold _____
   burning _____ spastic _____ colicky _____ cutting _____ throbbing _____ boring _____ lurking _____ pulling ______
3. Location of Pain: fixed ______ moves ______ intermittent _____ constant ______
4. Circle your pain level : no pain – 1 2 3 4 5 6 7 8 9 10 – the worst
5. What trigger the pain? ____
6. What makes the pain better? Hot patch ________ Cold pack _______ Moving ________ Resting _________
7. On-set of pain, started from: ____
8. How does the pain limit your activity/interfere with your sleep? ____
9. Do you have backaches? __________ What conditions trigger it ____
10. Time of day you experience backaches ______________ What ease the discomfort? _____________________________
11. List medications/treatments you use for pain relief ____

Menstruation (Those in menopause, provide answers according to conditions when you were having your periods.)

1. Age of menstruation onset: ____
2. Is your cycle regular? ______ If not, usually comes early ______, late ______, starts, stops and then starts again _______
3. Color of blood: Red _______ Bright Red _______ Brown _______ Dark Red _______ Light Red _______ Pinkish ________
4. Duration of period: _______ days, Volume of flow: Sparse _____ Heavy _____ Moderate _____ Cramps _____ Clots ____
5. How are you being affected by PMS? ____
6. Do you have leucorrhea? ______________ What is the color? ___________________________