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Patient Intake Form

Successful health care and preventative medicine are only possible when the practitioner has complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

_____ _____ F _____ M _____
Name Last First Gender

_____/_____/_____ _____ _____
Date of Birth **Age** Occupation

_____ _____ _____ _____
Address **City** **State** **Zip Code**

(____)_____-_____ (____)_____-_____ _____
Telephone Home **Telephone** Work Email Address

Optional: Height_____ Weight_____ HIV_____ Hep_____

_____ (____)_____-_____ _____ (____)_____-_____
Physician Name Phone Number Chiropractor Name Phone Number

_____ _____ (____)_____-_____
In an Emergency Notify Name Relationship Phone

_____
How did you hear about our clinic?

_____
Have you been treated by acupuncture or Oriental medicine before?

Major Symptoms:

1. Main problem you would like us to help you with: _____
2. How long ago did this problem begin? _____

3. If you been given a diagnosis for this problem, what was it? _____
4. What kinds of treatments have you tried? _____
5. Are you currently receiving treatment for your problem? _____
   If so, please describe:_____
6. Has anything helped improving your problem? _____

Past Medical History:

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Diabetes
- ☐ Asthma
- ☐ Stroke
- ☐ Seizures
- ☐ Mental Illness
- ☐ Venereal disease
- ☐ HIV
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Rheumatic fever
- ☐ Cancer
- ☐ Fibromyalgia
- ☐ High cholesterol
- ☐ Glaucoma
- ☐ Vein condition
- ☐ Migraine
- ☐ Thyroid disorder
- ☐ Bleeding tendency
- ☐ Multiple Sclerosis
- ☐ Nervous system disorder
- ☐ Other

Surgeries (type and date):_____
Significant trauma (auto accidents, falls, etc.):_____
Birth history (prolonged labor, forcepts delivery, caesarian section, other):_____
Childhood health:_____
Allergies (medications, foods, animals):_____
Do you have, or have ever had any infectious diseases? Yes_____ No_____
If so, please describe_____
Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last 3 month)
_____
Do you have a pacemaker or any metal devices in your body?_____
Do you have any reason to believe or know if you could be pregnant? Yes_____ No_____
If so, how far along are you?_____
Recent tests: (please indicate test results and date bellow)

- ☐ Physical
- ☐ Cholesterol
- ☐ Prostate
- ☐ Blood
- ☐ HIV/STD
- ☐ Pap smear
- ☐ Mammography

X-Ray/CAT Scans/MRI's/NMR's/Special Studies (reason and when):_____

Family Medical History:

Mother's Side_____
Father's Side_____
Siblings_____
If any of the above is deceased, what was the cause?_____

Review of Symptoms:

Please check if you have of have had experienced (in the last three month) any of the following diseases or conditions.

General:

- ☐ Chills
- ☐ Fever
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed of bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold/hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
  Time of day:_____
- ☐ Edema
  Where:_____
- ☐ Poor sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change
  Gain/Loss_____

Neuropsychological:

- ☐ Seizures
- ☐ Concussion
- ☐ Traumatic brain injury
- ☐ Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Stroke
- ☐ Area of numbness
- ☐ Lack of coordination
- ☐ Loss of balance
- ☐ Fainting
- ☐ Disorientation
- ☐ Irritability
- ☐ Anxiety/Worried
- ☐ Mood swings
- ☐ Nervousness
- ☐ Mental tension
- ☐ Sadness
- ☐ Easily angered
- ☐ Post-Traumatic stress disorder
- ☐ Poor memory
- ☐ Difficulty making decisions
- ☐ Depression
- ☐ Mania
- ☐ Panic attack
- ☐ Easily susceptible to stress
- ☐ Sleep disorder
- ☐ Difficulty concentrating

Have you ever been treated for emotional problem?

☐ Yes ☐ No

Have you ever considered or attempted suicide?

☐ Yes ☐ No

Any other neuropsychological problems? _____

Energy and Immunity:

- ☐ Slow wound healing
- ☐ Chronic infection
- ☐ Frequent cold/flu
- ☐ Chronical fatigue syndrome
- ☐ Seasonal allergies

Head, Eye, Ear, Nose and Throat:

- ☐ Headaches

When:_____

Where:_____

- ☐ Facial Pain
- ☐ Dizziness
- ☐ Glasses/Lens
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Colorblindness
- ☐ Blind field
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Discharge from ear
- ☐ Nosebleed
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throat
- ☐ Hoarseness
- ☐ Sores on lips/tongue/gums
- ☐ Difficulty swallowing
- ☐ Other head/neck problems

Skin and hair:

- ☐ Rushes
- ☐ Itchiness
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff
- ☐ Easy bruising
- ☐ Warts
- ☐ Acne
- ☐ Other

Respiratory:

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty in breathing when laying down
- ☐ Phlegm
  Color? _____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other

Cardiovascular:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing
- ☐ Varicose veins/phlebitis
- ☐ Rheumatic fever
- ☐ Other

Gastrointestinal:

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn/acid reflux
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea/loose stool
- ☐ Constipation
- ☐ Alternative constipation and diarrhea
- ☐ Hernia
- ☐ Chronic laxative use
- ☐ Blood in stool
- ☐ Black stool
- ☐ Strong smell in stool
- ☐ Abdominal pain/cramps
- ☐ Gas
- ☐ Rectal pain/prolapse
- ☐ Hemorrhoids
- ☐ Little appetite
- ☐ Strong appetite
- ☐ Huger but no desire to eat
- ☐ Food cravings
- ☐ Regurgitation
- ☐ Weight loss
- ☐ Weight gain
- ☐ Anorexia nervosa
- ☐ Bulimia
- ☐ Parasites
- ☐ Gallbladder problems

☐ Bowel movement: Frequency: _____ Color: _____ Odor: _____ Texture/Form: _____ **Genito-Urinary:** ☐ Pain on urination ☐ Urgency to urinate ☐ Frequent urination ☐ Blood in urine ☐ Cloudy urine ☐ Decrease in flow ☐ Dribbling ☐ Urinary incontinence/retention ☐ Kidney stones ☐ Bladder/kidney infections ☐ Impotency ☐ Change of sexual drive ☐ Sore genitals Do you wake to urinate? ☐ Yes ☐ No How often?: _____ What color is your urine? _____ ☐ Other **Musculoskeletal:** ☐ Neck pain ☐ Shoulder pain ☐ Back pain ☐ Elbow pain ☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Foot/ankle/hill pain ☐ Joint/bone problems ☐ Osteoporosis ☐ Sprain of joints ☐ Joint instability ☐ Herniated disk ☐ Arthritis	☐ Muscle cramps ☐ Muscular weakness ☐ Muscular atrophy ☐ Genera aches ☐ Other **Female Health:** ☐ Irregular cycle ☐ Heavy flow ☐ Light flow ☐ Clots in menstrual blood ☐ Bleeding between cycles ☐ Painful period (is pain before, during and/or after period? _____ ☐ Menstrual related moodiness ☐ Menstrual related breast tenderness ☐ Hot flashes ☐ Vaginal dryness ☐ Breast lumps/cysts ☐ Nipple discharge ☐ Uterine fibroids ☐ Endometriosis ☐ Ovarian cysts ☐ Unusual vaginal discharge/odor ☐ Frequent yeast infections ☐ Decreased libido ☐ Menopause Age and year: _____ ☐ Postcoital bleeding ☐ Vaginal sores Do you use birth control? ☐ Yes ☐ No What type and how long? _____ ☐ Fertility problems	# of pregnancies: _____ # of birth: _____ # premature birth:_____ # of miscarriages: _____ # of abortions:_____ # of caesarian births:_____ # of difficult deliveries:____ Age of first menses:_____ Duration of period: Days:_____ Cycle-Days: _____ Last menses start date:_____ Last pap smear date: _____ ☐ Other **Male Health:** ☐ Prostate problems ☐ Change in sex drive ☐ Rashes/itching ☐ Election difficulty ☐ Low sperm count/motility. ☐ Premature ejaculation ☐ Decrease libido ☐ Groin pain ☐ Penile discharge ☐ Other **Endocrine:** ☐ Hypothyroid ☐ Hyperthyroid ☐ Hypoglycemia ☐ Diabetes mellitus ☐ Night sweats ☐ Feeling hot or cold ☐ other	

Lifestyle:

Do you have an exercise routine? _____
How many hours per night do you sleep on average? _____
Do you wake rested? Yes ____ No ____

What time do you usually go to bed? _____

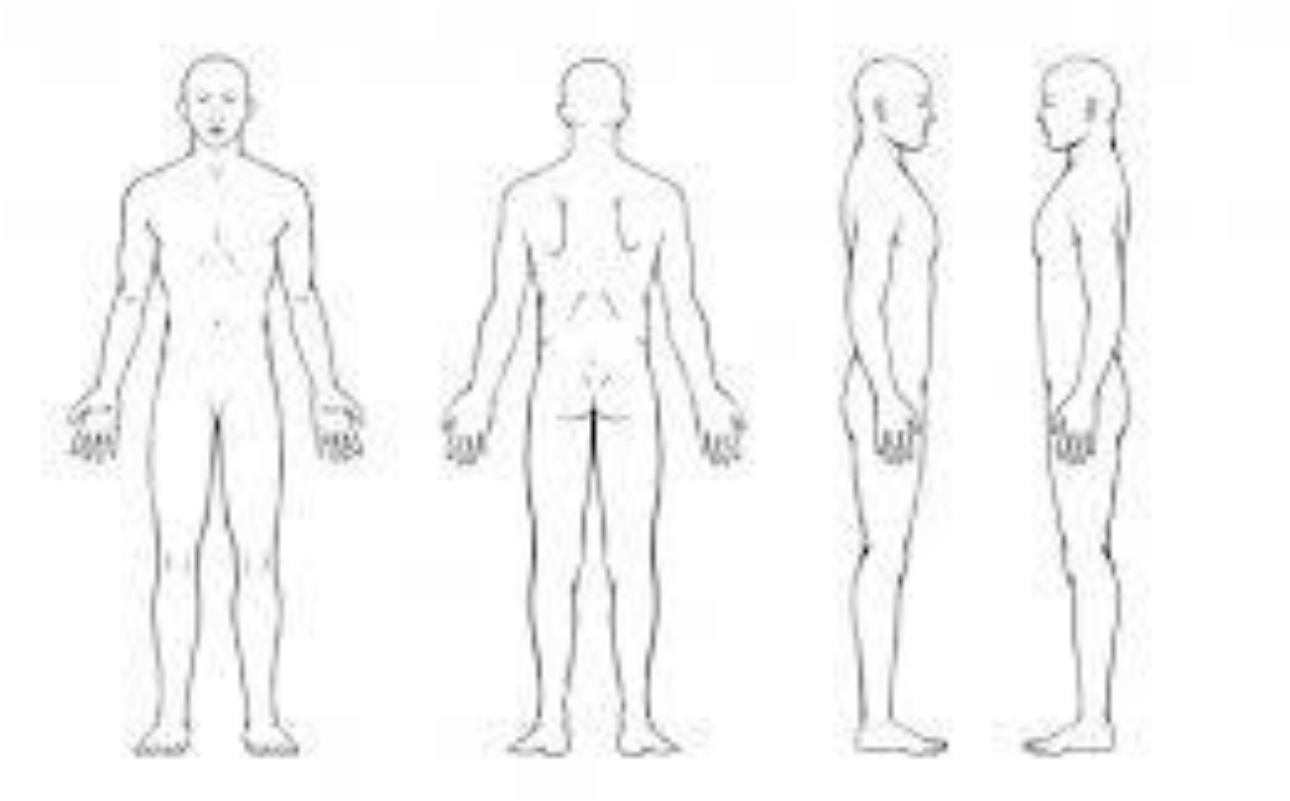
Please mark your current use levels of the following:
Tobacco frequently___ occasionally___ never___ Number of cigarettes per day_____Age started _____
Alcohol frequently___ occasionally___ never___ Number of drinks per week_____ Type of drinks _____
Caffeine frequently___ occasionally___ never___ Number of cups per day_____ Type of drinks _____
Other frequently_____ occasionally_____ never_____ Describe _____
Do you have any current or past problems with addiction or substance abuse? Yes____ No_____
Substance_____ Amount_____ When did you quit?_____

How many hours per week do you work? _____
Do you enjoy what you do? Y / N
How many hours a day do you spend sitting or driving? _____
Interests and hobbies? _____
How many glasses of water do you drink per day? _____
Do you typically eat at least 3 meals per day? Y / N If No, how many? _____
Your typical daily diet? _____
Are you a vegetarian or vegan? Y / N If yes which one and how long?_____

Energy level: _____
Stress level: _____
Current emotional health: _____
Current quality of life: _____
Current relationship quality: _____
Current predominant emotion: _____

Indicate painful or distressed area:

Please circle on the diagram any areas of concern.



Is the pain: ❑Sharp ❑Burning ❑Aching ❑Cramping ❑Dull ❑Moving ❑Fixed ❑Other:_____

Do the following improve the pain? ❑Pressure ❑Cold ❑Heat ❑ Exercise ❑ Other_____

Do the following worsen the pain? ❑Pressure ❑Cold ❑Heat ❑Other:_____