

# Patient Intake Form

Today's date \_\_\_\_\_

Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Address \_\_\_\_\_ Marital status \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ M  F   
City, State, Zip \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
E-mail \_\_\_\_\_ Cell, pager, etc. \_\_\_\_\_  
Referred by \_\_\_\_\_ Blood Type \_\_\_\_\_  
Emergency contact's name & phone \_\_\_\_\_

Main Problem:

Other Concurrent Therapies

## Past Medical History (include date):

### Significant Illnesses:

\_\_\_\_\_ Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Heart Disease  
\_\_\_\_\_ Hepatitis \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_ Thyroid Disease \_\_\_\_\_ Seizures  
\_\_\_\_\_ Other

### Surgeries:

Significant Trauma (auto accidents, falls, etc.)

Patient Birth History: (prolonged labor, forceps delivery, etc.)

Allergies: (drugs, chemicals, foods.)

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.)

Occupational Stresses (Chemical, physical, psychological, etc.)

### Exercise:

### Average daily diet:

Morning

Afternoon

Evening

Habits: \_\_\_ Cigarettes \_\_\_ Coffee \_\_\_ Tea \_\_\_ Cola \_\_\_ Alcohol \_\_\_ Drugs \_\_\_ Sugar \_\_\_ Salt \_\_\_ Other \_\_\_\_\_

Family Medical History \_\_\_ Diabetes \_\_\_ Cancer \_\_\_ High Blood Pressure \_\_\_ Heart Disease \_\_\_ Stroke \_\_\_ Seizures  
\_\_\_ Asthma \_\_\_ Allergies \_\_\_ Alcoholism \_\_\_ Other

Notes: \_\_\_\_\_

## GENERAL

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Poor appetite                         | <input type="checkbox"/> Heavy appetite     | <input type="checkbox"/> Poor Sleep                           | <input type="checkbox"/> Heavy Sleep  |
| <input type="checkbox"/> Insomnia                              | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Tremors                              | <input type="checkbox"/> Vertigo      |
| <input type="checkbox"/> Cold hands                            | <input type="checkbox"/> Cold feet          | <input type="checkbox"/> Cold Back                            | <input type="checkbox"/> Cold Abdomen |
| <input type="checkbox"/> Fevers                                | <input type="checkbox"/> Chills             | <input type="checkbox"/> Night Sweats                         | <input type="checkbox"/> Sweat Easily |
| <input type="checkbox"/> Change in Appetite                    | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor Coordination                    | <input type="checkbox"/> Cravings     |
| <input type="checkbox"/> Sudden energy drop at _____ (time)    |   | <input type="checkbox"/> Peculiar tastes/smells _____         |                                       |
| <input type="checkbox"/> Strong thirst (cold/hot drinks) _____ |   | <input type="checkbox"/> Bleed or bruise easily (where) _____ |                                       |

## SKIN AND HAIR

- |  |                                  |   |                                       |
|--|----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Rashes                      | <input type="checkbox"/> Itching | <input type="checkbox"/> Ulcerations                | <input type="checkbox"/> Hives        |
| <input type="checkbox"/> Eczema                      | <input type="checkbox"/> Pimples | <input type="checkbox"/> Dandruff                   | <input type="checkbox"/> Loss of hair |
| <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Purpura | <input type="checkbox"/> Other hair or skin problem |                                       |

## HEAD, EYES, EARS, NOSE, AND THROAT

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Dizziness                        | <input type="checkbox"/> Concussions             | <input type="checkbox"/> Migraines                         | <input type="checkbox"/> Glasses         |
| <input type="checkbox"/> Eyestrain                        | <input type="checkbox"/> Eye pain                | <input type="checkbox"/> Poor vision                       | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Color blindness                  | <input type="checkbox"/> Spots in eyes           | <input type="checkbox"/> Cataracts                         | <input type="checkbox"/> Blurry vision   |
| <input type="checkbox"/> Sinus Problems                   | <input type="checkbox"/> Earaches                | <input type="checkbox"/> Ringing in ears                   | <input type="checkbox"/> Poor hearing    |
| <input type="checkbox"/> Nose bleeds                      | <input type="checkbox"/> Mucus                   | <input type="checkbox"/> Dry throat                        | <input type="checkbox"/> Dry mouth       |
| <input type="checkbox"/> Copious Saliva                   | <input type="checkbox"/> Teeth problems          | <input type="checkbox"/> Jaw clicks                        | <input type="checkbox"/> Facial Pain     |
| <input type="checkbox"/> Grinding teeth                   | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Recurrent sore throat ___/mth     | <input type="checkbox"/> Gum problems    |
| <input type="checkbox"/> Headaches (where and when) _____ |  | <input type="checkbox"/> Other head or neck problems _____ |  |

**CARDIOVASCULAR**

- |  |   |   |                                     |
|--|---|---|-------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Irregular Heartbeat  | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Cold Hands/Feet     | <input type="checkbox"/> Swelling in Hands/Feet | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Phlebitis              | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Other      |

**RESPIRATORY**

- |  |   |  |                                     |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Cough                                       | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Asthma                                | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia                                   | <input type="checkbox"/> Tight Chest    | <input type="checkbox"/> Difficulty in breathing in lying down |                                     |
| <input type="checkbox"/> Production of phlegm _____ what color _____ |   | <input type="checkbox"/> Other lung problems                   |                                     |

**GASTROINTESTINAL**

- |                                    |   |  |   |
|------------------------------------|---|--|---|
| Bowel Movement:<br>_____ Frequency | <input type="checkbox"/> Vomiting                               | <input type="checkbox"/> Belching          | <input type="checkbox"/> Bad Breath     |
| _____ Color                        | <input type="checkbox"/> Nausea                                 | <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Rectal Pain    |
| _____ Odor                         | <input type="checkbox"/> Constipation                           | <input type="checkbox"/> Black Stools      | <input type="checkbox"/> Bloody Stools  |
| _____ Texture/form                 | <input type="checkbox"/> Hemorrhoids                            | <input type="checkbox"/> Sensitive Abdomen | <input type="checkbox"/> Pain or Cramps |
|                                    | <input type="checkbox"/> Laxative Use: _____ /week; type: _____ |  | <input type="checkbox"/> Gas            |

**GENITO-URINARY**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Pain on Urination  | <input type="checkbox"/> Frequent Urination   | <input type="checkbox"/> Blood in urine   | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Impotency     |
| <input type="checkbox"/> Wake up to urinate | How often _____ /night; time: _____           |   | <input type="checkbox"/> Other         |

**PREGNANCY AND GYNECOLOGY**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Number of Pregnancies                       | <input type="checkbox"/> Number of Births | <input type="checkbox"/> Premature Births _____ Last Menses           |
| <input type="checkbox"/> Age at first menses                         | <input type="checkbox"/> Period (days)    | <input type="checkbox"/> Irregular Periods _____ Duration             |
| <input type="checkbox"/> Flow (describe)                             | <input type="checkbox"/> Clots            | <input type="checkbox"/> Miscarriages _____ Last Pap                  |
| <input type="checkbox"/> Vaginal Discharge                           | <input type="checkbox"/> Vaginal Sores    | <input type="checkbox"/> Breast Lumps _____ Menopause                 |
| <input type="checkbox"/> Birth Control _____ type and duration _____ |   | <input type="checkbox"/> Changes in body/psyche prior to menstruation |

**MUSCULOSKELETAL**

- |  |                                      |  |   |
|--|--------------------------------------|--|---|
| <input type="checkbox"/> Neck Pain                     | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Back Pain (where) _____ | <input type="checkbox"/> Joint Pain _____ |
| <input type="checkbox"/> Other joint or bone problems? |                                      |  |   |

**NEUROPSYCHOLOGICAL**

- |  |  |   |                                     |
|--|--|---|-------------------------------------|
| <input type="checkbox"/> Seizures                                      | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Poor memory                  | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Depression                                    | <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Easily Stressed              | <input type="checkbox"/> Bad Temper |
| <input type="checkbox"/> Treated for emotional problems                |  | <input type="checkbox"/> Considered/attempted suicide |                                     |
| <input type="checkbox"/> Other neurological or psychological problems? |  |   |                                     |

**CLASSICAL**

Preference	Most Liked	Least Liked
Season		
Taste		
Climate		
Time of Day		
Temperature		

- Color \_\_\_\_\_  
 Tone \_\_\_\_\_  
 Odor \_\_\_\_\_  
 Yin/Yang \_\_\_\_\_  
 Firm/Weak \_\_\_\_\_  
 Hot/Cold \_\_\_\_\_  
 Surface/Interior \_\_\_\_\_

**COMMENTS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_