New Patient Information
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Patient Information

Name_____Today's Date_____/_____/_____Birth Date_____/_____/_____

Height_____ Weight_____

Sex Male Female Gender identity (if different) Male Female

Street Address_____ Apt. #_____

City_____State_____ Zip_____

Home Phone_(____)_____Office_(____)_____Mobile_(____)_____

Email_____ (we do not share with anyone or any entity)

MD's Name_____MD's Phone_(____)_____
Referred by_____

Person to call in
case of emergency Name_____Phone_(____)_____

Lifestyle

__ single __ married __ divorced __widowed __ domestic partnership __ other

__ full-time __ part-time __ self-employed __ student __ unemployed __ retired

Occupation_____Number of hours of work/study per week___

Billing and Insurance

Payment in full is due when services are rendered.

If you are covered by insurance, please bring your insurance card with you to your first visit, and provide the following:
Primary Insurance_____Insurance Phone_____
Insurance Address_____
Policy Holder's Name_____Relationship_____
Policy # _____ ID #_____ Group #_____

Will you require an itemized receipt or Superbill? Yes No

Late Cancel or Missed Appointment Policy

If you need to change or cancel your appointment please contact us 48 hours in advance. Failure to do so will result in a fee.

I understand cancellation policy.

Confidentiality

Your patient records are confidential. Patient information is shared only when necessary to provide care and services, or by your authorization, or when required by law.

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Health History
Main health issue_____

How long have you had this condition? _____

What makes it better?_____What makes it worse? _____

Is your condition Getting worse Getting better Constant Comes & Goes

Western Diagnosis (if known):_____Other health concerns_____

_____

Please list any medications, herbs,
and supplements you are currently taking: _____

_____

Known Allergies to:
Medication/Food/
Supplements_____Don't know

List and date any surgeries or operations you've had:_____

Family History: Please complete for yourself and each family member by placing an X in the appropriate box.

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder disorder							
Drug / Alcohol Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Suicide Attempt							
Age at Death							

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Directions: **Fill-in** or check to the **RIGHT** the following

Energy Level High (time of day) _____AM/PM Low (time of day) _____AM/PM

Stress None Moderate Severe What causes it? _____

Skin Dry Itchy Moist/Clammy Boils Changing moles Cysts/tumors
Frequent rashes Acne Eczema Psoriasis Dry scalp Dry hair Bruises easily
Bleed easily Skin puffiness/edema Facial puffiness

Perspiration
Excessive day sweating Night-sweating Clammy hands
Mostly sweating…Under arms On head On chest Other

Circulation Feelings of Hot Cold Where?_____

Sleep Problems Trouble falling asleep Trouble staying asleep Restful
Trouble breathing at night Excess dreaming Night terrors Sleep Walking Sleep apnea
How many hours do you sleep at night?_____

Head Headaches What area?_____ What time of day?_____
Dizziness Memory loss Dizziness Other head-related issue _____

Eyes Eye pain Dry eyes Red eyes Blurred vision Poor night vision
Glasses/contact lenses Nearsighted Farsighted Other eye issue_____

Ears Poor hearing Earaches Ear infections / discharge Ringing / buzzing Tinnitus
If ear ringing, High-pitched Low-pitched Other ear problem

Nose Frequent nose bleeds Sinus trouble Frequent colds Deviated septum
Seasonal or indoor allergies Frequent nasal discharge
If nasal discharge, clear/white Yellow/green

Throat Sore throat Frequent sore throats Hoarseness Difficulty swallowing
Jaw problems/TMJ Teeth / gum problems Swollen tongue
Frequent phlegm or mucus Other throat concern:_____

Chest Hard to breath Wheezing Shortness of breath Mucous when breathing
Pain / pressure in chest Palpitations Persistent cough Coughing blood
Coughing phlegm Other chest or cardiac concern:_____

Blood Pressure High Low Numbers_____ Do not know

Bowels Diarrhea Constipation Bloody stools Black stools Mucous in stools Hemorrhoids
Lower bowel gas Stools have foul odor
Number of bowel movements a day_____
Other bowel issue:_____

Urine Color_____ Amount seems: Normal Too much Too little
Frequent urination - daytime Frequent urination – nighttime Strong smelling Urine
Difficult to urinate Urgency to urinate Pain or burning when urinating Dribbling Blood in Urine
Frequent infections Water retention Incontinence Other urinary
concern:_____

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Neurological

Nervousness Depression Easily angered Poor concentration
Frequent crying Worry/fearful Mood swings Poor memory/confusion Thoughts of suicide
Hand tremors/shaking Numbness / tingling in limbs Poor coordination Seizures Shingles
Feel weak and shaky Neuralgia (nerve pain) Parathesia ("pins and needles" or lack of feeling)

Other neurological concerns: _____

Digestion Stomach gas Heartburn Burning / belching Abdominal pain
Stomach cramps Nausea Vomiting Bad breath Sores in mouth Weight gain
Weight loss Bitter / sour taste in mouth
Abdominal bloating If so, how long after eating?_____Hrs

Food allergies? Yes No If yes, to what?_____ Don't know

Other digestive concern:_____

Appetite Excessive appetite Poor appetite Appetite keeps changing
Feel tired or weak if a meal is missed Excessive thirst Never thirsty

Especially enjoy food that is: Sweet Sour Hot/spicy Salty Carbohydrates

Females

Pregnant? Yes No Last monthly period _____/_____/_____ Cycle length _____ days (if known)
Last PAP test _____/_____/_____ Don't know Age at first menses_____ Age stopped_____
Form of birth control _____ None Not sexually active now

Check or fill-in all that currently apply: Menstrual pain Low backache Irregular bleeding Clotting
Heavy bleeding Light bleeding Painful period Water retention Mood changes Missed periods
Low or no sex drive Painful breasts Hot flashes Food cravings Color is generally:_____
Other symptoms of PMS or menstruation_____
Discharges: Yellow White Clear Odor Itching Other_____
# of Pregnancies _____ # of Deliveries_____ # of Miscarriages_____ # of Abortions____ # of Cesareans_____

Males: Check or fill-in all that currently apply:

Low sex drive Impotence Painful ejaculation Premature ejaculation
Discharges: Yellow White Clear Odor Itching Other_____
Known prostate trouble
Other urogenital symptoms_____

Nutrition Please list some of your favorite foods:

What did you eat yesterday? (please include snacks & drinks)

Breakfast Lunch Dinner

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Do you typically…

Skip breakfast Eat a snack Eat a hearty breakfast
Eat fruits and vegetables at least twice a day Yes No
Eat dairy or meat 2 or more times a day Yes No
Eat green vegetables at least twice a day Yes No
Eat frequently between meals Yes No
Eat the same foods almost everyday Yes No
Chew your food thoroughly Yes No
Occasionally go on a "crash" diet Yes No
Eat when you are not hungry Yes No
Eat until you feel full Yes No
Drink juice or milk instead of water Yes No
Always add salt at the table Yes No

How many meals do you eat per day?_____ When is your biggest meal?
Do you eat when worried or rushed? Yes No How often?
How many glasses of water do you drink in a day?_____ Filtered Bottled

Do You use: Alcohol? Yes No Amount per week_____ Type
Tobacco? Yes No Packs per day_____ For how many years?_____
Recreational Drugs? Yes No
Which ones?_____For how many years?_____

Personal

Please list your overall health concerns in order of importance:

Please describe any regular program of exercise:

Do you have a religious or spiritual practice? If so, please describe:

How committed are you to improving your health? (Rate from 1-10, with 10 being 100% committed)

What might stop you from following the health & lifestyle recommendations that I may prescribe for you?

Thank you for completing this intake. It's an honor to work with you.