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 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
		Difficulty relaxing			# of live births			Year: _____
		Loneliness			# of miscarriages			Year: _____
		Sensitive			# of abortion			Year: _____
		Shyness			Menopause			
		Frequent crying			Irregular periods			Exposed to extreme
		Worries frequently			Menstrual cramps			hot/cold temperature Y / N
		Compulsive behaviors			Excessive blood flow			
		Difficulty focusing			Menstrual blood clots			Exposure to toxic environment – coal mine,
		Suicidal Thoughts			Breast tenderness			factory, chemical plant,
		Lose Temper			Abnormal pap smear			fumes Y / N
		Frustration			Vaginal infection			Hospital Operation Y / N
		Other			Vaginal pain/itching			Scar locations and causes Y / N
					Uterine fibroids			
					Endometriosis			
					Breast lumps, cysts			
					Increased libido			
					Decreased libido			
					Other			

Other information

_____

_____

_____

_____

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? _____