Patient Intake Form

First name_____ Middle Init. ___ Last Name_____

Female/Male. (Circle one) DOB_____ Age_____

Street Address_____

City/State_____ Zip Code_____

Mobile Phone (___)_____ Home Phone (___)_____

Email_____ Marital Status _____ Occupation _____

Emergency Contact _____ Phone (___)_____

Referred by _____

Please describe the main reason for your visit today:

_____

_____

_____

Please indicate if you have any of the following conditions (check one):

☐Pregnant
☐HIV/Aids positive
☐Hepatitis
☐Tuberculosis
☐Cardiac pacemaker
☐Seizure disorder
☐Bleeding disorder/on blood thinners
☐Fainting disorder
☐Other (please specify)_____

List all major childhood and adult illnesses, surgeries, major accidents and/or injuries:

_____

_____

List any medications, supplements (incl. herbs and vitamins) you're currently taking:

_____

_____

Please check off any of the following that you indulge in (type and amount per week):

Exercise _____

☐ Sugar/dessert/artificial sweeteners _____

☐ Coffee/Tea _____

☐ Caffeinated products (e.g. energy drinks, soda, etc.) _____

☐ Alcohol _____

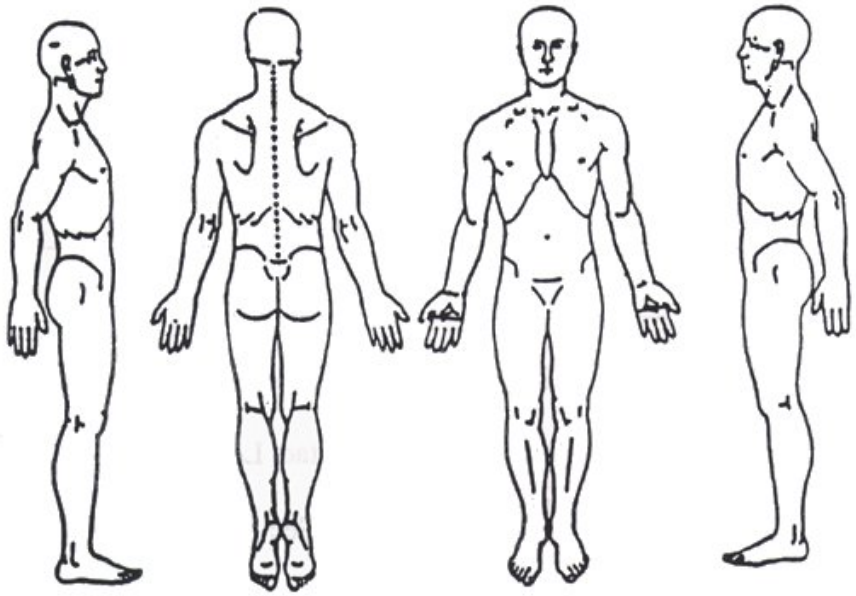
☐ Drugs (*no judgment here…please be honest*) _____

☐ Salty foods _____

☐ Water intake (indicate # of glasses per day) _____

☐

Please indicate distressed areas with an "x" and rate your level of pain on a scale of 1 (minimal pain) to 10 (a lot of pain).



❑Poor Circulation to limbs and/or hands and feet.
❑Cold hands and feet
❑Fatigue
❑Heat sensation in hands and feet, chest or limbs
❑Night sweats
❑Catches colds easily
❑Sweats easily during daytime
❑Dizziness
❑Seeing floaters, prisms of light or black spots

❑Palpitations
❑Sores on tongue
❑Rashes or hives
❑Restlessness
❑Anxiety
❑Chest pain
❑Insomnia

❑Cough
❑Sinus congestion
❑Dry ENT
❑Allergies -Seasonal
❑Allergies -Food related
❑Chills/fever
❑Sore throat
❑Difficulty breathing

❑Low appetite
❑Loose stools
❑Constipation
❑Abdominal bloating
❑Bruises easily
❑General feeling of heaviness
❑Mental fogginess
❑Swollen hands/feet
❑Bad breath
❑Large appetite
❑Prone to mouth canker and cold sores
❑Painful, bleeding or swollen gums
❑Heartburn
❑Belching
❑Stomach pain
❑Nausea/vomiting

❑Diarrhea alternating w/ constipation
❑Skin Rashes
❑Angers easily
❑Migraines or Headaches
❑Tremors
❑Muscle spasms
❑Low back pain
❑Sore, cold or weak knees
❑Frequent urination
❑Incontinence (lack of bladder control)
❑Hair Loss
❑Memory problems
❑Tinnitus (ear ringing)
❑Libido is (circle one): Normal. Low. High

Please check all symptoms that pertain to you at this current time.

❑ Please indicate any other symptom you're having that isn't listed on this form:

_____

Women Only
Are you pregnant now:
❑Yes.
❑No

Please answer even if you no longer have a menses.

Is/was your menses regular
❑Yes.
❑No.

Average number of days in flow:____

The flow is:
❑Normal.
❑Light.
❑Heavy.

The color is:
❑Bright red.
❑Dark Red.
❑Purple.
❑Brown.

Do/did you have any of the following menstrual related symptoms (circle all that apply):

❑Blood clots
❑Cramps
❑Nausea
❑Breast pain/tenderness
❑PMS
❑Break through bleeding between periods
❑Heavy vaginal discharge between periods

Men Only
Do you have any discomfort or issues with your reproductive organs (circle all that apply)?

❑Discharge
❑Pain or swelling of the testicles
❑Ejaculatory problems
❑Impotence/Erectile Dysfunction