Patient Intake Form

Name:		Phone: Home: Cell: Work:
Street:		Age: HT.: WT.: Email:
City:		Birth date: Sex:
State: Zip:		Occupation:
Physician:	Referred by:	Emergency contact:
Main Problem:		Emergency Phone:
Getting other treatment? Describe?		

<u>Past Medical History: (please includes dates</u>)

Significant illnesses: _____Cancer, _____Diabetes, _____High Blood Pressure, _____Heart Disease, _____Hepatitis _____AIDS/HIV, _____Rheumatic Fever, _____Thyroid Disease, _____Seizures, _____Osteoporosis, _____ MS _____Fibromyalgia, _____Chronic Fatigue Syndrome, ____ _CP, _____Parkinson's, _____Asthma, *Other*:

Surgeries (approx. datess):

Significant Trauma (auto accidents, falls, etc., approx. dates):

Allergies (drugs, chemicals, food, etc.)

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

Life Stresses: (Chemical exposure, physical, mental, emotional)

Comments:

Average daily diet:

Morning Afternoon Evening

Habits: __ Cigarettes, __ Coffee, __ Tea, __ Soft Drinks, __ Alcohol, __ Drugs, __ Sugar, __ Salt, __ Chocolate

Family Medical History: _____Cancer, _____Diabetes, _____High Blood Pressure, _____Heart Disease, ____ Hepatitis _____AIDS/HIV, _____Rheumatic Fever, _____Thyroid Disease, _____Seizures, _____Osteoporosis, ____ MS ____Fibromyalgia, ____Chronic Fatigue Syndrome, ____ CP, ____Parkinson's, ____Asthma

General:***Thirsty often*** Y/N? ___***Chills or Fever*** Y/N? ___, ***Body Temp feels:*** __ Cool, __ Cold, __ Warm, __ Hot

Body Systems:

(*Please check off any and all symptoms that you have currently. This is crucial for accurate diagnosis:*)

Skin & Hair: __ Rashes, __ Eczema, __ Hives, __ Itching, __ Dandruff, __ hair loss, __ Pimples, __ Bruises

Comments: ____

Head: __ Headaches, location?: _____________ , Concussion: Date: _______*Comments*: _________________________

Eyes: __ Floaters, __ Red Eyes, __ Painful Eyes, __ Dry Eyes, __ Itchy Eyes, __ Eye Strain, __ Cataracts, __ Blind spots, __ Color Blindness, __ Night Blindness, __ Blurred Vision, __ Wear Glasses: __ Near Sighted, __ Far Sighted.

Comments: ____

Nose: __ Runny Nose, __ Sniffles, __ Peculiar Smells, __ Nose Bleeds, __ Sneezing, __ Dry Nose, __ Sinus Infection, __ Sinusitis, __ Frequent Sinus Infections. *Comments*: ______________________________

Mouth: __ Dry Mouth,__ Excessive Saliva, __ Sores on Lips, __ Can't Taste, __ Sores on Tongue, __ Sores in Mouth, __ Heavy Tongue Coat, __ Grinding Teeth, __ Jaw Clicks, __ Jaw Pain, __ TMJ, __ Bad Breath, __ Gum Problems, __ Teeth Problems, __ Unusual Tastes, Comments: ______________________________

Throat: __ Sore, __ Scratchy __ Difficulty Swallowing, __ Feeling of Something stuck in Throat, __ Dry Throat

Comments: ____

Cardiovascular: __ High Blood Pressure, __ Low Blood Pressure, __ Phlebitis, __ Varicose Veins, __ Blood Clots, __ Cold hands, __ Cold Feet, __ Irregular Heart Beat, __ Missing Heart Beats, __ Chest Pain, __ Shortness of Breath, __ Dizziness, __ Swelling of Hands, __Swelling of Feet, __ Fainting, __ Numbness, __ Tingling, __Palpitations

Comments:____

Respiratory: __ Cough, __ Pneumonia, __ Coughing Blood, __ Asthma, __ Bronchitis, __ Difficulty Breathing When Lying Down, __ Tightness in Chest, __ Cough Up Phlegm, What Color? ______________, __Sneezing, *Comments*: ___

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Gastrointestinal: ***Appetite***: __ Heavy, __ light, __ Cravings: What: _______________, __ Changes in appetite: __ Inc. __ Decrease, __ Nausea, __ Gas, __ Bloating, __ Vomiting,, __ Vomiting Blood, __ Acid Regurgitation, __ Belching, __ Bad Breath, __ Abdominal Cramps, __ Abdominal Bloating, __ Constipation more than one day, __ Dry Stools, __ Stools Hard to Expel, __ Food In Stools, __ Explosive Diarrhea, __ BM Without Warning, __ Foul Smelling BM, __ Burning Anus After BM, __ Blood In BM, __ Mucus In BM, __ Black Stools, __ Tarry Stools, __ Hemorrhoids,

Comments: ____

Kidney/Bladder/Urination/Genito-Urinary: __ Kidney Stones, __ Bladder Infections, __ Frequent Urination; __ Painful Urination, __ Blood In Urine, __ Cloudy Urine, __ Urgent Urination, __ Difficult Urination, __ Dribbling Urination, __ Urinary Incontinence, __ Sand in Urine, __ Burning Urination, __ Dark Urine, __ Wake Up To Urinate; # of times per night: ___, __ Copious Urine, __ Urinate Little At A Time, __ Impotence, *Comments*:_________________________
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Liver/GallBladder: __ Frequent Sighing, __ Pain In Side, __ Hepatitis, __ Breast Tenderness, __ Cirrhosis, __ Gall Stones, __ Jaundice. *Comments*: ____

Musculoskeletal: __ Neck Pain; __ Back Pain, __ Sciatica; __ Foot pain, __ Shoulder Pain, __ Upper Arm Pain, __ Elbow Pain, __ Lower Arm Pain, __ Wrist Pain, __ Hand Pain, __ Finger Pain, __ Hip Pain, __ Thigh Pain, __ Knee Pain, __ Lower Leg Pain, __ Ankle Pain, __ Pain on Top of Foot, __ Pain on Bottom of Foot, __ Toe Pain, __ Any Other Body Pain; Describe Where & Nature of Pain: ____

Comments: ____

Cognition: __ Short Term Memory Loss, __ Long Term Memory Loss, __ Confusion, __ Forgetfulness, __ Seizures, __ Transient Ischemic Attacks, TIAs, __ Stroke, __ Disorientation, __ Easily Stressed. *Comments*: _________________
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Mood: (Check any that apply to you): _- Depressed, __ Sad, __ Happy, __ Joyful, __ Fearful, __ Moody, __ Agitated, __ Grief Stricken, __ Confused, __ Frustrated, __ Easily Angered, __ Lacking, __ Rage, __ Resentment, __ Not Good Enough, __ Stressed, __ Distraught, __ Unfulfilled, __ Fulfilled, __ Hateful, __ Passionate, __ Overly Aggressive, __ Hostile, __ Loved, __ Unloved, __ Hurt, __ Scared, __ Pessimistic, __ Have Considered Suicide. *Comments*: ______
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Sleep: __ Trouble Sleeping, __ Hard to Fall Asleep, __ Awaken Easily During the Night, __ Have Difficulty Falling Back To Sleep, __ Vivid Dreams, __ Awaken Rested, __ Awaken Tired, __ Scary Dreams. *Comments*:___________________
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Pregnancy: __ # Of Pregnancies, __ # Of Births, __ Age At 1st Menses, __, __ # Premature Births __, __ # Miscarriages __, *Comments*: ____

Gynecology: __ Excessive Bleeding During Period, __ Clots In Blood, __ Pain During Menstruation, __ Vaginal Sores, __ Vaginal Discharge, Color: ______,, __ Breast Lumps, __ Breast Tenderness or Soreness, __ Irregular Periods, __ Painful Periods, __ Late Period, __ Early Period, __ Variable Period (Comes Early or Late). __ Headaches Which Start Before or At Start of Period, __ Pain or Cramps Which End When Period starts, __ Pain or Cramps Which End When Period Ends, __ Headaches That End When Period Ends. __ Other, Please Describe: _______________________ __ Birth Control; Type, Name: ___________________, __ Menopause, __ Post Menopause, __ Hot Flashes, __ Night Sweats, __ Feeling of Heat in Palms & Soles of Feet. __ Flushing of the Face, __ Irritation, __ Mood Swings, __ Decrease in Sexual Desire, __Loss of Sexual Desire, __ Vaginal Dryness, __ Pain During Intercourse, *Comments*:
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Have You Ever Been Treated For Any Of The Following, (Only Check Off The Following, If They Apply): __ Heart Disease, __ Seizures, __ Any Kind Of Cancer, __ Multiple Sclerosis, __ Parkinson's, __ High Blood Pressure, __ Depression, __ Osteoporosis,__ Drug Addiction, __ Seasonal Affective Disorder, SAD, __ Chronic Fatigue Syndrome, CFS, __ Candida, __ Fibromyalgia, __ Sexually Transmitted Disease, __ Any Neurological Disorder, Please Specify: __________________, __ Any Mental Disorder? Please Describe anything of significance: ________________
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Statement Of Our Financial & Medical Records Privacy Policy:

- We only accept insurance for auto accident injuries, however we will provide billing statements for you to submit to your own insurance company for reimbursement.
- There is a $30 charge for all returned checks.
- Kindly give us 24 hours notice prior to canceling an appointment, to avoid a $20 cancellation fee.
- We accept payment by cash, check, Mastercard or Visa.
- We will not release your medical records nor divulge information about your treatment to anyone without your express consent in writing unless required by law.
- I have read, understand and accept the financial & Privacy policies of Acupuncture & Alternative Medicine Center, or Glenn Eichenauer, DOM, AP.

Patient Signature (*authorizes treatment*): ____, Date: __________________