East Meets West Healthcare

ORIENTAL MEDICINE AND PHYSICAL THERAPY BY REBECCA HAWKINS DPT, L.AC, ATC

NEW PATIENT INTAKE FORM

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____

Emergency Contact, Name & Phone: _____

Living situation: ☐ Single ☐ Married ☐ Partnered ☐ Divorced

Referred by, or how did you hear about us? _____

Do you have health insurance? ☐ Yes ☐ No

If yes, name of insurance company: _____

Insurance Company address if not BCBS: _____

Policy #: _____ Group #: _____

SS# (only if this is used as policy #): _____

Name of insured: _____

Reason for visit today: _____

How long have you had this condition? _____

What seems to be the initial cause? _____

Have you had Acupuncture before? ☐ Yes ☐ No Chinese Herbal Medicine? ☐ Yes ☐ No

Physician(s) you are currently seeing and for what reason: _____

_____

_____

_____

Any other practitioners you are currently seeing (massage, chiropractic, etc): _____

_____

_____

_____

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Family Medical History: (Circle all that apply)

Arthritis	Cancer	High Blood Pressure
Asthma	Diabetes	Stroke
Alcoholism	Heart Disease	Liver/Kidney Disease

Your Medical History: (Circle any that you currently have or have had in past)

AIDS/HIV	Hepatitis	Rheumatic Fever
Alcoholism	Herpes	Seizures
Asthma	High Blood Pressure	Stroke
Cancer	Mono	Thyroid Disorders
Diabetes	Multiple Sclerosis	Tuberculosis
Epilepsy	Pacemaker	Ulcers
Heart Disease	Liver/Kidney	Disease Osteoporosis

Surgeries: _____

Significant Trauma (car accident, fractures, falls, head injuries, etc.): _____

_____

Allergies (drugs, chemicals, foods, environmental): _____

_____

Medicines currently taking or recently taken (Include drugs, hormones, herbs, homeopathy, supplements, etc):

(Please indicate what you are taking them for) _____

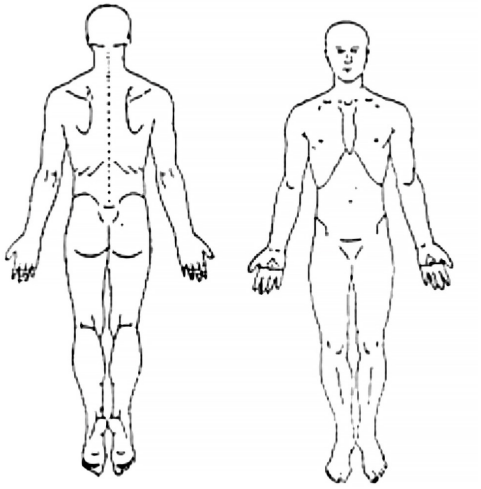
_____

_____

Musculoskeletal: (Please circle all that currently apply)

Headache	Shoulder pain	Hip pain	Leg cramps at night
Neck pain	Upper arm pain	Thigh pain	Loss of feeling in hands/feet
Upper shoulder pain	Elbow pain	Knee pain	Tingling in feet
Pain between shoulders	Lower arm pain	Calf/lower leg pain	Stiffness
Upper back pain	Wrist pain	Ankle pain	Muscle spasms
Mid- back pain	Hand pain	Weak ankles	Bones sore/ache
Low back pain	Finger pain	Foot/Toe pain	Weakness

Please mark your areas of pain:



How do your symptoms feel?

☐ Burning	☐ Heavy
☐ Stabbing	☐ Tingling
☐ Boring	☐ Throbbing
☐ Numbness	☐ Knife-like
☐ Dull	☐ Sharp
☐ Sharp	☐ Aching
☐ Constant	☐ Comes and goes

Other: _____

How long have you had this pain/problem? _____

Is there any particular incident or injury that may have brought this on? _____

_____

What makes the problem/pain better? ☐ Pressure ☐ Heat ☐ Cold Other: _____

What aggravates the problem/pain? ☐ Pressure ☐ Heat ☐ Cold Other: _____

If you have headaches, are they related to: (circle all that apply)

Time of day	Weather	Stress	Menstrual cycle
Alcohol intake	Water intake	Food	

Have you ever been emotionally, physically or sexually abused? _____

Have you recently had any unusually stressful experiences? _____

Is there a constant stress in your life, at work, with your family, etc? _____

Do you smoke or chew tobacco? _____ If yes, how long? _____ How much per day? _____

If yes, have you tried to quit? _____ Do you want to quit? _____

Height: _____ Weight: _____

What is your last measured blood pressure reading? _____

Please list any other conditions not already covered: _____

_____

What are your leisure activities? _____

How often do you exercise? _____

In what type of exercise do you engage? _____

What are your goals for your appointment today?

1. _____
2. _____
3. _____

Please circle if you have recently had problems with any of the following.

<u>General</u>

Frequent colds/flu	Fatigue easily	Recent weight loss
Recurrent fevers	Always tired	Recent weight gain
Chills	Sudden drop in energy	Often thirsty
Night sweats	Jaundice	Difficulty relaxing
Perspire easily without exertion	Anemia	Hyperactive

<u>Gastrointestinal</u>

Constipation	Ulcer	Indigestion
Hard stool	Colitis	Excessive appetite
Frequent laxative use	Diverticulitis	Bitter taste in mouth
Diarrhea	Parasites	Bad breath
Loose stool	Excess gas	Nausea
Undigested food in stool	Excess belching	Vomiting
Blood in stool	Bloating	Gallstones
Black stool	Abdominal cramping	Hiatal hernia
Mucus in stool	Stomach pain/burning	Poor appetite
Excess foul smelling stool	Acid regurgitation	

Please circle if you have recently had problems with any of the following.

Sleep

Difficulty falling asleep	Nightmares	Wake at night – thinking
Difficulty staying asleep	Snoring	Wake at night – mind empty
Dream disturbed sleep	Sleep with electric blanket	Sleep on magnetic mattress
Sleepy in afternoon		

Eyes

Glaucoma	Dry eyes	Itchy eyes
Cataracts	Blurred vision	Red eyes
Poor night vision	Floating spots (floaters)	

Ears, Nose, Mouth and Throat

Sinus congestion/pain	Congestion in ears	Dry mouth
Chronic sinus infections	Earache	
Jaw tension or clicking	Ringing in ears	Sores in mouth
Grinding teeth	Difficulty hearing	Sores around lips
Chronic sore throat	Ear infections	Difficulty swallowing
Gum problems	Nasal congestion	Lump or pit in throat
Dizziness or loss of balance	Swollen lymph nodes	Allergies

Cardiovascular

High blood pressure	Swelling in legs/feet	Angina or chest pain
Coronary artery disease	Blackouts	Blood clots
Irregular heartbeat	Heart murmur	Varicose veins
Rapid heartbeat or palpitations	Bruise easily	Anemia

Respiratory

Chronic cough	Cough up yellow phlegm	Cough up clear or white phlegm
Dry cough	Cough up blood	Cough up watery phlegm
Chronic bronchitis	Cough up sticky phlegm	Asthma – more difficult inhaling
Shortness of breath	Emphysema	Asthma – more difficult exhaling
Pain with deep breath		

Skin and Hair

Rashes	Acne	Moist palms/soles
Hives	Ulcerations or sores	Fungus under nails
Itching	Dry hair	Weak or brittle nails
Eczema	Recent new moles	Loss of hair
Psoriasis	Recent change in moles	Herpes zoster (shingles)
Warts	Herpes simplex (cold sores)	Dry skin

Urinary – Genital

Scanty urine	Dribbling of urine	Sores on genitals
Dark urine	Painful urination	Pain during intercourse
Cloudy urine	Pain in bladder area	Low sex energy
Profuse amount of urine	Blood in urine	Inability to achieve orgasm
Urgency to urinate	Bladder infection	Prostate problems
Unable to hold urine	Kidney infection	Premature ejaculation
Frequent urination	Kidney stones	Inability to maintain erection

Please circle if you have recently had problems with any of the following.

Pregnancy and Gynecological

Number of pregnancies	Light colored/pale blood	Vaginal discharge – white
Number of births	Painful periods	Vaginal discharge – itchy
Miscarriages	Cramping before period	Vaginal discharge – burning
Caesarian sections	Cramping during period	Abnormal PAP
Age at first menses	Low back ache with period	Uterine fibroids
Duration of flow	Spotting between periods	Ovarian cysts
Length of cycle	Missed periods	Breast cysts or lumps
Age at start of menopause	Premenstrual irritability	Pelvic inflammatory disease
Hysterectomy	Premenstrual mood swings	Currently use an IUD
Irregular cycle	Premenstrual breast tenderness	Previously used an IUD
Heavy flow	Premenstrual bloating	Currently using birth control pills
Light flow	Premenstrual headache	Previously used birth control pills
Clots	Premenstrual constipation	Infertility
Dark or brownish blood	Premenstrual diarrhea	Hot flashes

Neuro-Psychological

Depression	Anxiety or fear	Poor memory
Suicidal feelings	Mood swings	Difficulty concentrating
Frequently angry or irritated	Sadness or grief	Frequent crying
Tend to repress emotions	Cramping during period	Abnormal PAP

How much water do you drink a day? _____

How much coffee do you drink a day? _____ Regular or decaf? _____ Organic? _____

How much soda do you drink? _____ Regular or diet? _____

How much tea do you drink? _____ Herbal or caffeinated? _____

How much alcohol do you drink? _____

How much tobacco do you use? _____ How many years? _____

Are you vegetarian? _____ How many years? _____

Do you have any dietary restrictions? _____

Please list the 3 "healthiest" foods you might eat in a week.

1. _____
2. _____
3. _____

Please list the 3 "worst" foods you might eat in a week.

1. _____
2. _____
3. _____