ELEMENT 5 OM – NEW PATIENT INTAKE FORM

Thank you for choosing us as your acupuncture and herbal medicine provider. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. The information provided is important for proper diagnosis and treatment planning. All your information will be confidential. If you have questions, please ask.

DATE

Full Name		**Sex ☐ F ☐ M**	**Marital ☐ M ☐ S ☐ D**
Full Address			
Email		**Contact me by email**	**☐ YES ☐ NO**
Home Phone		**Cell Phone**	
Date of Birth	**Age**	**# of Children**	
Occupation		**Employer**	
Physician		**Chiropractor**	
Emergency Contact Name		**Phone**	
Have you had Acupuncture?	**☐YES ☐ NO**	**If YES, when?**	
Chinese Herbal Medicine?	**☐YES ☐ NO**	**If YES, when?**	
How were you referred?			

Main Health complaint(s):_____

What diagnosis, if any, have you received for this problem?_____

When did this problem begin?_____ What are the causes of this problem? _____

Does it bother your daily activities? ☐ Work ☐ Sleep ☐ Other

What kind of treatment have you tried?_____

What makes it worse?_____ What makes it better? _____

Family history of similar problems? ☐ YES ☐ NO

Personal History/Habits

Height: _____' _____" Weight:_____lbs. Want to loose weight? ☐ YES ☐ NO How much?_____

Regular exercise? ☐ YES ☐ NO Type _____ Frequency_____

Do you drink alcohol? ☐ YES ☐ NO How much? _____/day

Water_____ /day Coffee _____/day Sodas _____/day

Do you smoke? ☐ YES ☐ NO How many? _____/day Want to quit? ☐ YES ☐ NO

For how long?_____ ☐ YEARS ☐ MONTHS Rate determination to quit smoking. ☐ LOW ☐ AVG ☐ HIGH

Recreational drugs? ☐ YES ☐ NO Specify type/frequency_____

Dietary Habits, check all that apply. Standardized diet plan?_____

☐ Processed Foods ☐ Sugar/Sweeteners ☐ Fast Food
☐ High Protein ☐ Vegetarian/Vegan ☐ Diabetic

Medical History

Past or current major illnesses, accident or injuries:_____

Surgeries: _____ Hospitalization: _____

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

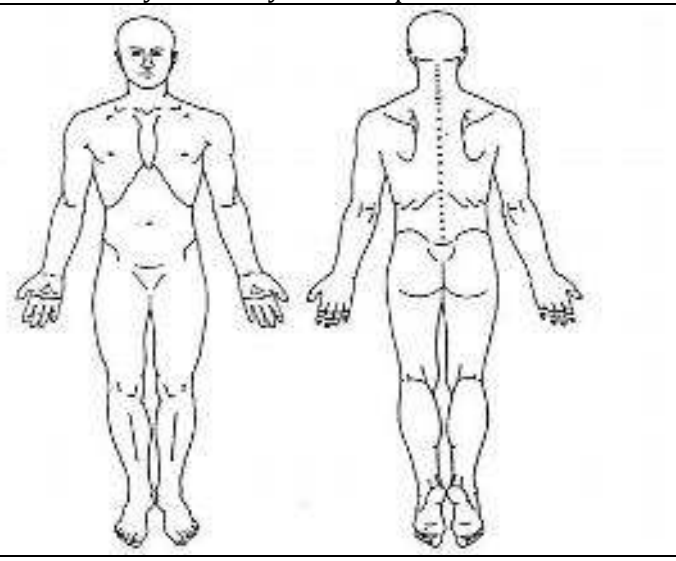
Previous/Current Conditions, check all that apply.

☐ AIDS/HIV	☐ Alcoholism	☐ Allergies	☐ Appendicitis	☐ Arteriosclerosis	☐ Asthma
☐ Birth Trauma	☐ Hemorrhage	☐ Chicken Pox	☐ Emphysema	☐ Epilepsy	☐ Glaucoma
☐ Goiter	☐ Gout	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol	☐ Irr. Pap Smear
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Lung Disease	☐ Measles	☐ Meningitis
☐ Migraines	☐ Mononucleosis	☐ Mumps	☐ Multiple Sclerosis	☐ Nervous Disorder	☐ Pacemaker
☐ Paralysis	☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Scarlet Fever
☐ Seizures	☐ Stroke	☐ Syphilis	☐ Thyroid Disorders	☐ Tuberculosis	☐ Typhoid Fever
☐ Ulcers	☐ Vein Condition	☐ Venereal Disease	☐ Whooping Cough		

☐ Cancer, type(s):_____

☐ Diabetes, type: _____ ☐ Hepatitis, type: _____ ☐ Herpes, type: _____

Pain - Please clearly mark any areas of pain and numbness.



Is the pain?

☐ Sharp ☐ Cramping ☐ Fixed ☐ Burning

☐ Aching ☐ Dull ☐ Moving

What lessens the pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise

What worsens the pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise

Pain Level:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Very Slight **Unbearable**

*Please check any of the following symptoms that **CURRENTLY** pertain to you:*

Body Temperature

☐ Cold Hands	☐ Sweaty Palms	☐ Cold Feet	☐ Sweaty Feet	☐ Hot Flashes	☐ Hot Body Temp
☐ Cold Body Temp	☐ Flushing	☐ Strong Thirst	☐ Profuse Perspiration	☐ Lack of Perspiration	☐ Night Sweating
☐ Perspire Easily	☐ Night Time Urination				

Energy and Stamina

☐ Shortness of Breath ☐ Easily Fatigued ☐ Lethargy ☐ Wheezing ☐ Heavy Sweating ☐ Frequent Cold/Flu/Sinus

Blood Function

☐ Hard Concentrating	☐ Poor Memory	☐ Fainting	☐ Brittle Nails	☐ Dizziness	☐ Tingling in Extremities
☐ Itchy/Dry Skin	☐ Tinnitus	☐ Blurry Vision	☐ Poor Night Vision	☐ Floaters in Vision	☐ Light Menses (Women only)

Heart Function

☐ Rapid Heart Rate	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Heart Palpitations	☐ Chest Pain Arrhythmia	☐ High Blood Pressure
☐ Low Blood Pressure	☐ Hemophilia	☐ Manic Moods	☐ Forgetfulness	☐ Tongue Ulcers	☐ Anxiety
☐ Restless Dreams	☐ Insomnia	☐ Hallucinations	☐ Speech Problem	☐ Mental Restlessness	☐ Depression

Lung Function

☐ Sinus Congestion	☐ Sore Throats	☐ Wheezing	☐ Difficulty Breathing	☐ Persistent Cough	☐ Nosebleeds
☐ Nasal Dryness	☐ Sneezing	☐ Chronic Allergies	☐ Dry/Flaky Skin	☐ Headaches	

Spleen Function

☐ Food Cravings ☐ Weak Appetite ☐ Indigestion ☐ Gas ☐ Gurgling Intestines ☐ Abdominal Bloating
☐ Hemorrhoids ☐ Weight Gain ☐ Weight Loss ☐ Fatigue after Eating ☐ Hypoglycemia ☐ Low Blood Sugar
☐ Bruise Easily

Stomach Function
☐ Heavy Appetite ☐ Nausea ☐ Belching ☐ Vomiting ☐ Heartburn ☐ Acid Reflux
☐ Hiccups ☐ Mouth Ulcers ☐ Bad Breath ☐ Stomach Ache ☐ Stomach Ulcers ☐ Bleeding Gums

Intestinal Function
☐ Mucous in Stools ☐ Blood in Stools ☐ Hard, Dry Stools ☐ Loose Stools ☐ Less than 1 BM/Day ☐ Constipation
☐ Diarrhea ☐ IBS/Colitis ☐ Chron's Disease ☐ Eating Disorder

Dampness
☐ Chest Congestion ☐ Mental Fogginess ☐ Mental Sluggishness ☐ Poor Mental Focus ☐ Swollen Hands ☐ Swollen Feet
☐ Edema in Legs ☐ Edema in Abdomen ☐ Joint Stiffness/Ache ☐ Heaviness in Body ☐ Symptoms with Weather Changes

Liver & Gallbladder Function
☐ Chest Pain ☐ Chest Tightness ☐ Irritability ☐ Depression ☐ Easily Frustrated ☐ Easily Overwhelmed
☐ Skin Rashes ☐ Heaviness in Ribs ☐ Pain in Ribs ☐ Acne ☐ All over Body Tension ☐ Muscle Spasms
☐ Muscle Cramps ☐ Headaches ☐ Migraines ☐ Gallstones ☐ Eye Pain/Dryness ☐ Seizures
☐ Convulsions ☐ Numbness/Tingling ☐ Lump in Throat ☐ Neck Tension ☐ Shoulder Tension ☐ Ringing in Ears
☐ Alternating Diarrhea/Constipation

Eyes
☐ Itchy Eyes ☐ Dry Eyes ☐ Watery Eyes ☐ Grittiness ☐ Irritation ☐ Bloodshot
☐ Poor Night Vision ☐ Seeing Spots ☐ Astigmatism ☐ Glaucoma

Kidney & Urinary Bladder Function
☐ Hair Loss ☐ Early Gray Hair ☐ Hearing Loss ☐ Ringing in Ears ☐ Quick to Fear ☐ Frequent Cavities
☐ Broken/Loose Teeth ☐ Weak Bones ☐ Weak Knees ☐ Knee Soreness ☐ Low Back Pain ☐ Cold Lower Back
☐ Cold Hip/Buttocks ☐ Cold Knees ☐ Incontinence ☐ Prostate Problems (Men Only)

Urinary Function
☐ Night Urination ☐ UTI Pain/Burning ☐ Hesitancy ☐ Difficult Urination ☐ Normal Color ☐ Dark Yellow
☐ Clear Color ☐ Reddish Color ☐ Cloudy ☐ Strong Odor ☐ Dribbling ☐ Small Amount
☐ Large Amount ☐ Very Frequent ☐ Weak Stream

Libido Function
☐ Normal ☐ High Sex Drive ☐ Infertility ☐ Diminished Sex Drive ☐ Fatigue after Sex ☐ Pain with Intercourse

Men Only
☐ Swollen Testes ☐ Testicular Pain ☐ Impotence ☐ Painful Ejaculation ☐ Premature Ejaculation ☐ Cold/Numbness in Genitalia

Women Only

Are you Pregnant? ☐ YES ☐ NO Trying to Be? ☐ YES ☐ NO

Number of Births Number of Children Number of Pregnancies

Age Menses Began_____ Age of Menopause _____ Days of Menstruation _____

Flow ☐ Low ☐ Moderate ☐ Heavy

Current Symptoms
☐ Irregular Periods ☐ Painful Periods ☐ PMS ☐ Mild Cramps ☐ Severe Cramps ☐ Vaginal Sores
☐ Vaginal Odor ☐ Discharge ☐ Breast Lumps
☐ Bleeding between Periods ☐ Cold/Numbness in Genitalia

Premenstrual Symptoms
☐ Nausea ☐ Vomiting ☐ Water Retention ☐ Breast Swelling ☐ Breast Tenderness ☐ Food Cravings
☐ Headaches ☐ Migraines ☐ Depression ☐ Irritability ☐ Anxiety