Today's Date ____/____/

New Patient Intake Form

____ ____/____/____ _________
First Name (Print) Last Name Birth Date Birth Time

____________________________ _____________
Birth Location (City, State) Age

________________________________ ____________________ __________
Current Address City Zip Code

_________________________ _________________________
Phone (home) Phone (work) or cell phone

____
How did you hear about us? (personal referral, website, flyer, Heartwood materials etc)

Email Address ____

Would you like to receive a monthly health newsletter (via email)? ___________ (yes or no)

Would you like a super-bill to submit to insurance or for flex account reimbursement _______ (yes or no)

Have you had acupuncture before?_______ For what?_______________________________________

Taken Chinese Herbal Medicine, Homeopathic, Flower Essence?_____(Yor N) What?_______________

Are you currently under the care of a M.D.? _______ For what?____________ How Long?__________

Result of treatment: ____

What are the three primary reasons for your visit today?

1. How long ? ___________Severity (0-10 10 worse)_______
2. How long ? ___________Severity (0-10 10 worse)_______
3 How long ? ___________Severity (0-10 10 worse)_______

Treatment Expectations and Commitment:

For each of your primary reasons for your visit today, what are **your treatment expectations** using acupuncture, NAET and/or holistic supplements? (the number of treatments a client will require will depend on the nature and severity of the condition- assume 6 weeks of at least 1x week treatment minimum) Please answer in terms of symptom relief and number of treatments.

1.

2.

3

Are you willing to take herbal or other holistic supplements (like digestive enzymes, homeopathic) for at least six weeks as recommended? ____________ (Yes or No)

Below, please list any pharmaceutical drugs, vitamin supplements, herbs, or other medicinal substances you are taking on a regular, daily basis

Medications:	How Long?	Treatment Goal:

Brief Health History:

Any major diseases, STD's, surgeries, broken bones, accidents that resulted in injury etc.? Please List:

Pain? ___________________________ How Long?__________ Weather/Diet Related?________

How many times per year do you get a cold or the flu? ______

Does this happen every year at the same time? When? ______________________________

How was this treated before (..z-pack et cetera..)? __________________________________

Emotions:

❑ Normal ❑ Problem
❑ Depression ❑ Sadness ❑ Panic attack ❑ Sensitive ❑ Worries ❑ Overly excited
❑ Anger ❑ Anxiety

Emotions play role in balanced health and correct identification of trends can aid in restoring balance.
Do any of the following groups of emotions apply to you in your everyday life? (check all that apply:

____ I hide my feelings behind a façade of cheerfulness
____ I dislike arguments and often give in to avoid a conflict
____ I turn to food, work, alcohol, drugs when down

____I feel anxious without knowing why
____I have a secret fear that something bad will happen
____I wake up feeling anxious

____I get annoyed by the habits of others
____I focus on others' mistakes
____I am critical and intolerant

____ I often neglect my own needs to please others
____ I find it hard to say "no"
____I tend to be easily influenced

___ I constantly second-guess myself
____I seek advice, mistrusting my own intuition
____I often change my mind out of confusion

____I'm afraid I might lose control of myself
____ I have sudden fits of rage
____ I feel like I am going crazy

____I make the same mistakes over and over
____I don't learn from my experience
____I keep repeating the same patterns

____I need to be needed and want my loved ones close
____ I feel unloved and unappreciated by my family
____ I easily feel slighted and hurt

____I often feel spacey and absent minded
_____I find myself unable to concentrate
_____I get drowsy and sleep more than most

____I am overly concerned with cleanliness
____I feel unclean or unattractive
____I tend to obsess over little things

____I feel overwhelmed by responsibilities
____I have temporarily lost self-confidence
____I don't cope well under pressure

___I become discouraged with set-backs
___I am disheartened when things get hard
___I am often skeptical and pessimistic

___I feel hopeless and can't see a way out
___I lack faith that life will improve
___I feel sullen and depressed

___I am obsessed with my own troubles
___I dislike being alone and like to talk
___I usually like talking about myself

___I am suspicious of others
___I feel discontented and unhappy
___I am full of jealousy, mistrust or hate

___I'm often homesick for "the way it was"
___I think more about past than present
___I often think about what might have been

___I often feel too tired to face the day ahead
___I feel mentally exhausted
___I tend to put things off

____I find it hard to wait for things
____I am impatient and irritable
____I prefer to work alone

____I lack self-confidence
____I feel inferior and am discouraged
____I never expect anything but failure

____I am afraid of things such as spiders, illness
____I am shy, overly sensitive and modest
____I get nervous and embarrassed

____I feel extreme heartache
____I have reached the limits of endurance
____I am in complete despair, all hope gone

____I get depressed without reason
____I feel my moods swinging back and forth
____I get gloomy feeling that come and go

___I get high strung and very intense
___I try to convince others of my opinions
___I am sensitive to injustice, fanatical

____I tend to overwork even when exhausted
____I have strong sense of duty
____I neglect my own needs to finish tasks

____I tend to take charge of projects
____I consider myself a leader
____I am strong-willed and bossy

____I feel completely exhausted
____I am totally drained of energy no reserve
____I have been through a long period of stress

____I am experiencing change in my life
____I get drained by people or situations
____I want to be free to follow ambitions

____I feel unworthy and inferior
____I often feel guilty
____I blame myself for things that go wrong

____I give the impression that I'm aloof
____I prefer to be alone when overwhelmed
____I often don't connect with people

____I am overly worried about loved ones
____I am distressed by problems of others
____I worry that harm may come to loved ones

____I constantly have unwanted thoughts
____I relive unhappy events or arguments
____I am unable to shut my mind off to sleep

____I sometimes feel terror and panic
____I become helpless and frozen when afraid
____I suffer from nightmares

___I can't find my path in life
___I am drifting in life and lack direction
___I am ambitious but unfocused

____I set high standards for myself
____I am disciplined with health, work
____I am always striving for perfection

___I am apathetic and resigned to whatever
___I have the attitude "it doesn't matter"
___I feel no joy in life

____I find it difficult to make decisions
____I often change my mind
____I have intense mood swings

___I feel resentful and bitter
___I have difficulty forgiving and forgetting
___I think life is unfair think "poor me"

____I feel devastated due to recent shock
____I am withdrawn due to traumatic events in my life
____I have never recovered from loss or fright

Energy:

❑ Normal ❑ Problem

❑ Low ❑ Up and down ❑ Exhausted ❑ Hyperactive ❑ Nervous energy ❑ Abundant

Describe: ____

____

Sleep Pattern:

❑ Normal ❑ Insomnia

Falling Asleep: ❑ Sometimes Difficult ❑ Always difficult

❑ Sometimes very difficult ❑ Always very difficult

❑ Sleep in daytime ❑ Take naps

Waking up: ___ Times per night ❑ Wake up too early

❑ Wake up at night and cannot go back to sleep again

Sleep Quality:

❑ Deep ❑ Light ❑ Bad

❑ Many dreams ❑ Bad dreams ❑ Grinding teeth ❑ Talking in sleep ❑ Other

Describe: ____

____

Temperature:

❑ Normal ❑ Abnormal

❑ Feel cold easily ❑ Cold Hands ❑ Cold feet ❑ Alternating hot and cold

❑ Feel hot easily ❑ Hot flash ❑ Sensitive to weather changes

Describe: ____

____

Sweating:

❑ Normal ❑ Abnormal

❑ Too easily ❑ Too much ❑ Difficult ❑ Too little ❑ Night Sweats ❑ Other

Describe: ____

____

Drinking:

❑ Normal ❑ Abnormal

❑ Thirsty ❑ Dry Mouth ❑ Drink a lot ❑ Dry mouth but no desire to drink

❑ Not thirsty but drink a lot anyway

Describe: ____

____

Urination:

❑ Normal ❑ Abnormal

❑ Frequent ❑ Urgent ❑ Burning ❑ Painful ❑ Cloudy ❑ Dark Color

❑ Foul smell ❑ Bloody ❑ Difficult ❑ Retention

Number of times per day_____ Number of times per night_____ Other____________

Describe: ____

Lifestyle:

Regular exercise:

Type________________ Frequency____________

Type_________________ Frequency____________

Menstrual:

What was the date of your last period?___________________ How long do they last? _________

Are you on oral contraception (OCP)? ___________ At what age did you first use OCP?______

Did you first use OCPs for menstrual pain or period regulation? _______

Are you prone to : PMS________ Bloating __________ Irritability________

Appetite and Digestion:

❑ Normal ❑ Abnormal

❑ Rapid Hungering ❑ Poor appetite ❑ Nausea ❑ Anorexia ❑ Bloating ❑ Gas

❑ Hungry, but no desire to eat ❑ Other

Describe: ____

____

Bowel Movement:

❑ Normal ❑ Abnormal Time of day: __________

❑ Constipation ❑ Diarrhea ❑ Loose ❑ Watery ❑ Incomplete ❑ Hard and Dry

❑ Strong Smell ❑ With mucous ❑ With blood ❑ Other

Describe: ____

____

Body Weight:

❑ Normal ❑ Overweight ❑ Underweight

Sensitivity and Allergies:

❑ No ❑ Yes

❑ Cold ❑ Hot ❑ Dampness ❑ Light ❑ Noise or Radiation

❑ Airborne particles ❑ Food ❑ Drugs ❑ Weather changes ❑ Pet Dander

Do you eat eggs? ________ (yes or no)

Do you eat gluten or gluten products (wheat, oat, corn)?________

Do you eat dairy (yogurt, cheese, cow's milk, ice cream, cream)? _________

Do you eat soy or soy products?____________

Do you cough up phlegm or get phlegm in response to eating certain foods?_______

Do you have post-nasal drip?__________

Menstrual History

Age at which Menses Began _____

Age at which it stopped _____

Are your periods painful? ❑ Yes ❑ No

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? ❑Light ❑Normal ❑ Heavy

What color is the blood? ❑Light red ❑Red ❑Dark Red ❑Brown ❑Black

Is there clotting? ❑Yes ❑No

Do you have premenstrual tension? ❑Yes ❑No

Does your face break out before or during your period? ❑Yes ❑No

Do your breasts become tender pre-menstrually? ❑Yes ❑No

Do you retain water during your period? ❑Yes ❑No

Do you bleed or spot between periods? ❑Yes ❑No

Are your menstrual cycles spaced irregularly? ❑Yes ❑No

How many days are there from one period to the next? _______

Date of last menstrual period _______________

	Number	Years
How many pregnancies have you had?	______	______________
How many children do you have?	______	______________
How many abortions have you had?	______	______________
How many miscarriages have you had?	______	______________
How many times has a D&C been performed?	______	__________

Complications? ____

Have you ever had an abnormal pap smear? ❑Yes ❑No

Have you ever had a cervical biopsy, operation, cauterization or conization? ❑Yes ❑No

Have you ever had a venereal disease? ❑Yes ❑No

Do you get yeast infections regularly? ❑Yes ❑No

Have you ever been diagnosed with a chlamydial infection? ❑Yes ❑No

Do you have chronic vaginal discharge? ❑Yes ❑No

Do you have any sores on your genitalia? ❑Yes ❑No

Have you ever had pelvic inflammatory disease? ❑Yes ❑No

Were you treated for it? ❑Yes ❑No

How? ____

____

Date of last Pap smear __________________________

Have you ever been diagnosed with uterine fibroids or polyps? ❑Yes ❑No

Have you ever been diagnosed with endometriosis? ❑Yes ❑No

Have you been diagnosed with pelvic adhesions? ❑Yes ❑No

Have you been diagnosed with any pelvic abnormalities? ❑Yes ❑No

Have you taken any medications other than contraceptives for gynecological conditions?

Medicine	**Reason**	**How long**
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________
____________________	____________________	__________

Have your cycles changed since they began? ❑Yes ❑No

How? ____

Do you ovulate on your own? ❑Yes ❑No

On what day of your cycle? ___________________________

Do your breasts get tender at/during ovulation? ❑Yes ❑No

Do you get premenstrual low back pain? ❑Yes ❑No

Do your bowel movements become loose at the beginning of your period? ❑Yes ❑No

Fertility History

How long have you been trying to conceive?_________________

Is there a history of infertility in your family? ❑Yes ❑No

Describe: ____

Have you had fertility treatments? ❑Yes ❑No

If yes, when and where? ______________________

By whom? _________________________________

What types? _______________________________

Have you taken medication to help you ovulate? ❑Yes ❑No

When? _________________ How long? ______________

Have your fallopian tubes been evaluated medically? ❑Yes ❑No

What were the results? ______________________________

Have you had any tubal operations? ❑Yes ❑No

Have you had any hormone laboratory tests performed? ❑Yes ❑No

What were the results? _____________________________

Do you have a single partner with whom you have been trying to conceive? ❑Yes ❑No

How long have you been married or living together?________

Has he had a fertility workup? ❑Yes ❑No

What were the results? ______________________________

Is your partner supportive of your wish to conceive? ❑Yes ❑No

Have you taken oral contraceptives? ❑Yes ❑No

When?__________________ How long?__________________

Have you ever had an IUD? ❑Yes ❑No

When? __________________ How long?__________________

Have you ever taken DepoProvera? ❑Yes ❑No

When? __________________ How long? _________________

Have you had a diagnosis relating to infertility? ❑Yes ❑No

What was it? ____

How is your sexual energy? ❑Low ❑Normal ❑High

Are you experiencing any sexual problems? ❑Yes ❑No

Does your partner experience any sexual dysfunction? ❑Yes ❑No

Do you douche regularly? ❑Yes ❑No

With what? _____________________________

Do you use vaginal lubricants? ❑Yes ❑No

Are you more than 20% over your ideal body weight? ❑Yes ❑No

Are you more than 20% below your ideal body weight? ❑Yes ❑No

Do you have a stressful occupation? ❑Yes ❑No

Do you exercise regularly? ❑Yes ❑No

Do you have excessive facial hair? ❑Yes ❑No

Do you have excessively oily skin? ❑Yes ❑No

Have you experienced excessive loss of head hair? ❑Yes ❑No

Have you noticed discharge from your nipples? ❑Yes ❑No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? ❑Yes ❑No

Have you been exposed to any known environmental toxins or hormones? ❑Yes ❑No

Are you presently taking steroids? ❑Yes ❑No