WATER BY THE RIVER

ASIAN MEDICINE CLINIC

New Patient Intake Form

Patient Information:

Patient Name:

_____

(Last) (First) (Middle Initial)

DOB:_____-_____-_____ Sex: _____ Age: _____ Height: _____

Weight: _____ Marital Status: _____

How did you hear about us?_____

Contact Information:

Address:_____

(Street Address) (Zip)

City:_____ State:_____

Home Phone:_____-_____-_____ Cell Phone:_____-_____-_____

Work Phone: _____-_____-_____

Email Address:_____@_____

Permission to Contact (Please Circle): Home Cell Work Email Any

Occupation:_____

Current concerns or issues (Sleep, pain, digestion etc.)_____

_____

History of current complaint (How long as it been going on, What happened etc?)_____

_____

_____

Has it been checked by Western MD? Y or N

Have you seen your Western MD in the last 90 days? Y or N

If Yes, what was the diagnosis?_____

OTC/Prescribed/Supplements currently taking:_____

_____

Sleep:

How many hours per night:_____ Do you wake feeling rested? Yes No

Insomnia? Yes No Excessive Dreaming? Yes No Nightmares? Yes No

Nighttime Urination? Yes No

Energy:

What is your daily energy level (1-10 high):_____

Do you experience crashes throughout the day? Y or N If yes, when?_____

Diet:

Describe a typical days worth of meals (Breakfast, Lunch, dinner)_____

_____

_____

Do you Smoke? Y or N If Yes, how much?_____

Do you Drink Alcohol? Y or N If Yes, how often?_____

Do you do Recreational Drugs? Y or N If yes, what and how often?

_____

What do you do for stress relief?

_____

What do you do for exercise?

_____

Women

Menstruation:

Period (Please give date of last cycle) _____

Flow (How many days) _____

Quantity (Type of flow, excessive, miniscule etc.)_____

Quality:Clots (Circle one): Yes No If 'Yes' size: Dime Nickel Quarter

Other_____ Color (Circle one): Red Dark Red Purple Blue

PMS (Circle one): Yes No

-If 'yes' please describe PMS Symptoms:

_____

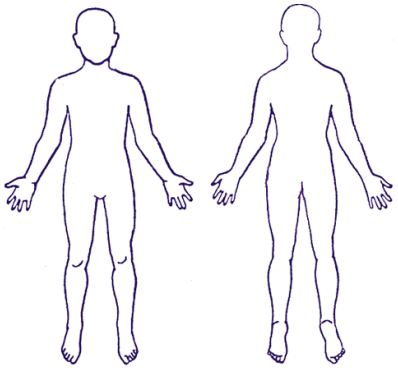
Pap smear (Give date of last exam)_____

Mammogram (Give date of last exam) _____

Are you currently pregnant? Yes No

# of Children: _____

PAIN (Please circle where it is located)



Please mark below the level of pain:

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

No Pain Intermediate Pain Worst Pain

Please check the duration of your pain:

___Continuous ___Positional ___Intermittent (on/off) ___Unable to rate