

Deepa Health *Deeper Healing from the Inside Out*

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NEW PATIENT INTAKE FORM Today's Date _____

Name..... Birthdate..... Age.....
Occupation..... Male Female Height..... Weight..... Marital Status.....
Address..... City, State, Zip.....
Home Phone Work Phone..... Cell Phone.....
E-mail..... Referred by
Emergency Contact - Name & Phone..... Relationship.....
Reason for visit today.....
How long have you had this condition?..... Is it getting worse?.....
Does it bother your Sleep Work Other (what?).....
What seemed to be the initial cause?
What seems to make it better?.....
What seems to make it worse?.....
Are you under the care of a physician now? Yes No If yes, for what?.....
Who is your physician?..... Physician's phone.....
Other concurrent therapies.....
Have you had acupuncture before? Yes No Have you had Chinese herbal medicine before? Yes No

ALLERGIES (Please list)

FAMILY MEDICAL HISTORY

- Arteriosclerosis Cancer (please list) Diabetes Seizures
 Asthma Heart disease Stroke
 Alcoholism High blood pressure

YOUR PAST MEDICAL HISTORY / LIFESTYLE

Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

- | | | | | |
|---|---|--|--|---|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Epilepsy | <input type="radio"/> Pneumonia | <input type="radio"/> Thyroid disorders | <input type="radio"/> Major trauma (Car, fall, etc.-list) |
| <input type="radio"/> Alcoholism | <input type="radio"/> Goiter | <input type="radio"/> Polio | <input type="radio"/> Travel out of US (list countries and dates)..... | ..... |
| <input type="radio"/> Allergies | <input type="radio"/> Gout | <input type="radio"/> Rheumatic fever | ..... | ..... |
| <input type="radio"/> Appendicitis | <input type="radio"/> Heart disease | <input type="radio"/> Scarlet fever | ..... | ..... |
| <input type="radio"/> Arteriosclerosis | <input type="radio"/> Hepatitis | <input type="radio"/> STD's | | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Asthma | <input type="radio"/> Herpes | <input type="radio"/> Seizures | | <input type="radio"/> Typhoid fever |
| <input type="radio"/> Birth trauma (your own birth) | <input type="radio"/> High blood pressure | <input type="radio"/> Stroke | | <input type="radio"/> Ulcers |
| <input type="radio"/> Cancer | <input type="radio"/> Measles | <input type="radio"/> Surgery (list) | <input type="radio"/> Major disorders | <input type="radio"/> Venereal disease |
| <input type="radio"/> Chicken pox | <input type="radio"/> Multiple sclerosis | | | <input type="radio"/> Whooping cough |
| <input type="radio"/> Diabetes | <input type="radio"/> Mumps | | | <input type="radio"/> Other (Specify) |
| <input type="radio"/> Emphysema | <input type="radio"/> Pacemaker | ..... | ..... | ..... |
| | <input type="radio"/> Pleurisy | ..... | ..... | ..... |

YOUR DIET

- Appetite Coffee Artificial sweetener Salty food
 Low Medium High Soft drinks Sugar Thirst for water – # glasses per day

AVERAGE DAILY MENU

Morning	Snack	Noon	Snack	Evening	Snack
.....
.....
.....

PHARMACEUTICALS, VITAMINS & SUPPLEMENTS YOU CURRENTLY USE: (Please list)

.....
.....
.....

YOUR LIFESTYLE

- Alcohol
- Marijuana
- Stress
- Tobacco
- Recreational drugs
- Occupational hazards
- Regular Exercise*
- Type.....
- Frequency.....
- Type.....
- Frequency.....

GENERAL SYMPTOMS

- Poor appetite
- Poor sleep
- Bodily heaviness
- Chills
- Heavy appetite
- Heavy sleep
- Cold hands or feet
- Night sweats
- Strongly like cold drinks
- Dream-disturbed sleep
- Poor circulation
- Muscle cramps
- Strongly like hot drinks
- Fatigue
- Shortness of breath
- Vertigo or dizziness
- Recent weight loss/gain
- Lack of strength
- Fever
- Multiple Sclerosis
- Tired after meals
- Dizzy with position change
- Bleed or bruise easily
- Peculiar taste (describe)

HEAD, EYES, EARS, NOSE, THROAT

- Glasses
- Night blindness
- Sores on lips or tongue
- Lumps in throat
- Eye strain
- Glaucoma
- Dry mouth
- Enlarged thyroid
- Eye pain
- Cataracts
- Excessive saliva
- Nose bleeds
- Red eyes
- Teeth problems
- Sinus problems
- Ringing in ears
- Itchy eyes
- Grinding teeth
- Excessive phlegm - color of phlegm.....
- Poor hearing
- Spots in eyes
- TMJ
- Recurrent sore throat
- Earaches
- Poor vision
- Facial pain
- Swollen glands
- Headaches
- Blurred vision
- Gum problems
- Migraines
- Concussions
- Other head or neck problems

RESPIRATORY

- Difficulty breathing when lying down
- Shortness of breath
- Cough
- Color of phlegm
- Tight Chest
- Wet or dry?.....
- Asthma/wheezing
- Mucous thick or thin?
- Coughing blood
- Pneumonia

CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Chest pain
- Tachycardia
- Blood clots
- Fainting
- Difficulty breathing
- Heart palpitations
- Phlebitis
- Irregular heartbeat

GASTROINTESTINAL

- Nausea
- Diarrhea
- Intestinal pain or cramping
- Please describe your bowel movements:
- Texture/form.....
- Vomiting
- Constipation
- Itchy anus
- Frequency.....
- Odor.....
- Acid regurgitation
- Laxative Use
- Burning anus
-
- Gas
- Black stools
- Rectal pain
- Color.....
- Hiccup
- Bloody stools
- Hemorrhoid
- Bloating
- Mucous in stools
- Anal fissures
- Bad breath
- Move bowels with meals

MUSCULOSKELETAL

- Neck/shoulder pain
- Upper back pain
- Joint pain
- Limited range of motion
- Other (describe)
- Muscle pain
- Low back pain
- Rib pain
- Limited use

SKIN AND HAIR

- Rashes
- Eczema
- Dandruff
- Change in hair/skin textures
- Other hair or skin problems
- Hives
- Psoriasis
- Itching
- Fungal infections
- Ulcerations
- Acne
- Hair loss

NEUROPSYCHOLOGICAL

- Seizures
- Poor memory
- Irritability
- Considered/attempted suicide
- Other (specify)
- Numbness
- Depression
- Easily stressed
- Seeing a therapist
- Tics
- Anxiety
- Abuse survivor

GENITO-URINARY

- Pain on urination
- Blood in urine
- Venereal disease
- Increased libido
- Impotence
- Frequent urination
- Unable to hold urine
- Bedwetting
- Decreased libido
- Premature ejaculation
- Urgent urination
- Incomplete urination
- Waken to urinate...how often?
- Kidney stone
- Nocturnal emission

GYNECOLOGY

- Age menses began
- Irregular periods
- Consistency of flow.....
- Vaginal odor
- Premature births
-
- Length of cycle (day 1 to day 1).....
- Painful periods
-
- Clots
- Age at menopause
- Duration of flow
- PMS
- Color of flow.....
- describe.....
- Breast lumps
- Date of last PAP
-
- Date last period began
- color.....
- Breast pain
-
-
- Vaginal sores
- # Pregnancies.....
-
- # Live births.....

OTHER CONCERNS, HISTORY;