

**Acupuncture And Holistic Medicine Healing Center: New Patient Patient At A Distance Intake Form**

Name: _____		Phone: Contact me No.: _____		Cell: _____	
Street: _____		Email: _____		<b>Permission To Email You With Health Improvement Info or special offers? Please circle Y or N. We never sell or share your info. We respect your privacy!</b>	
City: _____		Birth date: _____		Age: _____	
State: _____		Zip: _____		Occupation: _____	
		HT.: _____		WT.: _____	
Physician: _____		Referred by: _____		Emergency contact: _____	
Main Problem: _____		Emergency Phone: _____			
Getting other treatment? Describe? _____					

**Past Medical History: (please includes dates)**

*Significant illnesses:* \_\_\_ Cancer, \_\_\_ Diabetes, \_\_\_ High Blood Pressure, \_\_\_ Heart Disease, \_\_\_ Hepatitis  
 \_\_\_ AIDS/HIV, \_\_\_ Rheumatic Fever, \_\_\_ Thyroid Disease, \_\_\_ Seizures, \_\_\_ Osteoporosis, \_\_\_ MS  
 \_\_\_ Fibromyalgia, \_\_\_ Chronic Fatigue Syndrome, \_\_\_ CP, \_\_\_ Parkinson's, \_\_\_ Asthma, *Other:*

*Surgeries (approx. datess):*

*Significant Trauma (auto accidents, falls, etc., approx. dates):*

*Allergies (drugs, chemicals, food, etc.)*

*Medicines taken within the last two months (include vitamins, other the counter drugs, herbs, etc.)*

*Life Stresses: (Chemical exposure, physical, mental, emotional)*

*Comments:*

*Average daily diet:*

Morning	Afternoon	Evening
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**Habits:** \_\_\_ Cigarettes, \_\_\_ Coffee, \_\_\_ Tea, \_\_\_ Soft Drinks, \_\_\_ Alcohol, \_\_\_ Drugs, \_\_\_ Sugar, \_\_\_ Salt, \_\_\_ Chocolate

**Family Medical History:** \_\_\_ Cancer, \_\_\_ Diabetes, \_\_\_ High Blood Pressure, \_\_\_ Heart Disease,  
 \_\_\_ Hepatitis \_\_\_ AIDS/HIV, \_\_\_ Rheumatic Fever, \_\_\_ Thyroid Disease, \_\_\_ Seizures, \_\_\_ Osteoporosis,  
 \_\_\_ MS \_\_\_ Fibromyalgia, \_\_\_ Chronic Fatigue Syndrome, \_\_\_ CP, \_\_\_ Parkinson's, \_\_\_ Asthma

**General:** *Thirsty often* Y/N? \_\_\_ *Chills or Fever* Y/N? \_\_\_, **Body Temp feels:** \_\_\_ Cool, \_\_\_ Cold, \_\_\_ Warm, \_\_\_ Hot

**Body Systems:**

*(Please check off any and all symptoms that you have currently. This is crucial for accurate diagnosis:)*

**Skin & Hair:** \_\_\_ Rashes, \_\_\_ Eczema, \_\_\_ Hives, \_\_\_ Itching, \_\_\_ Dandruff, \_\_\_ hair loss, \_\_\_ Pimples, \_\_\_ Bruises

*Comments:* \_\_\_\_\_

**Head:** \_\_\_ Headaches, location?: \_\_\_\_\_, Concussion: Date: \_\_\_\_\_ *Comments:* \_\_\_\_\_

**Eyes:** \_\_\_ Floaters, \_\_\_ Red Eyes, \_\_\_ Painful Eyes, \_\_\_ Dry Eyes, \_\_\_ Itchy Eyes, \_\_\_ Eye Strain, \_\_\_ Cataracts, \_\_\_ Blind spots,  
 \_\_\_ Color Blindness, \_\_\_ Night Blindness, \_\_\_ Blurred Vision, \_\_\_ Wear Glasses: \_\_\_ Near Sighted, \_\_\_ Far Sighted.

*Comments:* \_\_\_\_\_

**Nose:** \_\_\_ Runny Nose, \_\_\_ Sniffles, \_\_\_ Peculiar Smells, \_\_\_ Nose Bleeds, \_\_\_ Sneezing, \_\_\_ Dry Nose, \_\_\_ Sinus Infection,  
 \_\_\_ Sinusitis, \_\_\_ Frequent Sinus Infections. *Comments:* \_\_\_\_\_

**Mouth:** \_\_\_ Dry Mouth, \_\_\_ Excessive Saliva, \_\_\_ Sores on Lips, \_\_\_ Can't Taste, \_\_\_ Sores on Tongue, \_\_\_ Sores in Mouth,  
 \_\_\_ Heavy Tongue Coat, \_\_\_ Grinding Teeth, \_\_\_ Jaw Clicks, \_\_\_ Jaw Pain, \_\_\_ TMJ, \_\_\_ Bad Breath, \_\_\_ Gum Problems,  
 \_\_\_ Teeth Problems, \_\_\_ Unusual Tastes, *Comments:* \_\_\_\_\_

**Throat:** \_\_\_ Sore, \_\_\_ Scratchy \_\_\_ Difficulty Swallowing, \_\_\_ Feeling of Something stuck in Throat, \_\_\_ Dry Throat

*Comments:* \_\_\_\_\_

**Cardiovascular:** \_\_\_ High Blood Pressure, \_\_\_ Low Blood Pressure, \_\_\_ Phlebitis, \_\_\_ Varicose Veins, \_\_\_ Blood Clots,  
 \_\_\_ Cold hands, \_\_\_ Cold Feet, \_\_\_ Irregular Heart Beat, \_\_\_ Missing Heart Beats, \_\_\_ Chest Pain, \_\_\_ Shortness of Breath,  
 \_\_\_ Dizziness, \_\_\_ Swelling of Hands, \_\_\_ Swelling of Feet, \_\_\_ Fainting, \_\_\_ Numbness, \_\_\_ Tingling, \_\_\_ Palpitations

*Comments:* \_\_\_\_\_

**Respiratory:** \_\_\_ Cough, \_\_\_ Pneumonia, \_\_\_ Coughing Blood, \_\_\_ Asthma, \_\_\_ Bronchitis, \_\_\_ Difficulty Breathing When  
 Lying Down, \_\_\_ Tightness in Chest, \_\_\_ Cough Up Phlegm, What Color? \_\_\_\_\_, \_\_\_ Sneezing, *Comments:* \_\_\_\_\_

**Gastrointestinal: Appetite:** \_\_\_ Heavy, \_\_\_ light, \_\_\_ Cravings: What: \_\_\_\_\_, \_\_\_ Changes in appetite: \_\_\_ Inc.  
 \_\_\_ Decrease, \_\_\_ Nausea, \_\_\_ Gas, \_\_\_ Bloating, \_\_\_ Vomiting, \_\_\_ Abdominal pai, where: \_\_\_\_\_

Vomiting Blood, \_\_\_ Acid Regurgitation, \_\_\_ Belching, \_\_\_ Bad Breath, \_\_\_ Abdominal Cramps, \_\_\_ Abdominal Bloating, \_\_\_  
 Constipation more than one day, \_\_\_ Dry Stools, \_\_\_ Stools Hard to Expel, \_\_\_ Food In Stools, \_\_\_ Explosive Diarrhea, \_\_\_

BM Without Warning, \_\_ Foul Smelling BM, \_\_ Burning Anus After BM, \_\_ Blood In BM, \_\_ Mucus In BM, \_\_ Black Stools, \_\_ Tarry Stools, \_\_ Hemorrhoids, \_\_ Additional info and *Comments*: \_\_\_\_\_

**Kidney/Bladder/Urination/Genito-Urinary:** \_\_ Kidney Stones, \_\_ Bladder Infections, \_\_ Frequent Urination; \_\_ Painful Urination, \_\_ Blood In Urine, \_\_ Cloudy Urine, \_\_ Urgent Urination, \_\_ Difficult Urination, \_\_ Dribbling Urination, \_\_ Urinary Incontinence, \_\_ Sand in Urine, \_\_ Burning Urination, \_\_ Dark Urine, \_\_ Wake Up To Urinate; # of times per night: \_\_, \_\_ Copious Urine, \_\_ Urinate Little At A Time, \_\_ Impotence, *Comments*: \_\_\_\_\_

**Liver/GallBladder:** \_\_ Frequent Sighing, \_\_ Pain In Side below liver, \_\_ Hepatitis, \_\_ Breast Tenderness, \_\_ Cirrhosis, \_\_ Gall Stones, \_\_ Jaundice. *Comments*: \_\_\_\_\_

**Musculoskeletal:** \_\_ Neck Pain; \_\_ Back Pain, \_\_ Sciatica; \_\_ Foot pain, \_\_ Shoulder Pain, \_\_ Upper Arm Pain, \_\_ Elbow Pain, \_\_ Lower Arm Pain, \_\_ Wrist Pain, \_\_ Hand Pain, \_\_ Finger Pain, \_\_ Hip Pain, \_\_ Thigh Pain, \_\_ Knee Pain, \_\_ Lower Leg Pain, \_\_ Ankle Pain, \_\_ Pain on Top of Foot, \_\_ Pain on Bottom of Foot, \_\_ Toe Pain, \_\_ Any Other Body Pain; Describe Where & Nature of Pain: \_\_\_\_\_

*Comments*: \_\_\_\_\_

**Cognition:** \_\_ Short Term Memory Loss, \_\_ Long Term Memory Loss, \_\_ Confusion, \_\_ Forgetfulness, \_\_ Seizures, \_\_ Transient Ischemic Attacks, TIAs, \_\_ Stroke, \_\_ Disorientation, \_\_ Easily Stressed. *Comments*: \_\_\_\_\_

**Mood:** (Check any that apply to you): \_\_ Depressed, \_\_ Sad, \_\_ Happy, \_\_ Joyful, \_\_ Fearful, \_\_ Moody, \_\_ Agitated, \_\_ Grief Stricken, \_\_ Confused, \_\_ Frustrated, \_\_ Easily Angered, \_\_ Lacking, \_\_ Rage, \_\_ Resentment, \_\_ Not Good Enough, \_\_ Stressed, \_\_ Distraught, \_\_ Unfulfilled, \_\_ Fulfilled, \_\_ Hateful, \_\_ Passionate, \_\_ Overly Aggressive, \_\_ Hostile, \_\_ Loved, \_\_ Unloved, \_\_ Hurt, \_\_ Scared, \_\_ Pessimistic, \_\_ Have Considered Suicide. *Comments*: \_\_\_\_\_

**Sleep:** \_\_ Trouble Sleeping, \_\_ Hard to Fall Asleep, \_\_ Awaken Easily During the Night, \_\_ Have Difficulty Falling Back To Sleep, \_\_ Vivid Dreams, \_\_ Awaken Rested, \_\_ Awaken Tired, \_\_ Scary Dreams. *Comments*: \_\_\_\_\_

**Pregnancy:** \_\_ # Of Pregnancies, \_\_ # Of Births, \_\_ Age At 1<sup>st</sup> Menses, \_\_, \_\_ # Premature Births \_\_, \_\_ # Miscarriages \_\_, *Comments*: \_\_\_\_\_

**Gynecology:** \_\_ Excessive Bleeding During Period, \_\_ Clots In Blood, \_\_ Pain During Menstruation, \_\_ Vaginal Sores, \_\_ Vaginal Discharge, Color: \_\_\_\_\_, \_\_ Breast Lumps, \_\_ Breast Tenderness or Soreness, \_\_ Irregular Periods, \_\_ Painful Periods, \_\_ Late Period, \_\_ Early Period, \_\_ Variable Period (Comes Early or Late). \_\_ Headaches Which Start Before or At Start of Period, \_\_ Pain or Cramps Which End When Period starts, \_\_ Pain or Cramps Which End When Period Ends, \_\_ Headaches That End When Period Ends. \_\_ Other, Please Describe: \_\_\_\_\_

\_\_ Birth Control; Type, Name: \_\_\_\_\_, \_\_ Menopause, \_\_ Post Menopause, \_\_ Hot Flashes, \_\_ Night Sweats, \_\_ Feeling of Heat in Palms & Soles of Feet. \_\_ Flushing of the Face, \_\_ Irritation, \_\_ Mood Swings, \_\_ Decrease in Sexual Desire, \_\_ Loss of Sexual Desire, \_\_ Vaginal Dryness, \_\_ Pain During Intercourse, *Comments*: \_\_\_\_\_

**Have You Ever Been Treated For Any Of The Following**, (Only Check Off The Following, If They Apply): \_\_ Heart Disease, \_\_ Seizures, \_\_ Any Kind Of Cancer, \_\_ Multiple Sclerosis, \_\_ Parkinson's, \_\_ High Blood Pressure, \_\_ Depression, \_\_ Osteoporosis, \_\_ Drug Addiction, \_\_ Seasonal Affective Disorder, SAD, \_\_ Chronic Fatigue Syndrome, CFS, \_\_ Candida, \_\_ Fibromyalgia, \_\_ Sexually Transmitted Disease, \_\_ Any Neurological Disorder, Please Specify: \_\_\_\_\_, \_\_ Any Mental Disorder? Please Describe anything of significance: \_\_\_\_\_

**Statement Of Our Financial & Medical Records Privacy Policy:**

- We accept payment by cash, check, Mastercard , Visa and PayPal.
- We will not release your medical records nor divulge information about your treatment to anyone without your express consent in writing unless required by law.
- I have read, understand and accept the financial & Privacy policies of Acupuncture & Holistic Medicine Center, or Glenn Eichenauer, DOM, AP.

Patient Signature (*authorizes treatment*): \_\_\_\_\_, Date: \_\_\_\_\_