CANYON HEALTH CENTER

New Patient Intake Form

CLIENT INFORMATION

Name _____ Today's Date _____

Birthdate _____ F ❑ M ❑ HT _____ WT _____

Address _____ City, State, Zip _____

Telephone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Email _____ Preferred way to be contacted _____

Emergency Contact Name & Telephone _____

Occupation _____ Referred By _____

Have you had acupunture before? Yes ❑ No ❑ Chinese Herbal Medicine? Yes ❑ No ❑

Reason for visit today? _____

How long have you had this condition? _____

Is it getting worse? Yes ❑ No ❑ Does it bother your Sleep ❑ work ❑ Other ❑ _____

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? _____

Physician's Name & Telephone _____

Other Concurrent Therapies _____

FAMILY MEDICAL HISTORY

❑ Allergies (list) _____ _____
❑ Arteriosclerosis
❑ Asthma
❑ Alcoholism
❑ Cancer (type) _____
❑ Depression
❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure
❑ Seizures
❑ Stroke

YOUR PAST MEDICAL HISTORY

(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.)

❑ AIDs/HIV
❑ Alcoholism
❑ Allergies
❑ Appendicitis
❑ Anemia
❑ Arteriosclerosis
❑ Asthma
❑ Birth Trauma (your own birth)
❑ Cancer
❑ Chicken Pox
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Epstein-Barr
❑ Goiter
❑ Gout
❑ Heart Disease
❑ Hepatitis
❑ Herpes
❑ High Blood Pressure
❑ Measles
❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker
❑ Pleurisy
❑ Pneumonia
❑ Polio
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Seizures
❑ STDs
❑ Stroke
❑ Surgery (list) _____ _____ _____ _____
❑ Thyroid Disorders
❑ Tuberculosis
❑ Ulcers
❑ Whooping Cough
❑ Abuse Survivor
❑ Major Trauma (list) _____
❑ Other (list) _____ _____

YOUR DIET

Do you crave: Sweet ❑ Salty ❑ Sour ❑ Bitter ❑ Spicy ❑

Foods you eat: Vegetables ❑ Fruits ❑ Nuts ❑ Grains ❑ Meat ❑ Chicken ❑ Fish ❑ Dairy ❑

Appetite: Low ❑ High ❑ Coffee/Tea ❑ Soft Drinks/Juices ❑ Protein Intake: Low ❑ High ❑ Artificial Sweeteners ❑ Sugar ❑ Salty Foods ❑ Thirst for water: Yes ❑ No ❑ Glasses per Day? _____

AVERAGE DAILY MENU

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PHARMACEUTICALS

Medications taken in the last 2 months: _____

_____

Vitamins/supplements taken in the last 2 months: _____

_____

YOUR LIFESTYLE

❑ Alcohol
❑ Tobacco
❑ Marijuana
❑ Drugs
❑ Occupational Hazards

Stress level: Current (1-10) _____ General (1-10) _____

Regular exercise:
_____ Frequency _____
_____ Frequency _____

GENERAL SYMPTOMS

❑ Poor appetite
❑ Heavy appetite
❑ Strongly like cold drinks
❑ Strongly like hot drinks
❑ Recent weight loss/gain
❑ Feel hot
❑ Feel cold
❑ Poor sleep
❑ Dream-disturbed sleep
❑ Fatigue
❑ Lack of strength
❑ Bodily heaviness
❑ Cold hands or feet
❑ Shortness of breath
❑ Fever
❑ Chills
❑ Night sweats
❑ Sweat easily
❑ Muscle cramps
❑ Vertigo or dizziness
❑ Bleed or bruise easily
❑ Taste in mouth (describe)
_____
_____
_____

HEAD, EYES, EARS, NOSE, THROAT

❑ Glasses (What age?)
❑ Eye strain
❑ Eye pain
❑ Red eyes
❑ Itchy eyes
❑ Spots in eyes/floaters
❑ Poor vision
❑ Blurred vision
❑ Dry Eyes
❑ Night blindness
❑ Macular degeneration
❑ Glaucoma
❑ Cataracts
❑ Teeth problems
❑ Grinding teeth
❑ TMJ
❑ Facial pain
❑ Gum problems
❑ Sores on lips or tongue
❑ Dry mouth
❑ Excessive saliva
❑ Sinus problems
❑ Recurrent sore throat
❑ Sensation of something stuck in throat
❑ Swollen glands
❑ Enlarged thyroid
❑ Nosebleeds
❑ Ringing in ears
❑ Poor hearing
❑ Headaches
❑ Migraines
❑ Concussions
❑ Other head/neck problems
_____
_____
_____

RESPIRATORY

❑ Difficulty breathing when lying down
❑ Shortness of breath
❑ Frequent colds
❑ Frequent respiratory Infections
❑ Edema
❑ Tight chest
❑ Asthma/wheezing
❑ Difficult inhilation
❑ Diffcult exhalation
❑ Cough
Wet ____ Dry ____
Thick ____ Thin ____
❑ Color of phlegm
_____
❑ Coughing up blood
❑ Pheumonia

CARDIOVASCULAR

❑ High blood pressure
❑ Low blood pressure
❑ Blood clots
❑ Heart disease
❑ Poor circulation
❑ Fainting
❑ Chest pain
❑ Difficulty breathing
❑ Tachycardia
❑ Heart palpitations
❑ Phlebitis
❑ Irregular heartbeat

GASTROINTESTINAL

❑ Nausea
❑ Vomiting
❑ Acid regurgitation
❑ Gas
❑ Hiccup
❑ Bloating
❑ Bad breath
❑ Food allergy/intolerance
❑ Diarrhea
❑ Constipation
❑ Black stools
❑ Bloody stools
❑ Mucous in stools
❑ Hemorroid
❑ Itchy anus
❑ Intestinal pain/cramping
❑ Burning anus
❑ Rectal pain
❑ Anal fissures
❑ Laxative use
❑ IBS
❑ Colitis
❑ Chron's Disease
Bowel movements:
Frequency _____
Color _____
Texture/form _____
Odor _____

MUSCULOSKELETAL

❑ Neck/shoulder pain
❑ Muscle pain
❑ Upper back pain
❑ Lower back pain
❑ Scoliosis
❑ Joint replacement
❑ Disc problems
❑ Joint pain
❑ Rib pain
❑ Limited range of motion
❑ Limited use
❑ Other (describe):
_____
_____
_____

SKIN & HAIR

❑ Rashes
❑ Hives
❑ Ulcerations
❑ Dryness
❑ Eczema
❑ Psoriasis
❑ Acne
❑ Dandruff
❑ Itching
❑ Hair Loss
❑ Change in hair/skin
❑ Fungal infections
❑ Other (describe):
_____
_____

NEUROPSYCHOLOGICAL

❑ Seizures
❑ Numbness/tingling
❑ Tics
❑ Neuropathy
❑ Poor memory
❑ Depression
❑ Anxiety
❑ Irritability
❑ Easily stressed
❑ Abuse survivor
❑ Considered/attempted suicide
❑ Seeing a therapist
❑ Other (describe):
_____

GENITOURINARY

❑ Pain on urination
❑ Frequent urination
❑ Urgent urination
❑ Dark Urine
❑ Cloudy urine
❑ Blood in urine
❑ Unable to hold urine
❑ Incomplete urination
❑ Wake to urinate
❑ Increased libido
❑ Decreased libido
❑ Kidney stone
❑ Impotence
❑ Premature ejaculation
❑ Nocturnal emission

FEMALE

❑ Age menses began _____
Length of cycle _____
Duration of flow _____
❑ PMS
❑ Irregular periods
❑ Painful periods
❑ Clots
❑ Frequent vaginal infections
❑ Frequent yeast infections
❑ Vaginal odor
❑ Vaginal discharge
❑ Vaginal sores
❑ Low libido
❑ Infertility
❑ Trying to get pregnant
❑ Birth control Method _____
❑ Hysterectomy
❑ Breast lumps
Pregnancies # _____
Live births # _____
Premature births # _____
Age at menopause _____
Date of last PAP:
_____
Date last period began:
_____

MALE

❑ Enlarged prostate
Last prostate exam:
_____
❑ Erectile dysfunction
❑ Impotence
❑ Low libido