

Lillie Stewart

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## Patient Intake Form

Please complete this form as thoroughly as possible; all answers are confidential.

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### GENERAL INFORMATION

Name \_\_\_\_\_ Gender  M  F Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Phone:  Home \_\_\_\_\_  Work \_\_\_\_\_  Cell \_\_\_\_\_  
(please indicate preferred contact number)

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Single  Married  Partnered  Widowed  Separated/Divorced

Emergency contact \_\_\_\_\_ Relation \_\_\_\_\_

Emergency contact number: Home \_\_\_\_\_ Cell \_\_\_\_\_

Name of physician \_\_\_\_\_ Phone number \_\_\_\_\_  
(No contact will be made without your permission)

Your signature \_\_\_\_\_

**GOALS** — What health concerns would you like to address through treatment

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### LIFESTYLE HABITS

Alcohol (drinks per week) \_\_\_\_\_ Coffee/Tea (cups per day) \_\_\_\_\_ Soda (regular or diet) \_\_\_\_\_

Cigarettes (packs per day) \_\_\_\_\_ Drug use (recreational) \_\_\_\_\_

Exercise  Yes  No How often? \_\_\_\_\_

What kind of exercise? \_\_\_\_\_

**FAMILY HISTORY** — Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse/partner	children
Adopted						
Good health						
Alcohol or other drug use						
Depression or mental illness						
Allergies						
High blood pressure/heart disease/stroke						
Cancer or tumors						
Diabetes						
Seizures						
Hepatitis/other liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Blood or bleeding disorders/anemia						
Thyroid disorders						
Kidney disorders						
Deceased (age)	N/A					

**MEDICAL** If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

Year	Operation/Illness	Hospital or Treatment Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MEDICINES** Please list all medications, vitamins and/or food supplements you are currently taking:

Medications	Dosage	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins & Supplements	Dosage	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

**CONDITIONS/SYMPTOMS** — Please mark any condition you have experienced in the past or currently.

### Temperature (Kidney)

*past current*

- Cold hands
- Cold fingers
- Cold feet
- Cold toes
- Sweaty hands
- Sweaty feet
- Hot overall
- Cold overall
- Afternoon flushes
- Night sweats
- Heat in the hands, feet, and chest
- Hot flashes
- Thirsty
- Perspire easily
- Lack of perspiration
- Take water to bed

### Energy (Lung/Kidney)

*past current*

- Shortness of breath
- Difficulty keeping eyes open during day
- General weakness
- Easily catch colds
- Low energy
- Feel worse after exercise

### Blood (Liver/Spleen/Heart)

*past current*

- Dizziness
- See floating black spots

### Heart Function

*past current*

- Palpitations
- Anxiety
- Sores on the tip of the tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Pacemaker
- Frequent dreams
- Wake unrefreshed

### Lung Function

*past current*

- Nasal discharge, color: \_\_\_\_\_
- Cough
- Nose bleeds
- Sinus Congestion
- Dry mouth
- Dry throat
- Dry nose
- Dry skin
- Respiratory allergies, to what? \_\_\_\_\_
- Alternating chills & fever
- Sneezing
- Headache, location: \_\_\_\_\_
- Overall achy feeling
- Stiff neck
- Stiff shoulders
- Sore throat
- Difficulty breathing
- Sadness
- Melancholy

### Spleen Function

*past current*

- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling In stomach
- Fatigue after eating
- Prolapsed organs (diagnosed): \_\_\_\_\_
- Easily bruised
- Hemorrhoids
- Pensive
- Over-thinking
- Worry

### Spleen, Stomach, Large Intestine Function

*past current*

- Loose stool
- Constipated
- Incomplete evacuation
- Diarrhea
- Blood In stools
- Mucous In stools
- Undigested food in stools

### Dampness

*past current*

- General sensation of heaviness
- Mental heaviness
- Mental sluggishness
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

### Stomach Function

*past current*

- Burning sensation after eating
- Large appetite
- Bad breath
- Mouth (canker) sores
- Bleeding, swollen or painful gums
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccups
- Stomach pain
- Vomiting

### Eyes (Liver Function)

*past current*

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

**Liver/Gall Bladder Function**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <i>past</i>              | <i>current</i>           | <input type="checkbox"/> <input type="checkbox"/> Alternation diarrhea & constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain  |
| <input type="checkbox"/> | <input type="checkbox"/> | Tight sensation in chest  |
| <input type="checkbox"/> | <input type="checkbox"/> | Bitter taste In mouth   |
| <input type="checkbox"/> | <input type="checkbox"/> | Anger easily  |
| <input type="checkbox"/> | <input type="checkbox"/> | Frustration   |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression  |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritability  |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequently unable to adapt to stress; cause of stress: _____                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin rashes   |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache: at top of head  |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling sensation  |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness  |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle spasms   |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle twitching  |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramping   |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures  |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions   |
| <input type="checkbox"/> | <input type="checkbox"/> | Lump in throat  |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck tension  |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck: limited range-of-motion   |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression  |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder tension  |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder: limited range-of-motion   |
| <input type="checkbox"/> | <input type="checkbox"/> | High-pitched ringing in ears  |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall stones   |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease(s); spcify: _____  |

**Kidney/Urinary Bladder Function**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <i>past</i>              | <i>current</i>           | <input type="checkbox"/> <input type="checkbox"/> Frequent cavities |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily broken bones   |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore knees  |
| <input type="checkbox"/> | <input type="checkbox"/> | Weak knees  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold sensation in knees   |
| <input type="checkbox"/> | <input type="checkbox"/> | Low back pain   |
| <input type="checkbox"/> | <input type="checkbox"/> | Memory problems   |
| <input type="checkbox"/> | <input type="checkbox"/> | Wake frequently to urinate  |
| <input type="checkbox"/> | <input type="checkbox"/> | Low-pitched ringing in ears   |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones   |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder infections  |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of bladder control   |
| <input type="checkbox"/> | <input type="checkbox"/> | Fear  |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily startled   |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive hair loss   |

**Urination**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <i>past</i>              | <i>current</i>           | <input type="checkbox"/> <input type="checkbox"/> Normal color |
| <input type="checkbox"/> | <input type="checkbox"/> | Dark yellow  |
| <input type="checkbox"/> | <input type="checkbox"/> | Clear  |
| <input type="checkbox"/> | <input type="checkbox"/> | Reddish  |
| <input type="checkbox"/> | <input type="checkbox"/> | Cloudy   |
| <input type="checkbox"/> | <input type="checkbox"/> | Scanty   |
| <input type="checkbox"/> | <input type="checkbox"/> | Profuse  |
| <input type="checkbox"/> | <input type="checkbox"/> | Strong odor  |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood  |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful  |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge  |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult  |
| <input type="checkbox"/> | <input type="checkbox"/> | Urgent   |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent   |

**Male — Genital**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <i>past</i>              | <i>current</i>           | <input type="checkbox"/> <input type="checkbox"/> Impotence |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature ejaculation                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Nocturnal emission  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/itching of genitalia                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Lumps in testicles  |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased libido  |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased libido  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (describe) _____                                      |

**Women — Gynecology**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <i>past</i>              | <i>current</i>           | <input type="checkbox"/> <input type="checkbox"/> Menopause |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods   |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual cramps  |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive blood flow  |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual blood clots                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal pap smear  |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal infections  |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal pain/itching  |
| <input type="checkbox"/> | <input type="checkbox"/> | Uterine fibroids  |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis   |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast tenderness   |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast lumps, cysts   |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased libido  |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased libido  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (describe) _____                                      |

Currently pregnant: trimester \_\_\_\_\_

Past pregnancies:  
 # of live births: \_\_\_\_\_  
 # of miscarriages \_\_\_\_\_  
 # of abortions \_\_\_\_\_

**Other Information**

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_