

HARMONY

Integrative Medicine

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NEW PATIENT INTAKE FORM TODAY'S DATE: ____ / ____ / 20____

NAME: _____ **EMAIL:** _____ **DL #** _____

Address: _____ **DOB** ____ / ____ / ____ **Age:** ____ **HT:** ____ **WT:** ____

City: _____ **State:** ____ **Zip:** _____ **Home Phone:** _____ **Sex (circle):** M F

Occupation: _____ **Work Phone:** _____

Emergency Contact: _____ **Phone #:** _____ **Relationship to you:** _____

Reason for Visit: _____

How long have you had this condition? _____ **Is it worsening?** _____ **Does it bother your :** sleep work other: _____

What appeared to be the initial cause? _____

What makes it better? _____ **Worse?** _____

Primary Care Physician: _____ **Telephone # :** _____

Are you under a Physician's care at present? _____ **For what ailments?** _____

List other current Therapies: _____

Have you had Acupuncture before? _____ **Date** _____ **Herbal Medicine?** _____

Referred by: _____

FAMILY MEDICAL HISTORY Check all those that apply:

Allergies	Arteriosclerosis	Auto Immune Dz	Cancer	Diabetes	Seizures
Asthma/COPD	_____	_____	_____	Heart Dz	High Blood Pressure
Alcoholism	_____	_____	_____	Stroke	High Cholesterol

YOUR MEDICAL HISTORY Please check past and present conditions:

AIDs/HIV	Cancer	Heart Dz	Pain Pump	Thyroid Disorder	_____
Alcoholism	Chicken Pox	Hepatitis	Pleurisy	Tuberculosis	_____
Allergies	COPD	Herpes	Polio	Typhoid Fever	Major Trauma: (auto, fall, etc>)
Appendicitis	Diabetes	Hypertension	Pneumonia	Ulcers	_____
Arteriosclerosis	Emphysema	Measles	Surgeries	Venereal Disease	_____
Asthma	Epilepsy	Multiple Sclerosis	_____	Whooping Cough	_____
Auto Immune Dz	Goiter	Mumps	_____	Other (Describe)	_____
Birth Trauma	Gout	Pacemaker	_____	_____	_____

YOUR DIET APPETITE: Low Caffeine Artificial Sugar Thirst for Water: # glasses day ____
 High Soft Drinks Sweeteners Salty Foods

AVERAGE DAILY MENU

Morning	Snack	Noon	Snack	Dinner	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmaceuticals taken in the last 2 months: _____

Vitamins / Supplements taken in last 2 months: _____

YOUR LIFESTYLE

Tobacco Alcohol Marijuana Stress Regular Exercise: Type _____ frequency: _____
 Drugs Occupational Hazards Type _____ frequency: _____

GENERAL SYMPTOMS (check all that apply)

Poor Appetite	Poor Sleep	Bodily Heaviness	Chills	Bleed or Bruise easily
Heavy Appetite	Dream disturbed sleep	Cold hands or feet Night	Sweats	Peculiar Taste
Like hot drinks	Heavy Sleep	Poor circulation	Fever	_____
Like cold drinks	Shortness of Breath	Recent weight loss/gain	Sweat easily	
Fatigue	Lack of strength	Vertigo dizziness	Muscle Cramps	

HEAD, EYES, EARS, NOSE, THROAT

Glasses	Night Blindness	Sores on lips/tongue	Recurrent sore throat	Migraines
Eye strain	Glaucoma	Dry Mouth	Swollen Glands	Concussions
Eye pain	Cataracts	Excessive Saliva	Lumps in Throat	Other head or neck problem:_____
Red Eyes	Teeth problems	Sinus problems	Enlarged Thyroid	_____
I tchy Eyes	Grinding teeth	Excessive Phlegm	Nose Bleeds	_____
Spots in eyes	TMJ	Color of Phlegm _____	Ringing in ears	_____
Poor vision	Facial pain	_____	Poor hearing	_____
Blurred Vision	Gum Problems	Earaches	Headaches	_____

RESPIRATORY

Difficulty breathing when lying down	Tight Chest	Pneumonia	Thick or thin
Shortness of breath	Asthma/Wheezing	Cough	Color of Phlegm _____
	Coughing Blood	Wet / Dry	

CARDIOVASCULAR

High Blood Pressure	Blood Clots	Chest Pain	Irregular Heartbeat	Tachycardia
Low Blood Pressure	Fainting	Difficulty Breathing	Heart Palpitations	Phlebitis

GASTROINTESTINAL

Nausea	Diarrhea	Hemorrhoids	Bowel Movements:
Vomiting	Constipation	Anal Fissures	Frequency_____Texture/ Form _____
Acid Regurgitation	Laxative Use	I tchy Anus	Color _____Odor _____
Gas	Bloody Stools	Burning Anus	
Hiccup	Black Stools	I ntestinal Pain Cramping	Bad Breath
Bloating	Mucous in stools	Rectal Pain	

MUSCULOSKELETAL

Neck / Shoulder Pain	Upper Back Pain	Joint Pain	Limited Range of Motion	Other _____
Muscle Pain	Low Back Pain	Rib Pain	Limited Use of _____	

SKIN and HAIR

Rashes	Eczema	Dandruff	Hair Loss	Ulcerations	Change in Hair/skin texture
Hives	Psoriasis	I tching	Acne	Fungal I nfections	Other Problems _____

NEUROPSYCHOLOGICAL

Seizures	Tics	Poor Memory	I rritability	Considered / attempted suicide	Abuse Survivor
Anxiety	Numbness	Depression	Easily Stressed	Seeing a therapist	Other _____

GENITO-URINARY

Pain on urination	Blood in urine	Venereal Disease	I ncreased libido	I mpotence
Frequent urination	Unable to hold urine	Bedwetting	Decreased libido	Premature ejaculation
Urgent urination	I ncomplete urination	Wake to urinate	Kidney Stone(s)	Nocturnal emission

GYNECOLOGY

Age menses began _____	Duration of flow _____	Vaginal Discharge	Breast lumps	Date of last PAP _____
Length of cycle (day 1 to day 1) _____		I rregular periods	Vaginal odor	Date last period began _____
Clots /Cysts	# Pregnancies_____	Painful periods	Vaginal sores	_____
		# Live Births_____	#Premature births_____	Age at menopause_____

OTHER: _____
