Integrative Hospital Associates

New Patient Intake Form

Name _____ Date_____

Birthday____/_____/____ Age_____ Male / Female (please circle) Ht/Wt_____/_____

Address_____ City, Zip_____

Home Phone_____ Work Phone_____

Occupation_____

Emergency Contact_____ Phone Number_____

Referred by_____

Are you under the care of a Physician? ☐Yes ☐No Physician's Name _____

Please list any allergies you may have: _____

Reason for visit today/chief complaint: _____

How long have you had this condition? _____

What makes it better? _____

What makes it worse? _____

Have you had acupuncture, chiropractic, complementary medicine before? ☐Yes ☐No

Other, prior treatments have you tried for this condition (including medication):

_____

_____

Please list all medications you are currently taking (including supplements):

Name of Medication	Dosage	Reason

Are you currently experiencing any of the following?

☐ Unexpected weight loss, fever, and/or chills?
If so, please explain: _____

☐ Recent changes in vision, tearing, or eye irritation?
If so, please explain: _____

☐ Recent changes in hearing or ear pain?
If so, please explain: _____

☐ Nasal drainage and/or congestion?
If so, please explain: _____

☐ Dental pain or carries?
If so, please explain: _____

☐ Sore throat, hoarseness, trouble swallowing, and/or postnasal drainage?
If so, please explain: _____

☐ Chest pain, heaviness, jaw or arm pain, edema (swelling), and/or palpitations?
If so, please explain: _____

☐ Shortness of breath and/or cough?
If so, please explain: _____

☐ Constipation, diarrhea, blood in the stool, and/or tarry stools?
If so, please explain: _____

☐ Pain/difficulty urinating, frequency, blood in the urine, and/or trouble holding in urine?
If so, please explain: _____

☐ Joint pain, limited movement, decreased range or motion?
If so, please explain: _____

☐ Recent rash or itchiness?
If so, please explain: _____

☐ Recent headaches or dizziness?
If so, please explain: _____

☐ Abnormal bleeding and/or bruising?
If so, please explain: _____

☐ Changes in mental health?
If so, please explain: _____

Family Medical History: (please check those that apply)

☐Allergies	☐Arthritis	☐Asthma	☐Alcoholism	☐Cancer_____
☐Diabetes	☐Drug Abuse	☐Epilepsy	☐High Blood Pressure	
☐Heart Disease	☐Kidney Disease	☐Stroke		

Surgical History:

_____

_____

Lifestyle:

☐Alcohol	☐Yes ☐No	If yes, how often? _____
☐Tobacco	☐Yes ☐No	If yes, how often? _____
☐Drugs	☐Yes ☐No	If yes, how often? _____
☐Caffeine	☐Yes ☐No	If yes, how often? _____
☐Exercise	☐Yes ☐No	If yes, how often? _____
☐Dieting	☐Yes ☐No	If yes, how often? _____

Your Past Medical History: (please check any of the conditions you currently have or have had in the past)

☐AIDS/HIV	☐Alcoholism	☐Allergies	☐Anemia	☐Appendicitis
☐Asthma	☐Cancer	☐Chicken Pox	☐Diabetes	☐Emphysema
☐Epilepsy	☐Goiter	☐Gout	☐Heart Disease	☐Hepatitis
☐High Blood Pressure	☐ Herpes	☐Measles	☐Multiple Sclerosis	☐Mumps
☐Nephritis	☐Pacemaker	☐Pneumonia	☐Rheumatic Fever	☐Scarlet Fever
☐Stroke	☐Thyroid Dysfunction	☐Tuberculosis	☐Ulcers	☐GI Disorders
☐Surgery				
☐Other: _____				

General Symptoms:

☐Poor appetite	☐Poor sleep	☐Chills	☐Bodily heaviness	☐Bleed or bruise easily
☐Heavy appetite (describe)	☐Heavy sleep	☐Night sweats	☐Cold hands/feet	☐Peculiar taste
☐Poor circulation	☐Fatigue	☐Lack of strength	☐Dream disturbed sleep	
_____				
☐Shortness of breath	☐Weight loss/gain	☐Fever	☐Muscle cramps	☐Vertigo or dizziness

Head, Eyes, Ears, Nose, Throat:

☐Glasses	☐Eye strain	☐Red eyes	☐Itchy eyes	☐Poor vision
☐Night blindness	☐Glaucoma	☐Blurred vision	☐Cataracts	☐Light sensitivity
☐Teeth problems	☐Grinding teeth	☐TMJ	☐Facial pain	☐Gum problems
☐Dry mouth	☐Excessive saliva	☐Sinus problems	☐Excessive phlegm	☐Recurring sore throat
☐Lumps in throat	☐Enlarged thyroid	☐Nose bleeds	☐Ringing in ears	☐Poor hearing
☐Headaches	☐Migraines	☐Memory loss	☐Fainting	☐Earaches

- ☐Sinus
- ☐Entire head
- ☐Back of head
- ☐Forehead
- ☐Temples
- ☐Migraine

Respiratory:

☐Tight chest ☐Cough ☐Coughing blood ☐Shortness of breath ☐Difficulty breathing
☐Asthma/wheezing ☐Pneumonia when lying down

Cardiovascular:

☐High blood pressure ☐Low blood pressure ☐Heart palpitations ☐Irregular heartbeat ☐Blood clots
☐Chest pain ☐Pain around ribs ☐Recent stroke ☐Recent Heart Attack

Gastrointestinal:

☐Nausea ☐Vomiting ☐Acid reflux ☐Gas ☐Hiccups
☐Bloating ☐Bad breath ☐Diarrhea ☐Constipation ☐Laxative use
☐Black stool ☐Bloody stool ☐Mucus in stool ☐Itchy anus ☐Intestinal pain/cramps
☐Hemorrhoids ☐Bowel movements: Frequency_____ Color_____ Consistency_____

Musculoskeletal:

☐Neck/shoulder pain ☐Low back pain ☐Upper back pain ☐Muscle pain ☐Rib pain
☐Joint pain ☐Arthritis ☐Limited use ☐Limited Range of motion
☐Other- describe

Skin and Hair:

☐Rashes ☐Eczema ☐Dandruff ☐Changes in hair/skin ☐Psoriasis
☐Hives ☐Ulcerations ☐Itching ☐Hair loss ☐Fungal infection

Neuropsychological:

☐Seizures ☐Numbness ☐Tics ☐Poor memory ☐Depression
☐Anxiety ☐Irritability ☐Easily stressed ☐Abuse survivor ☐Suicide attempts
☐Seeking a therapist ☐Other_____

Genito-Urinary:

☐Painful urination ☐Blood in urine ☐Venereal disease ☐Increased libido ☐Decreased libido
☐Frequent urination ☐Unable to hold urine ☐Bedwetting ☐Impotence ☐Premature ejaculation
☐Urgent urination ☐Incomplete urination ☐Wake to urinate ☐Kidney stone ☐Prostate enlargement

Gynecology:

☐Age menses began _____ ☐Duration of flow _____ ☐Vaginal Sores ☐Irregular periods ☐Vaginal ulcers ☐Cramping ☐Breast lumps ☐PMS
☐Hysterectomy ☐Menopause ☐Tumors ☐Pregnancy_____ ☐Infertility
☐Are you or do you think you are pregnant