New Patient Health History Intake Form

Chief Complaint:

Please indicate the severity of this problem at its worst (with 10 being worst)

□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Please indicate the severity of this problem at its best (with 0 being no problem)

□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

When did this problem start

How often do you experience it? Is it constant? Does it come and go? How long are the episodes when you experience it?

What makes it better?

What makes it worse?

Please list a second most important complaint (if you have any)

Please indicate the severity of this problem at its worst

□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Please indicate the severity of this problem at its best

□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Please check the applicable boxes. You can give details or add any additional information in the notes box after each section.

Medical History - Please Mark The Check Box If You Previously Suffered From These Conditions.

□ Asthma	□ Kidney Stones	□ Diabetes Type 2
□ Colitis	□ Tuberculosis	□ Eating Disorder
□ Epilepsy/Seizures	□ Anemia	□ Goiter
□ Fibromyalgia	□ Diabetes Type 1	□ Hepatitis B
□ Gout	□ Heart Disease	□ High Cholesterol
□ Hepatitis C	□ Hypertension	□ High Blood Pressure
□ HIV	□ Herpes Simplex	□ Low Blood Pressure
□ Hyper Thyroid	□ PTSD	□ Paralysis
□ Mental Illness	□ STD's	□ Physical Abuse
□ Pacemaker	□ Ulcers	□ Reynaud's Disease
□ Polio	□ Appendicitis	□ Stroke

Details for any boxes checked above or other non listed problem:

Important Information: Please check the appropriate boxes.

- ☐ I have a bleeding disorder.
- ☐ I am currently taking blood thinning medication.
- ☐ I have an electrical implant such as pacemaker, insulin pump or stimulator
- ☐ I am currently undergoing treatment for cancer
- ☐ I am currently undergoing treatment for hepatitis
- ☐ I am pregnant, may be pregnant or planning to be pregnant.
- ☐ I have epilepsy
- ☐ I have a history of cancer
- ☐ Surgical history/hospitalizations
- ☐ I have needling restrictions on areas of my body (note below)
- ☐ Other
- ☐ None of these apply

Please give details for any boxes checked above.

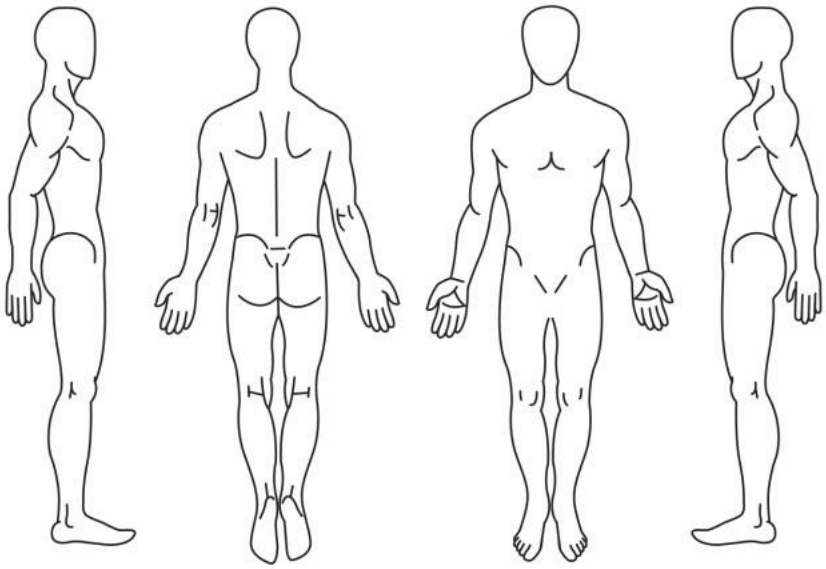
Current Medications and Supplements

Significant Family Health History

Musculoskeletal and pain

- ☐ Joint pain - multiple sites
- ☐ Knee pain
- ☐ Neck pain
- ☐ Back pain
- ☐ Hand pain
- ☐ Foot Pain
- ☐ Wrist pain
- ☐ Carpal tunnel syndrome
- ☐ Elbow pain
- ☐ Hip pain
- ☐ Arthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Visceral Pain

Please indicate areas of pain on figures below



Head

- ☐ Migraines
- ☐ Headaches
- ☐ Concussions
- ☐ Dizziness
- ☐ Jaw clenching/grinds teeth
- ☐ Vertigo

☐ Facial Pain ☐ TMJ Pain ☐ No problems

Details for any boxes checked above or other non listed problem

Skin/hair

☐ Dry skin ☐ Rash ☐ Wounds slow to heal

☐ Hair loss ☐ Eczema

☐ Psoriasis ☐ Acne

Details for any boxes checked above or other non listed problem

Eyes, Ears, Nose, Throat

☐ Chronic sinus congestion ☐ Watery eyes ☐ Cataracts

☐ Chronic cough ☐ Itchy eyes ☐ Macular degeneration

☐ Gum or teeth problems ☐ Red eyes ☐ Ear pain

☐ Thirst excessive, dry mouth or lack of ☐ Dry eyes ☐ Ringing in ears - high pitched

☐ Sinus pain ☐ Sore Throat ☐ Ringing in ears - low pitched

☐ Allergies ☐ Feeling that something is stuck in throat

Details for any boxes checked above or other non listed problem

Respiratory/Immunologic

☐ Asthma ☐ Emphysema ☐ Frequent low grade fever

☐ Cough ☐ TB ☐ Immunologic disorder

☐ Chest Congestion ☐ Fungal infection

☐ COPD ☐ Frequent colds

Details for any boxes checked above or other non listed problem

Cardiovascular/Hematological

☐ Pacemaker ☐ Palpitations ☐ Anemia

☐ High Blood Pressure ☐ High cholesterol ☐ Sickle Cell Disease

☐ Low Blood Pressure ☐ Ankle swelling ☐ History of DVT

☐ Irregular Heartbeat ☐ Chest pains ☐ Varicosities

Details for any boxes checked above or other non listed problem

Neurological

☐ Seizures ☐ Fainting ☐ Poor memory

☐ Tremors
☐ Parkinson's Disease
☐ Loss of balance
☐ Twitches
☐ Areas of numbness (list below)
☐ Lack of coordination
☐ Neuropathy

Details for any boxes checked above or other non listed problem

GI

☐ Bloating
☐ Acid reflux
☐ Hepatitis
☐ Ulcers
☐ Foul smelling gas
☐ Gall bladder problems
☐ Pain/cramping
☐ Nausea
☐ Difficulty digesting fats
☐ Constant pain
☐ Vomiting
☐ Gas
☐ Fatty Liver

Details for any boxes checked above or other non listed problem

Bowel Movements

☐ Well formed, daily
☐ Loose
☐ 2-3 movements per day
☐ Diarrhea
☐ Hemorrhoids
☐ 3-4 movements per day
☐ Constipation
☐ 1-2 movements per day
☐ more than 4 movements per day

Details for any boxes checked above or other non listed problem

Gynecological

☐ N/A
☐ Spotting between menses
☐ History of failed IVF
☐ PMS symptoms (list below)
☐ Light/scanty menses
☐ C-section
☐ PMDD symptoms (list below)
☐ Heavy menses
☐ Full term delivery
☐ Cycle less than 25 days
☐ Hysterectomy - total
☐ Pain with intercourse
☐ Cycle more than 32 days
☐ Hysterectomy - partial (please give details below)
☐ Abortions
☐ Irregular cycle
☐ Oophorectomy
☐ Miscarriages
☐ Amenorrhea
☐ Inability to conceive
☐ Menopause
☐ Dysmenorrhea-painful periods
☐ Frequent miscarriages
☐ Hormone Therapy
☐ Spotting before menses
☐ Currently working with RE specialist ☐ Birth Control
☐ Spotting after menses
☐ History of failed IUI

Details for any boxes checked or other non listed problem

Endocrine

☐ Thyroid disease Hypo ☐ Thyroid disease Hyper ☐ Diabetes ☐ Pre-diabetes ☐ PCOS

Details for any boxes checked above or other non listed problem

Urological

☐ Urgency to urinate
☐ Frequent Urination
☐ Urinary incontinence
☐ Painful urination
☐ Blood in urine
☐ Kidney stones
☐ Kidney disease
☐ Enlarged Prostate
☐ Erectile dysfunction
☐ Hormonal therapy (men)

Details for any boxes checked above or other non listed problem

Sleep

☐ No Problems
☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Difficulty falling and staying asleep
☐ Wakes early
☐ Pain interfering with sleep
☐ Night sweating
☐ Snoring
☐ Wakes frequently because of partner/baby/animals or other outside influence
☐ Works night shift
☐ Disturbing dreams
☐ Waking to urinate more than once per night

Details for any boxes checked above or other non listed problem

Psychological, Mood and Energy

☐ Brain fog
☐ Fatigue
☐ Always tired in the afternoon
☐ Always tired when waking
☐ Low energy
☐ Fears/Phobias
☐ Bad temper
☐ Irritability
☐ Worry
☐ Crying
☐ Anxiety
☐ Depression
☐ In therapy
☐ Mood swings
☐ Lethargy
☐ ADHD
☐ Bipolar disorder

Details for any boxes checked above or other non listed problem

Diet/Lifestyle

☐ Vegetarian diet
☐ Vegan diet
☐ Pescatarian diet
☐ Gluten Free
☐ Paleo
☐ Food Allergies/sensitivities
☐ Alcohol use
☐ Smoking
☐ Recreational drug use

Any other questions or concerns not covered above