**Christina Pabers PhD, MA TCM, L.Ac – Patient Intake Form**

## Patient Information

Dx:_________________ (Office Use Only)

Date: ______________________ Patient Name: _______________________________________________________

Street: _______________________________ City:__________________________ State:_______ Zip:____________

Phone Home: _____________________ Cell: _________________________ Email: ____________________________

Emergency Contact Name:___________________________ Phone:_________________________________________

Date of Birth: ______________ Age: ______ Height: _____ Blood Type: ____________ Occupation: _________________

General Practitioner: _______________ Gynecologist: _______________________ Specialist: _____________________

Current Weight: _________ Weight 5 Years Ago:_________ Weight in High School: ________

Please State Primary Health Complaints:______________________________________________________________________

_____________________________________________________________________________________________

Secondary Health Complaints: __________________________________________________________________________

_____________________________________________________________________________________________

Other Health Complaints: ______________________________________________________________________________

_____________________________________________________________________________________________

Occupational Stress Factors: ___________________________________________________________________________

Currently Smoking/Day: _______________ Smoking History/Day: ________________ Cups Coffee/Week: _________________

Alcohol/Week:_______ What do you drink? _________ Foods High in Sugar: _________________________________________

Primary Exercises and How Often: _______________________________________________________________________

Any Known Food Allergies: _____________________________________________________________________________

Tested Positive HIV, Tuberculosis, Hepatitis or Cancer/When: _____________________________________________________

How was it treated? _________________________________________________________________________________

Approximate number of times taken antibiotics in 3 years: _______________________________________________________

_____________________________________________________________________________________________

## GOALS OF CARE

To help us better serve you, indicate your health goals:

- ☐ Reduce Pain
- ☐ Increase Flexibility and Mobility
- ☐ Increase Activity Level
- ☐ Improve Diet
- ☐ Lose/Gain Weight
- ☐ Stress Reduction
- ☐ Improve Sense of Well Being
- ☐ Lifestyle Improvement
- ☐ Improve General Health
- ☐ Increase Mental Function
- ☐ Achieve Emotional Balance
- ☐ Address Addiction

Additional Comments: ________________________________________________________________________________

________________________________________________________________________________________________

## PAST MEDICAL HISTORY

Please check if you have experienced or been diagnosed with any of the following:

- ☐ Diabetes
- ☐ Asthma
- ☐ Fainting
- ☐ Stroke/Heart Disease
- ☐ Cancer (What type and how was it treated?) ____________________________________________________
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Alcoholism
- ☐ Drug Abuse
- ☐ Autoimmune Disease
- ☐ Thyroid Disease
- ☐ Bleeding Illnesses
- ☐ Birth Trauma
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Bottle Fed
- ☐ Poisoning

Additional Comments: ________________________________________________________________________________

## FAMILY MEDICAL HISTORY

Please check if anyone in the family has been diagnosed with any of the following:

- ☐ Allergies
- ☐ Diabetes
- ☐ Asthma
- ☐ Stroke/Heart Disease
- ☐ Cancer (Who/What type?) ______________________________________________________________________
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Alcoholism
- ☐ Drug Abuse
- ☐ Autoimmune Disease
- ☐ Thyroid Disease
- ☐ Bleeding Illnesses
- ☐

Additional Comments: ________________________________________________________________________________

## Current Medication List

**Name of Patient**

**Please list all pharmaceuticals, vitamins and supplements you are taking. Check the appropriate box to indicate who prescribed them.**

| Year Started | Year Stopped | Name of Medication | For What Condition | Doctor Prescribed |
|---|---|---|---|---|
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**ILLNESS INJURIES SURGERIES** List major illness, injuries and all surgeries in your life. Include major dental work.

Incidence Approximate Age

**DIET**

Are you currently gluten free? If so why? ___________________________________________

Do you currently adhere to a vegan, raw, vegetarian, or any other special program in your diet? If so why? ________________________________________________________________

Do you eat a primarily organic and non GMO diet? ____________________________________

List 3 examples of each: Breakfast, Lunch, Dinner, Snacks and Beverages.

## CURRENT GENERAL HEALTH INDICATORS

□ Poor Appetite □ Heavy Appetite □ Changes in Appetite

□ Disturbed Sleep □ Heavy Sleep □ Insomnia

□ Fatigue □ Localized Weakness □ Profuse Sweating

□ Poor Coordination □ Strong Thirst □ Cravings

□ Weight Gain (how much? _________) □ Weight Loss (how much?________)

□ Cold hands □ Cold feet □ Cold Body

□ Night Sweats □ Fevers □ Chills

□ Poor Balance □ Sensitive to Tastes/Smells □ Tremors

□ Bleeding/Bruising Easily □ Ringing in Ears

## HEAD, EYES, EARS, NOSE, THROAT

□ Dizziness □ Concussions □ Migraines □ Spots in front of eyes □ Night Blind □ Eye Strain

□ Cataracts □ Blurry Vision □ Ringing Ears □ Poor hearing □ Earaches □ Mucus □ Facial pain

□ Dry throat/mouth □ Sinus Congestion □ Sinus itching □ Recurrent sore/itchy throats

□ Sores on lips or tongue □ # of cavities _____ □ # of root canals ________

□ Are any of them silver/mercury amalgams? ___________ □ Gum disease □ TMJ

□ Nose bleeds □ Grinding Teeth

## CARDIOVASCULAR/RESPIRATORY

□ Low blood pressure □ Chest pain □ Irregular heart beat □ High blood pressure □ Fainting

□ Cough □ Cold hands & feet □ Swelling limbs □ Blood clots □ Difficulty breathing

□ Phlebitis □ Allergies □ Asthma □ Pneumonia past or present □ Anxiety Attacks

## GASTROINTESTINAL

□ How often do you have a bowel movement? ________________________________________

□ Nausea □ Vomiting □ Diarrhea □ Flatulence □ Belching □ Black Stools □ Bad Breath

□ Rectal Pain □ Hemorrhoids □ Abdominal pain or cramps □ Dependence on laxatives

## URINARY (MEN AND WOMEN)

□ Pain w/urination □ Frequent urination □ Blood in urine □ Urgent urination

□ Dark urine □ Difficult urination □ Kidney stones □ Decrease in flow

□ Waking at night to urinate □ Frequent bladder infections

## REPRODUCTIVE/GYNECOLOGIC (WOMEN ONLY)

□ Breast pain □ Breast swelling □ Breast injury □ Breast infections □ Breast cysts

□ Suspicious lumps □ Breast cancer □ Abnormally strong underarm odor □ Yeast infections

□ Number of pregnancies ______ □ Number of abortions/miscarriage _______

□ Night sweats □ Did you breast feed? _____

□ Different breast size from right and left □ Hot flashes

□ Age of menarche _____ □ Age of menopause _____________ □ Facial Hair

□ Infertility □ Hormone Replacement □ Menstrual pain

□ Emotional prior to menses □ Menstrual clots □ Heavy bleeding

□ Strong menstrual odor □ Vaginal discharge □ Birth control pill, patch, shots □ IUD

□ Tubal ligation □ Uterine Fibroids □ Hysterectomy □ Endometriosis □ Polycystic Ovaries

□ Uterine Prolapse □ Low libido □ Headaches prior to or during menstruation

□ Vaginal dryness or pain □ Painful intercourse □ Low Libido

□ Venereal Disease □ Other_______________________________________________

## REPRODUCTIVE (MEN ONLY)

□ Sexual Dysfunction □ Prostate Pathology □ Venereal Disease □ Hormone Imbalance

□ Infertility □ Genital Pain □ Enlarged Breasts not from muscular development

□ Painful Breasts □ Low Testosterone Levels □ Low libido □ Low Back Pain

## PAIN

□ Joint Pain □ Diagnosis of Arthritis What Kind? ______________________________

□ Muscle Pain – If so where? ______________________________ □ Abdominal Pain

□ Nerve Pain – If so where? _______________________________ □ Headaches

□ Do you rely on medications to be functional? _________ □ Does pain affect sleep? _____

□ Do you have an autoimmune diagnosis? _____________________________________

□ Have you ever had an autoimmune diagnosis? _________________________________

□ Does massage or exercise help your pain? Describe. _____________________________

______________________________________________________________________

□ How does sleep and rest affect your pain? ____________________________________