**Private Appointment New Patient Intake Form**

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| **Personal Health History** |
| Reason for visit |
| Other symptoms/complaints |
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| Goals of visit |
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| Have you seen an acupuncturist/naturopathic doctor before? No Yes, Acupuncturist Yes, Naturopathic Doctor |
| List any medical problems that other doctors have diagnosed (include approximate date of diagnosis) |
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| List all medications and supplements taken regularly |
| Name of Drug/Supplement | Dose (strength and frequency) | Prescribed by |
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| **Allergies to medications or other** |
| **Allergen** | **Reaction** |
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| **Personal and Family Health History** |
| **Condition** | **Self** | **Mother** | **Father** | **Sibling** | **Maternal Grandparent** | **Paternal Grandparent** | **Other** |
| Alcoholism |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |
| Autoimmune |  |  |  |  |  |  |  |
| Cancer (specify) |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |
| Eczema |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |
| Hypertension |  |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |  |
| Migraine |  |  |  |  |  |  |  |
| Multiple Sclerosis |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |
| Seizures |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| Thyroid |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |
| **Previous Hospitalizations, Surgeries or Trauma** | **Date** |
|  |  |
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| **General Wellbeing** |
| Sleep Quality | Average number of hours of sleep: |
| Do you wake feeling rested? yes no |
| Do you have trouble falling asleep? yes no |
| Do you wake during the night? yes no |
|  If yes, what time do you typically wake? And do you have trouble falling back asleep? yes no |
| Rate your current energy on a scale of 1-10 (10= highest energy) |
| Rate your current stress level on a scale of 1-10 (10=highest stress) |
| Do you have a spiritual practice? If so, what? |
| **Exercise** | In a typical week, how many times do you do the following kinds of exercise for over 15 min? |
| Sedentary (No exercise) |
| \_\_\_\_\_Times per week Mild exercise (climb stairs, walk, yoga, golf) |
| \_\_\_\_\_Times per week Moderate exercise (fast walking, tennis, garden, dance) |
| \_\_\_\_\_Times per week Vigorous exercise (run, hockey, ski, soccer, long distance bicycling) |
| **Diet** | Do you follow a specific diet? yes no | If yes, what? |
| Do you avoid any foods? yes no | If yes, what? |
| How many cups of the following do you drink per day? ­­­­­­­\_\_\_water \_\_\_coffee \_\_\_green/black tea |
| \_\_\_herbal tea \_\_\_soda \_\_\_juice  |
| Per week? \_\_\_energy drink \_\_\_wine \_\_\_beer \_\_\_liquor |
| Do you use tobacco? yes no If yes, amount per day ­­­\_\_\_ # of years \_\_\_ or year quit \_\_\_ |
| Do you currently use recreational or street drugs? yes no If yes, what? |
| List the typical foods you eat for: |
| Breakfast |
| Lunch |
| Dinner |
| Snacks |
| Are you interested in dietary recommendations? yes noHow easy is it to implement dietary changes on a scale of 1-10? (10=most difficult)­­ \_\_\_\_\_\_\_\_\_\_What is the biggest obstacle for making dietary changes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have social support for implementing lifestyle changes? yes no |
| **Review of Systems** |
| Please check the box if you have been experiencing the following in the past 6 months or give dates for problems with the following in the past. |
| Fatigue | Shortness of breath at night | Urinary difficulty |
| Chills | Shortness of breath with exercise | Urinary incontinence |
| Fever | Leg swelling | Frequent urination |
| Sweating/night sweats | Elevated blood pressure | Bruise easily |
| Unintentional weight gain/loss | Low blood pressure | Anemia |
| Anxiety | Irregular heartbeat | Chronic pain |
| Depression | Varicose Veins | Muscular pain |
| Insomnia | Fainting | Joint pain |
| Memory Loss | Poor appetite | Arthritic pain |
| Mood changes | Excessive appetite | Hay fever |
| Blurred vision | Excessive thirst | Eczema |
| Vision loss | Difficulty swallowing | Hives |
| Pain/soreness around the eyes | Bleeding gums | Itchy skin |
| Nosebleeds | Abdominal pain | Psoriasis flare up |
| Hoarseness | Blood in the stool | Rash |
| Cough | Constipation | Cold/heat intolerance |
| Hearing loss | Diarrhea | Dry skin |
| Ringing in the ear | Heartburn/Indigestion | Difficulty concentrating |
| Sinus congestion/pain | Hemorrhoids | Dizziness |
| Sore throat | Nausea/Vomiting | Headache |
| Asthma | Gas/Bloating | Numbness |
| Wheezing | Rectal Bleeding | Seizures |
| Chest pain | Jaundice | Tingling  |
| Shortness of breath at rest | Painful urination | Tremors |
| **Please indicate painful or distressed areas:Pain Indicator Heads.tiff****Additional Remarks:** | Pain Indicator Guy.tiff |
| **Chemical Exposure**—Please indicate exposure to any of the following: |
| Arsenic | Herbicides/Pesticides | Lead | Mercury |
| Mold | Polychlorinated biphenyls | Phenols | Other |
| **Women Only** |
| Age of first menses | First day of last menses: / / | Number of days of bleeding |
| How many days pass between the first day of each menses? |
| Do you experience heavy periods, irregular menses, spotting, pain, or discharge? yes no (please circle to specify) |
| Do you experience pain, bloating, irritability, acne, or other symptoms around the time of your period? yes no |
| Are you pregnant or breastfeeding? yes no | Any hot flashes or night sweats? yes no |

I certify that the information provided in this form is correct to the best of my knowledge. I will not hold Dr. Wong responsible for any error or omission I may have made in the completion of this form.

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Patient/Guardian signature Date