**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 no  How 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