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New Client Intake Form

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully.
This form may take 15-20 to complete.

Full name:			Today's Date:	
Date of birth:	Age:	Birth Sex: ☐ F ☐ M	Has it changed? ☐ Yes ☐ No	
Height:	Weight:	Occupation:		
Primary phone #:		E-mail address:		
Street Address:		City:	State:	Zip:
Emergency contact name & phone #:				
Primary healthcare provider:				
Do you have health insurance? ☐ Yes ☐ No		Name of insurance company:		
Note: While I do not currently accept insurance, I am gathering information to determine which insurance I may take in the future.				
Have you had acupuncture before? ☐ Yes ☐ No		If yes, please explain your experience:		
How did you find out about *Jiv Daya Whole Health?* ☐ Friend ☐ Referred by_____ ☐ Location or drive/walk-by ☐ Yelp ☐ Website ☐ Facebook ☐ Other (please specify) _____				

Main complaint/concerns(s): _____

_____

What diagnosis, if any, have you received? by whom? _____

How long has this been going on?_____Do you know the root cause(s)? please explain:

_____

_____

Are you undergoing treatment(s)? what type(s)? _____

What makes this problem worse?_____What makes this problem better?_____

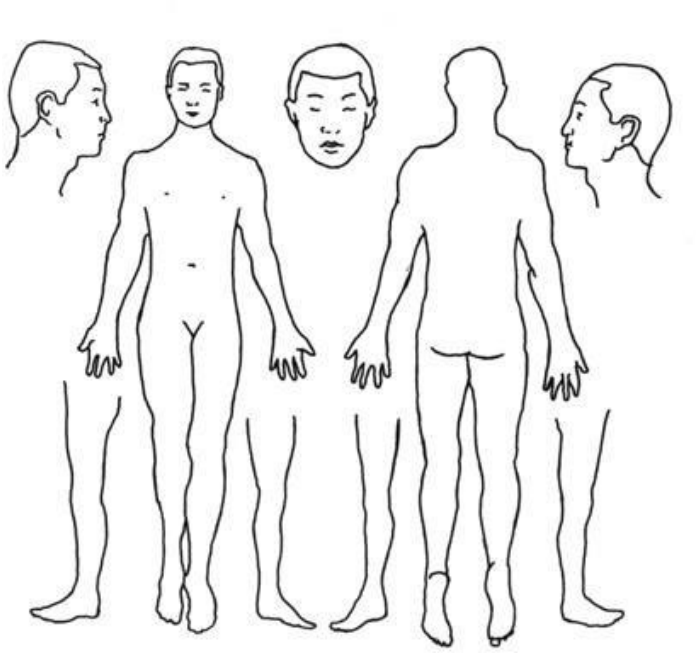
To what extent does this problem interfere with your daily activities (sleep, work, relationships, exercise, mood)?

_____

What do you hope to achieve from our visits together? What are your health goals?_____

_____

Indicate painful or distressed areas (please circle):



On a scale of 0 to 10, what is your level of discomfort today? please circle:

(0 is no discomfort, 10 is the most discomfort)

0 1 2 3 4 5 6 7 8 9 10

Please describe the quality of the discomfort:

- ☐ Sharp pain
- ☐ Dull pain
- ☐ Intermittent pain (goes away and comes back)
- ☐ Shooting pain (moves/travels to other areas)
- ☐ Numbness
- ☐ Tingling
- ☐ Other (please describe): _____

Medical History:

Diagnosis	Self	Family	Diagnosis	Self	Family		Self	Family
Cancer			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Venereal disease			High blood pressure		
Thyroid disease			Digestive disorders			Low blood pressure		
Seizures			Alcoholism			Fainting		
Arthritis			Depression or anxiety			Anemia		
Other (please explain):								

Previous Surgeries: _____

Previous Hospitalizations: _____

Significant traumas (physical or emotional): _____

Allergies: (drugs, chemicals, foods, environmental):_____

Please list all current medication and supplements: (prescription drugs, over-the-counter drugs, vitamins, herbs, etc.)

_____

_____

_____

Habits:

Do you smoke? ☐ Yes ☐ No What do you smoke?_____How much per day?_____For how long?_____

Do you use recreational drugs? ☐ Yes ☐ No If yes, please list: _____

Do you drink alcohol? ☐ Yes ☐ No What kind of alcoholic beverages?_____# of drinks/week? ____

Do you drink coffee? ☐ Yes ☐ No ☐ Decaf How many cups of coffee per day? _____

Do you drink sodas? ☐ Yes ☐ No What type of soda?_____How many sodas do you drink per day? _____

Water Intake:

How much water do you drink per day? Do you prefer: ☐ ice water ☐ cold water/no ice ☐ room temp water

What other beverages do you drink regularly? _____

Exercise:

Do you exercise regularly? ☐ Yes ☐ No How many days per week? _____ What type of exercise?

_____

Sleep:

Average hours of sleep per night: ____What time do you go to bed?_____What time do you wake up?_____

Diet:

Describe your current dietary lifestyle:

☐Carnivore (mostly meat) ☐ Omnivore (meat & veggies) ☐ Pescatarian (fish & veggies) ☐ Vegetarian ☐ Vegan

☐Gluten-free ☐ Dairy-free ☐ Sugar-free ☐ Low-Carb ☐ Paleo ☐ Other _____

Are you aware of foods that make you feel worse (foggy-headed, fatigued, bloated, upset stomach, reflux, etc.)

_____

Do you eat at regular times throughout the day? ☐ Yes ☐ No, explain: _____

Do you snack between meals? ☐ Yes ☐ No Do you fast? ☐ Yes ☐ No If yes, explain: _____

Please describe your average daily diet (please be as specific as possible):

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General:

☐ Poor appetite ☐ Poor sleep ☐ Fatigue ☐ Fevers ☐ Chills
☐ Night sweats ☐ Sweat easily ☐ Tremors ☐ Cravings ☐ Change in appetite
☐ Poor balance ☐ Bleed or bruise easily ☐ Localized weakness ☐ Weight loss ☐ Weight gain
☐ Peculiar tastes ☐ Desire hot food ☐ Desire cold food ☐ Strong thirst (cold or hot drinks)
☐ Sudden energy drop (What time of day) _____
Favorite season: ☐ Fall ☐ Winter ☐ Spring ☐ Summer
Least favorite season: ☐ Fall ☐ Winter ☐ Spring ☐Summer

Skin & hair: ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema
☐ Pimples ☐ Acne ☐ Dandruff ☐ Dry skin ☐ Recent moles ☐ Loss of hair
☐ Purpura ☐ Change in hair or skin texture ☐ Other _____

Musculoskeletal: ☐ Joint disorders ☐ Muscle weakness ☐ Pain/soreness in the muscles ☐ Tremors
☐ Cold hands/feet ☐ Difficulty walking ☐ Swelling of hands/feet ☐ Spinal curvature ☐ Back pain ☐ Hernia
☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck tightness ☐ Neck pain ☐ Shoulder pain
☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Joint sprain ☐ Other _____

Head, eyes, ears, nose, & throat: ☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens
☐ Eye strain ☐ Eye pain ☐ Color blindness ☐ Night blindness ☐ Poor vision ☐ Cataracts
☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Spots in front of eyes
☐ Sinus problems ☐ Nose bleeding ☐ Sore throat ☐ Grinding teeth ☐ Teeth problems ☐ Facial pain ☐
Jaw clicks ☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other _____

Cardiovascular: ☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting
☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Other _____

Respiratory: ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty breathing
☐ Bronchitis ☐ Pneumonia ☐ Chest pain ☐ Production of phlegm – What color? _____

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas
☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath ☐ Rectal pain
☐ Hemorrhoids ☐ Abdominal pain/cramps ☐ Gallbladder problems ☐ Parasites ☐ Chronic laxative use
Bowel movements: ☐ firm ☐ loose ☐ diarrhea ☐ hard/constipation ☐ other, please describe _____
Frequency (how many times/day): _____ Color _____ Strong Odor? ☐ Yes ☐ No

Neuro-psychological: ☐ Loss of balance ☐ Lack of coordination ☐ Concussion ☐ Other _____

☐ Depression ☐ Anxiety ☐ Stress ☐ Bad temper ☐ Bi-polar

Genito-urinary: ☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate

☐ Kidney stones ☐ Unable to hold urine ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection

☐ Genital pain ☐ Genital itching ☐Genital rashes ☐ STD ☐ Other _____

Female: ☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Vaginal/genital discharge

☐ Fibroids ☐ Ovarian cysts ☐ Irregular periods ☐ Clots ☐ Pain/cramps prior/during periods

☐ Breast tenderness ☐ Breast Lumps ☐ Fertility Problems ☐ Hot flashes ☐ Moodiness related to periods

_____Number of pregnancies _____Number of births _____Miscarriages _____Abortions

_____Premature births _____C-section _____ Difficult delivery

First date of last period_____Age of first period_____Duration of periods_____days, cycle_____days

Do you practice birth control ? ☐ Yes ☐ No If yes, what type and for how long? _____

Male: ☐ Prostate problems ☐ Discharge ☐ Erectile dysfunction ☐ Ejaculation problems

☐ Frequent seminal emission ☐ Fertility problems ☐ Painful/swollen testicles ☐ Other

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Are there any other health issues you want to discuss that were not covered above?

I have completed this form correctly to the best of my knowledge.

Signature: _____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse