

New Patient Intake Form

Today's date ____/____/____

Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home: _____ Work: _____ Cell/Pager: _____

Male Female Height: _____ Weight: _____ Marital Status: _____ Age: _____

Occupation: _____ Hobbies: _____

Emergency Contact Person and Phone #: _____

Referred by: _____

Reason for visit: _____

How long have you had this condition: _____

Is it getting worse? _____ Does it bother your: Sleep Work Other (what?) _____

What seemed to be the initial cause? _____

What makes it feel better? _____

What makes it feel worse? _____

Are you under the care of a physician now? Yes No If yes, for what? _____

Who is your physician? _____ Physician's Phone#: _____

Other concurrent therapies? _____

Have you had a massage before? _____ If so, how long ago? _____

Are you sensitive to touch or pressure in any area? _____ If so, where? _____

Is it difficult to lay down in any certain position? _____

Are you pregnant or think you are pregnant? _____ If so, how far along? _____

Do you wear contacts? _____ Do you wear dentures? _____

Family Medical History

- Allergies _____
- Arteriosclerosis _____
- Cancer _____
- Diabetes _____
- Seizures _____
- Asthma _____
- Heart Disease _____
- Stroke _____
- Alcoholism _____
- High Blood Pressure _____

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past.)

- AIDs / HIV _____
- Emphysema _____
- Multiple Sclerosis _____
- Surgery _____
- Tuberculosis _____
- Alcoholism _____
- Epilepsy _____
- Mumps / Measles _____
- Typhoid Fever _____
- Allergies _____
- Goiter _____
- Pacemaker _____
- Ulcers _____
- Appendicitis _____
- Gout _____
- Parkinson's Disease _____
- Venereal Disease _____
- Arteriosclerosis _____
- Heart Disease _____
- Pleurisy _____
- Thyroid Disorder _____
- Whooping Cough _____
- Arthritis _____
- Hepatitis _____
- Pneumonia _____
- Major Trauma _____
- Other (Specify) _____
- Asthma _____
- Herpes _____
- Polio _____
- (Car, Fall, Broken Bone) _____
- Body Piercing(s) _____
- High / Low Blood Pressure _____
- Rheumatic Fever _____
- Cancer _____
- Hyper / Hypoglycemia _____
- Scarlet Fever _____
- Chicken Pox _____
- Hyper / Hypothyroidism _____
- Seizures _____
- Diabetes _____
- Irritable Bowel Syndrome _____
- Stroke _____

Medicine and Vitamins

Pharmaceuticals taken in last 2 months: _____

Vitamins/supplements taken in last 2 months: _____

Your Lifestyle

- Alcohol _____
- Marijuana _____
- Stress/Tension _____
- Regular Exercise Type _____ Frequency _____
- Tobacco _____
- Drugs _____
- Occupational hazards _____
- Type _____ Frequency _____

General Symptoms

- Poor Sleep _____
- Bodily Heaviness _____
- Chills _____
- Bleed or Bruise easily _____
- Heavy Sleep _____
- Cold hands or feet _____
- Sweat easily _____
- Recent weight loss/gain _____
- Poor Circulation _____
- Muscle cramps _____
- Vertigo/Dizziness _____
- Fever _____
- Fatigue _____
- Shortness of Breath _____
- Difficult breathing _____
- Lack of strength _____

Cardiovascular

- High blood pressure _____
- Low blood pressure _____
- Chest pain _____
- Tachycardia _____
- Phlebitis _____
- Blood clots _____
- Fainting _____
- Varicose veins _____
- Heart palpitations _____
- Irregular heartbeat _____

Head, Eyes, Ears, Nose, and Throat

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Chronic sore throat | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Excessive Saliva | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Teeth problems / Dentures | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Other head and neck problems |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Nose bleeds | _____ |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> TMJ | <input type="checkbox"/> Color of phlegm | <input type="checkbox"/> Ringing in ears | _____ |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Facial pain | _____ | <input type="checkbox"/> Poor hearing | _____ |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Gum problems | _____ | <input type="checkbox"/> Earaches | _____ |

Musculoskeletal

- | | | | | |
|--|---|--|---|---|
| <input type="checkbox"/> Neck/shoulder pain/soreness | <input type="checkbox"/> Upper back pain/soreness | <input type="checkbox"/> Joint pain/swelling | <input type="checkbox"/> Limited range of motion or use | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Muscle pain/soreness | <input type="checkbox"/> Low back pain/soreness | <input type="checkbox"/> Rib pain/soreness | <input type="checkbox"/> Broken bones | _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Injury to bones | <input type="checkbox"/> Injury to joints | _____ | _____ |

Skin and Hair

- | | | | | |
|--------------------------------------|------------------------------------|------------------------------------|---|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Other hair or skin problems |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching | <input type="checkbox"/> Fungal Infections | _____ |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne | <input type="checkbox"/> Hair loss | _____ | _____ |

Neuropsychological

- | | | | | |
|-----------------------------------|--------------------------------------|--|--|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered or attempted suicide | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Seeing a therapist | _____ |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abuse survivor | _____ | _____ |

Other _____

Note: The remaining questions are only needed if administering Tui Na or Shiatsu

Have you had Tui Na massage before? _____ Shiatsu before? _____ How long ago? _____

Have you had Cupping, Moxabustion, or Guasha before? _____

If yes, which ones? _____ How long ago? _____

Your Diet

- Appetite Low High Coffee Soft Drinks Artificial Sweetener Sugar Salty Food

General Symptoms

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Peculiar Taste (describe) | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Strongly like cold drinks | _____ | <input type="checkbox"/> Dream-disturbed Sleep | <input type="checkbox"/> Worry easily |
| <input type="checkbox"/> Strongly like hot drinks | _____ | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Malar Flush to face |

Respiratory

- | | | | | |
|---|--------------------------------------|--------------------------------|-----------------------|---|
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Cough | Color of phlegm _____ | <input type="checkbox"/> Coughing blood |
| | <input type="checkbox"/> Wheezing | Wet or Dry? _____ | _____ | |
| | | Thick or thin? _____ | | |

Gastrointestinal

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain or cramping | <input type="checkbox"/> Bowel movements: Frequency _____ Texture/form _____ |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Itchy anus | Color _____ Odor _____ |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Burning Anus | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Black stools | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Anal fissures |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Rectal pain | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Mucus in stools | | |

Urinary/Genital

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Nocturnal emission |

Gynecology

- | | | | | |
|---|--|--|---------------------------------------|---|
| <input type="checkbox"/> Age menses began | <input type="checkbox"/> Duration of flow | <input type="checkbox"/> Vaginal discharge (color) _____ | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Date of last PAP |
| Length of cycle (day 1 to day 1) | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal sores | # Pregnancies _____ | |
| _____ | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal odor | # Live births _____ | |
| _____ | <input type="checkbox"/> PMS | <input type="checkbox"/> Clots | Premature births _____ | <input type="checkbox"/> Date last period |
| | | | Age of Menopause _____ | _____ |

Other _____