

Total Health Guidance
New Patient Intake Form
(Please Print)

Date _____

PT ID _____

Patient's Name _____

Address _____ (Last) _____ (First) _____ (MI) _____
City _____ State _____ Zip _____

Mailing Address (if different) _____

Home Phone (____) _____ Age _____ Date of Birth _____

Cell Phone (____) _____ Height _____ Weight _____ Sex _____

Marital Status _____ Married _____ Divorced _____ Separated _____ Widowed

E-mail Address _____ Newsletter Appointment Confirmation

Social Security # _____ Employer's Name _____

Employer's Address _____ City _____ State _____ Zip _____

Business Phone (____) _____ Occupation _____

Spouse's Name _____ Spouse's Employer _____

Employer's Address _____ City _____ State _____ Zip _____

Business Phone (____) _____ Occupation _____

Person to Notify in Case of Emergency _____ Phone _____

Referred By _____

Health Insurance Co _____ Phone _____ Policy# _____

Physician _____ Phone _____ Copy to Physician? Yes No

Please List Past Surgeries _____

Medications 1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Supplements 1) _____ 2) _____ 3) _____

Allergies 1) _____ 2) _____ 3) _____

Is This Related to an Auto Accident? _____ Date of Accident _____ Claim# _____

Is This Related to a Personal Injury? _____ Date of Injury _____ Claim# _____

Attorney _____ Phone _____

Insurance Co _____ Adjuster _____ Phone _____

Do you drink Coffee Black Tea How Much _____

Do you use alcohol? Yes No How Much _____

Do you smoke cigarettes? Yes No How many per day? _____ Cigarettes _____ Packs

Do you Exercise? Yes No How many days per week? _____

Major Complaint(s):

Please rate each complaint on a scale of 1-10. (#1 is virtually symptom-free and #10 is unbearable)

1. Major Complaint: _____ Rate: _____

2. Secondary Complaint: _____ Rate: _____

3. Other Complaint: _____ Rate: _____

Overall Energy (Lung, Kidney function):

- Shortness of Breath
- Difficulty keeping eyes open in the day
- Overall Weakness
- Easily catch colds
- Low Energy
- Feel worse after exercise

- Stiff Neck/Stiff Shoulders
- Sore throat
- Difficulty breathing
- Sadness
- Melancholy
- Smoke cigarettes
(# per day: _____)

Heart function:

- Palpitations
- Anxiety
- Sores on the tip of the tongue
- Lack of Taste
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake up tired
- Insomnia
- Mental sluggishness
- Mental foginess

Blood (Liver, Spleen, Heart functions):

- Dizziness
- See floating spots
- Poor Memory
- Pale Skin

Spleen, Stomach, Large Intestine, Small Intestine function:

- Loose
- Constipated
- Incomplete
- Diarrhea
- Blood in stools
- Mucous in stools
- Undigested food in stools

Spleen function:

- Low appetite
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in the stomach
- Fatigue after eating
- Prolapsed organs (organ?: _____)
- Easily bruised
- Hemorrhoids
- Over-thinking
- Worry

Dampness:

- Heavy sensation in body
- Mental heaviness
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

Lung function:

- Nasal Discharge (Color: _____)
- Cough
- Nose Bleeds
- Sinus Congestion
- Dry Mouth
- Dry Throat
- Dry Nose
- Dry Skin
- Allergies (To What? _____)
- Alternating chills and fever
- Sneezing
- Headache (Location: _____)
- Overall achy feeling in body
-

Eyes (Liver function)

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

Kidney, Bladder function:

- Frequent cavities
- Easily broken bones
- Sore knees
- Weak knees
- Cold sensation in the knees
- Low back pain
- Memory problems
- Excessive hair loss
- Low pitched ringing in ears
- Kidney stones
- Bladder infections
- Wake during the night to urinate
(How many times? _____)
- Lack of bladder control
- Fear
- Easily startled

Stomach function:

- Burning sensation after eating
- Very large appetite
- Bad breath
- Mouth (canker) sores
- Bleeding, swollen or painful gums
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccups
- Stomach pain
- Vomiting

Overall Temperature (Kidney function):

- Cold hands
- Cold feet
- Sweaty hands
- Sweaty feet
- Heat in the hands, feet or chest
- Hot flushes
- Cold body temperature (sensation)
- Lack of perspiration
- Perspire easily
- Thirsty
- Take water to bed Night sweats
- Hot body temperature (sensation)

Liver, Gallbladder function:

- Irritability
- Frequent unable to adapt to stress
- Depression
- Skin rashes
- Headache at top of the head
- Tingling sensation
- Numbness
- Muscle spasms
- Muscle twitching
- Muscle cramping
- Seizures
- Convulsions
- Lump in the throat
- Neck Tension
- Limited Range-of-Motion in shoulders
- Drink alcohol
- Recreation drugs?
(Which? _____)
(How much per week? _____)
- High-pitched ringing in ears
- Gall-stones
- Sexually transmitted disease
(Which? _____)
- Frustration
- Alternating diarrhea and constipation
- Chest pain
- Tight sensation in the chest
- Bitter taste in the mouth
- Anger easily

Urination

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful
- Difficult
- Urgent
- Frequent

Libido: Normal High Low

Women only:

Age of first menstruation? _____ Reg menstrual cycle? Yes No Number of children? _____

Avg. number of days of flow: _____ Pregnant? Yes No Number of pregnancies: _____

Age of menopause: _____ Vaginal discharge: Severe Moderate Slight Normal

Bleeding between periods: Severe Moderate Slight Normal

Do you experience any of the following pre-menstrual syndromes?

- Nausea Food Cravings Depression Vomiting
 Irritability Migraines Anxiety Water Retention
 Breast Swelling Breast Tenderness Headaches

How do these conditions impair your daily activities? _____

Please fill in the following menstrual chart:
(Put in a number and what color it is)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Mood							
Breast tenderness, soreness							

Men only:

- Swollen testes ___ Severe ___ Moderate ___ Slight ___ Normal
- Testicular pain ___ Severe ___ Moderate ___ Slight ___ Normal
- Impotence ___ Severe ___ Moderate ___ Slight ___ Normal
- Premature ejaculation ___ Severe ___ Moderate ___ Slight ___ Normal
- Feeling of cold or numbness in external genitalia ___ Severe ___ Moderate ___ Slight ___ Normal
- Other: _____

Pain:

How did pain begin?: _____

When did pain begin?: _____

Does Pain limit your Range of Motion? _____ Does pain wake you at night? _____

Quality of the pain:

Sharp Burning Aching Cramping Dull Moving Fixed Other: _____

Intensity of the pain:

0 1 2 3 4 5 6 7 8 9 10

No Pain

Moderate

Intense

Do any of the following **Lessen** the pain?

Pressure Cold Heat Exercise Other: _____

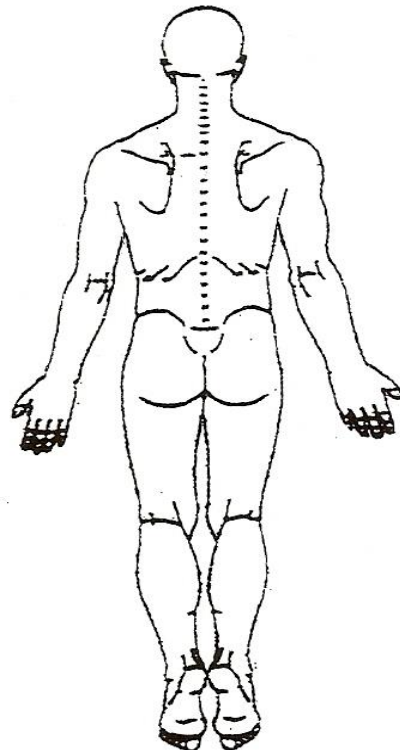
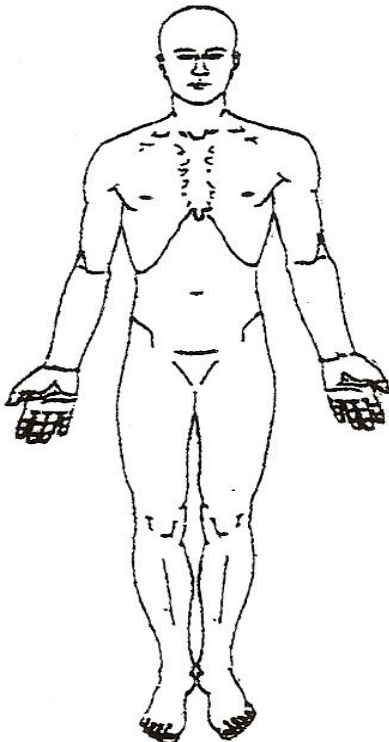
Do any of the following **Worsen** the pain?

Pressure Cold Heat Exercise Other: _____

Where is the pain? _____

*Please clearly mark areas of pain and any scars.

- Circle body part(s) that are in pain
- Mark with an **X** all specific areas of pain
- Mark with an **S** areas of scar tissue



Patient Medical History:

How was your childhood health? _____

Hospital Visits/Stays: _____

Recent tests: (please indicate test results and date below)

Physical Cholesterol Prostate Blood HIV/STD Pap Smear Mammography

Other: _____

Test Results and Date: _____

Check any you have had in the past:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Mumps | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Vein Condition | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> HIV | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Gonorrhoea |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Migraines | <input type="checkbox"/> other liver illnesses |
| <input type="checkbox"/> other stomach illnesses | <input type="checkbox"/> other lung illnesses | <input type="checkbox"/> other kidney illness | <input type="checkbox"/> other heart illnesses |
| <input type="checkbox"/> other spleen illnesses | <input type="checkbox"/> other: _____ | | |

Immunizations: _____

Surgeries (type and date): 1) _____ 2) _____
3) _____ 4) _____

Family History:

Where are you in the birth order? First Last Middle Only child

Check the following that have occurred in your blood relatives:

- | | | | |
|--|------------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Obesity | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Nervous Illness | <input type="checkbox"/> Balding | <input type="checkbox"/> Other _____ | |

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY THIS OFFICE IF ANY OF THIS INFORMATION SHOULD CHANGE.