THE EMPEROR'S MEDICINE
AN INTEGRATIVE MEDICINE CLINIC

NEW CLIENT INTAKE FORM

Today's Date:_____

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Nickname or preferred name: _____ Marital Status: □S □M □D □W □Other _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email Address: _____

Occupation: _____ Employer: _____

In case of Emergency – Contact: _____ Relationship: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

How did you hear about us? _____

Primary Care Physician:_____ Phone:_____

HEALTH INFORMATION

Health Concerns: Please list your top health concerns or complaints that you would like to address (in order of priority):

1) _____
2) _____
3) _____

Are these concerns affecting your quality of life? (Please check all applicable)

Work/School: □Y □N Recreation: □Y □N Sleep: □Y □N Exercise/Sports: □Y □N

Eating: □Y □N Walking: □Y □N Sitting: □Y □N Intimate/Personal Life: □Y □N

MEDICAL HISTORY: Please check all that apply (**P** = Past / **C** = Current):

P/C	P/C	P/C	P/C	P/C
☐☐ Abdominal Pain	☐☐ Elbow/Hand Pain	☐☐ High Blood Pressure	☐☐ Paralysis	☐☐ Sweating
☐☐ Ankle/Food Pain	☐☐ Excessive Thirst	☐☐ Hip Pain	☐☐ Persistent Cough	☐☐ Swollen Ankles
☐☐ Blurred Vision	☐☐ Eye Pain	☐☐ Insomnia	☐☐ Poor Appetite	☐☐ Swollen Joints
☐☐ Chest Pressure	☐☐ Facial Pain	☐☐ Irritability	☐☐ Poor Circulation	☐☐ Teeth Grinding
☐☐ Clammy Hands	☐☐ Fainting	☐☐ Joint Stiffness	☐☐ Rapid Heart Rate	☐☐ Tingling in Feet
☐☐ Confusion	☐☐ Fatigue	☐☐ Knee Pain	☐☐ Shakiness	☐☐ Tingling in Hands
☐☐ Constipation	☐☐ Feel Loss of Control	☐☐ Low Back Pain	☐☐ Shoulder Pain	☐☐ Unusual Lumps
☐☐ Convulsions	☐☐ Forgetfulness	☐☐ Low Blood Pressure	☐☐ Sinusitis	☐☐ Urination Difficulty
☐☐ Decreased Sex Drive	☐☐ Frequent Urination	☐☐ Lump in Throat	☐☐ Slow Heart Rate	☐☐ Walking Problems
☐☐ Dizziness	☐☐ Fullness of Bladder	☐☐ Menstrual Irregularities	☐☐ Sore Muscles	☐☐ Weak Muscles
☐☐ Dry Mouth	☐☐ Headache	☐☐ Nausea/Vomiting	☐☐ Sore Throat	☐☐ Other:

☐☐ Earache ☐☐ Hemorrhoids ☐☐ Neck Pain ☐☐ Swallowing Pain _____

Are you currently under the care of any other provider (s)? (MD, Dentist, Psychologist, please list condition or general care, etc.)

_____

WOMEN ONLY: Is there any chance you might be pregnant? □Y □N Date of last menstrual cycle: _____

Are you experiencing perimenopause? □Y □N Reached menopause? □Y □N Are you experiencing symptoms? □Y □N

Do you currently or have you used any of the following? (please circle all that apply) Birth Control Pills

Hormone Replacement Therapy / Hormone IUD / Copper IUD / Contraceptive Shot (ex. Depo) / Vaginal Ring

Contraceptive Patch / Emergency Contraceptive

Length of use of each type: _____ Have you ever had an abnormal PAP? □Y □N

Age of menarche (periods began): _____ Age you gave birth (if applicable): _____

Number of pregnancies (if any): _____ Number of C-Sections (if any): _____

Number of Children (if any):____ Number of abortions (if any):____ Number of miscarriages (if any):____

Menstruation (check all that apply):

Blood Color: ____dark red ____ bright red ____pale/pink ____blackish ____purple ____brown

Clot: ____ no clots ____ some small clots ____some large clots ____ dark clots ____ red clots ____ dilute/watery

Flow: ____ none ____1-3 days ____ 4-6 days ____ 7 or more days

Menstrual Pain: ____ before flow ____ first day ____during period, any day ____ after periods ____ on ovulation

Fertility: ____ I am trying to conceive

____ I am not trying to get pregnant, but could become pregnant during the course of treatment

If trying to conceive, please explain what you have done in the past and what you are doing currently to try to conceive a child:

_____

_____

HEAD & FACE

____ Headaches ____ Migraines ____ Tension ____ Cluster ____ Hormonal ____ Sinus

Where do you feel the headaches?

____ Front/Forehead ____ Top of Head ____ Side/Temples ____Back/Occipital/Neck ____Behind Eye(s)

How often do you get a headache?

____ 1-2 a year ____ 3-11 a year ____1/month ____2-4 month ____1-2/week ____ more than 2 a week

How long does the headache last without medication?

ACCIDENTS: Have you been involved in any of the following types of accidents? (check all that apply)

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Playground ☐ Abuse ☐ Other

Year ***(approximate)***	**Please describe** ***(injuries, treatment, outcome)***

INJURIES: Have you injured any of the following regions? (check all that apply)

☐ Head ☐ Neck ☐ Rib/Chest ☐ Back ☐ Pelvis/Hip ☐ Arm/Hand ☐ Leg/Foot

Year *(approximate)*	**Please describe *(injuries, treatment, outcome)***

SERIOUS ILLNESS/HOSPITALIZATIONS/SURGERIES: Please detail hospitalizations/serious illnesses/surgeries

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Playground ☐ Abuse ☐ Other

Year *(approximate)*	**Reason**	**Outcome**

MEDICATIONS: Please list all medications you are currently or have recently taken (prescribed or over-the-counter)

Medication Name	**Condition**	**Date Started**	**Prescribed By**

NUTRITIONAL SUPPLEMENTS: List all Vitamins & Nutritional Supplements you are currently or have recently taken

Supplement	**Brand & Amount Consumed**	**Date Started**	**Prescribed By** (if applicable)

PREVIOUS MEDICATION HISTORY: Please list an approximate number of times you have taken antibiotics for illnesses, yeast infections, skin disorders (including acne), dental procedures, surgery etc. _____ Have you ever been on a long-term antibiotic (1 month or longer) or Intravenous (IV)? □Y □N Have you ever taken probiotics? □Y □N

ALLERGIES / SENSITIVITIES: Please check and list all allergies / sensitivities

☐ **Food:** ☐ Gluten ☐ Dairy ☐ Soy ☐ Nuts ☐ Other _____

☐ **Medications:** _____

☐ **Seasonal/Latex/Other:** _____

Have you taken oral steroids (Cortisone, Prednisone)? If yes, please list: _____

As a child did you have a restricted diet, or were you allergic to any foods? If yes: _____

HABITS: Please include current and previous amounts

	Daily	Weekly	Monthly	Never	Amount
Alcohol	☐	☐	☐	☐	_____
Coffee	☐	☐	☐	☐	_____
Soda/Diet Soda	☐	☐	☐	☐	_____
Tobacco	☐	☐	☐	☐	_____
Rec. Drugs	☐	☐	☐	☐	_____

If you no longer consume the above, please note length of consumption and date stopped

	5-7x/wk	3-5x/wk	1-3x/wk	None
Exercise	☐	☐	☐	☐

	8+hrs	7-8hrs	6-7hrs	5-6hrs	<5hrs
Sleep	☐	☐	☐	☐	☐

	5+	4	3	2	1
Meals/day	☐	☐	☐	☐	☐

	8+ cups	4-7 c	2-4 c	<8oz
Water/day	☐	☐	☐	☐

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Sitting ☐ Standing ☐ Walking/Moving ☐ Driving

STRESS LEVEL: ☐ Very High ☐ High ☐ Medium ☐ Low

Are you interested in the following services? ☐ Massage ☐ Nutrition ☐ Gluten Issues ☐ Thyroid Dysfunction ☐ Weight-loss ☐ Cholesterol Issues ☐ Pain Management ☐ Other: _____

If you have any concerns or questions you would like to note here or issues you think might be related to your condition please list them below. Do not hesitate to discuss these or any other matters with the functional medicine practitioner.

_____

_____

_____

(Please Provide the office with a copy of your driver's license and insurance card)

_____	_____	_____
Client Name (Printed)	Client Signature	Date

_____	_____
Parent and/or Guardian Printed	Parent and/or Guardian Signature

ASSIGNMENT AND RELEASE (INSURED PATIENTS ONLY) I certify that I (or my dependent) have insurance coverage with_____ and **I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE ACUPUNCTURE OFFICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.** I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Policy Holder Name_____ Policy Holder DOB_____
Relationship to Patient_____ Insurance Company Name_____
ID Number_____ Group Number_____

Patient/Guardian Signature_____ Date_____