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EASTERNHEALTH

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PATIENT INTAKE AND HEALTH HISTORY

Name ______________________________ Date ____ / ____ / ____

Address ______________________________

City ______________________________ State __________ Zip __________

Social Security Number No longer needed ______________________________ Date of Birth ____ / ____ / ____

Home Phone __________ Daytime/Cell Phone __________ Email __________

Emergency Contact ______________________________ Contact Phone __________

Health Insurance Co. ______________________________ Occupation __________

Referred By ______ optional ______ Dx Codes ______ optional ______

For Auto Accidents/Personal Injury Only

Insurance Company		Date of Injury	/ /
Company's Address		Claim No.	
Contact/Adjustors Name		Phone Number	
Name of Insured		Relationship to Insured	
Attorney Representing You		Attorney's Phone	

For Work Injuries Only

Employer		Date of Injury	/ /
Contact at Employer		Contact Phone	
Your Position/Title		Claim No.	
Attorney Representing You		Attorney Phone	

Sex ☐ Male ☐ Female Height __________ Weight __________

What health problem do you want treated? ______________________________

Have you been receiving treatment for this condition? ☐ Yes ☐ No

If Yes: By whom? ______________________________

What was the diagnosis? ______________________________

What was the outcome? ______________________________

Do you have other health concerns? ______________________________

Traditional Chinese Medicine is a system that considers the whole body when treating any health problem. Your answers to the following health questions will provide a framework for helping us understand you as an individual and to effectively treat your condition.

Family History
(check all that apply)

	Father	Mother	Brothers	Sisters	Children	Extended
Cancer	_______	________	________	________	________	________
Diabetes	_______	________	________	________	________	________
Heart Disease	_______	________	________	________	________	________
High Blood Pressure	_______	________	________	________	________	________
Stroke	_______	________	________	________	________	________
Mental Illness	_______	________	________	________	________	________
Asthma/Hay fever/Hives	_______	________	________	________	________	________
Kidney Disease	_______	________	________	________	________	________

Your Past Medical History

Significant illnesses: ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Pace Maker
☐ High Blood Pressure ☐ Bleeding Disorder ☐ Emphysema ☐ Seizures ☐ Hepatitis ☐ HIV/AIDS
☐TB ☐Herpes Virus Surgeries:________________________ Other__________________________
Accidents/Injuries: ____
Abuse: ☐Sexual ☐Psychological ☐Physical Addictions:__________________________________
Allergies: (to what, symptoms, season)____

Lifestyle

Diet: ☐ American ☐ Vegetarian __Other (describe)____
How is your appetite? ☐Low ☐Moderate ☐ Good ☐ Excessive Number of meals/day_______
Any food cravings?_____________________________ Any food intolerances?_____________________________
Are you often thirsty? ☐ yes ☐ no Do you prefer ☐ hot drinks ☐ cold drinks ☐ neither
Is your weight stable? ☐ yes ☐ no Do you like your weight? ☐ yes ☐ no
Exercise: Do you exercise regularly? ☐ yes ☐no How often?______________ What kind of exercise do you do?____
Habits: Alcohol? ☐yes ☐no Smoking? ☐yes ☐no How much and how long?_________________________
If you quit, what and when?______________________ Coffee: cups/day_______ Pop: amount/day_______

Gastrointestinal

Stools tend to be: ☐ Diarrhea ☐ Loose ☐ Formed ☐ Difficult ☐ Constipation
You have / have had (check all that apply):
☐ Belching ☐ Nausea ☐ Vomiting ☐ Ulcers ☐ Bloating ☐ Acid reflux ☐ Heartburn
☐ Hernia ☐ Indigestion ☐ Stomach pains ☐Gas ☐Burning stools ☐ Hemorrhoids
Other (describe)____

Emotions and Sleep

How many hours do you usually sleep? _______ Stress: Do you feel that your life is stressful? ☐ yes ☐ no
Describe____
Of these choices, what emotion do you think is the most characteristic for you?
☐ Joy ☐ Grief ☐ Fear ☐ Anger ☐ Worry ☐ Sadness
You have / have had (check all that apply):
☐ Panic attacks ☐ Depression ☐ Anxiety ☐ Suicidal thoughts ☐ Bad temper
☐ Nervousness ☐ Poor memory ☐ Difficult concentration
Difficulties with: ☐ Falling asleep ☐ Staying asleep ☐ Disturbed sleep ☐ Waking too early
Other (describe)____

Urinary and Genital

Urination: ____times per day ☐ Pale yellow ☐ Dark yellow/orange ☐ Cloudy

You have / often have (check all that apply):

☐ Pain with urination ☐ Frequent urination ☐ Urgent urination ☐ Blood in urine ☐ Incontinence
☐ Incomplete urination ☐ Venereal disease ☐ Bed wetting
☐ Kidney stone ☐ Wake to urinate Sex drive: ☐ Low ☐ Moderate ☐ High
☐ Infertility ☐ Pain during intercourse

Other (describe)____

Women

Age of first period?_____ Number of days between cycles? _____ Duration of flow _____days

If you are currently using birth control, what do you use? ___________________________________

You have / often have (check all that apply):

☐ Irregular periods ☐ Heavy flow ☐ Clots ☐ Light flow ☐ Vaginal itching/burning
☐ No Flow ☐ Discomfort/pain before period ☐ Discomfort/pain during period ☐ Spotting
☐ Missed periods ☐ Vaginal discharge ☐ Blood/mucous breast discharge ☐ Breast lumps
☐ PMS (describe symptoms)____

No. of pregnancies:____ No. of deliveries:___ No. of abortions:___ No. of miscarriages:___

Other(describe)____

☐ Menopause When?_______Symptoms____

Hysterectomy? ☐ yes ☐ no Date and reason____

Men

You have / often have (check all that apply):

☐ Prostate problems ☐ Nocturnal emission ☐ Discharge ☐ Impotence ☐ Premature ejaculation

Muscles, Joints and Bones

Do you have pain or stiffness? ☐ yes ☐ no Where?____

You have / often have (check all that apply):

☐ Swollen joints ☐ Arthritis / joint pain ☐ Tendonitis ☐ Jaw problems ☐ Rheumatism
☐ Bone pain ☐ Muscle pain ☐ Repetitive strain injury ☐ Muscle cramping

Other(describe)____

Eyes, Ears, Nose, Throat and Head

You have / often have (check all that apply):

☐ Painful eyes ☐ Red eyes ☐ Itchy Eyes ☐ Floaters in eyes ☐ Blurred vision ☐ Poor vision
☐ Ringing in ears ☐ Poor hearing ☐ Earaches ☐ Nose bleeds ☐ Runny nose
☐ Sinus problems ☐ Sore throat ☐ Chronic cough ☐ Swollen glands ☐ Lumps in throat
☐ Dry mouth ☐ Excessive saliva ☐ Sores on lips or tongue ☐ Teeth problems ☐ Gum problems
☐ Facial pain ☐ Headaches ☐ Migraines

Other (describe)____

Cardiovascular

Blood pressure___/___ Have you been diagnosed with heart problems? ☐ yes ☐ no

You have / often have (check all that apply):

☐ Chest pain ☐ Palpitations ☐ Irregular heartbeat ☐ Blood clots ☐ Fainting
☐ Difficulty breathing ☐ Poor circulation ☐ Varicose veins ☐ Phlebitis

Other (describe)____

Skin and Hair

You have / often have (check all that apply):

☐ Rashes ☐ Hives ☐ Ulcerations ☐ Eczema ☐ Fungal infections ☐ Psoriasis ☐ Acne
☐ Dandruff ☐ Itching ☐ Hair loss

Other (describe)____

MEDICATIONS AND SUPPLEMENT CHART

Date	Rx	OTC	Prescription Drugs/ OTC Medications	Dose	Vitamins/ Supplements	Dose