# Intake | Rachelle Lambert, MAOM, Dip. OM, CO L.Ac.

**Today's Date:** / /

**Name:**

**Address:**

**City:** **State:** **Zip:**

**Cell Phone:**

**Home Phone:**

**Date of Birth:** / / **Age:**

**Marital Status:**

**Height:** ' " **Gender:** ☐ **Male** ☐ **Female**

**Weight:** **lbs**

**Referred by:**

**Occupation:**

**Email address:**

**May we contact you by...** ☐ **Phone?** ☐ **Email?** ☐ **Voicemail?**

## HEALTH HISTORY

**Please describe the reason for your visit:**

**How long have you had this condition?**

**Previous treatments for this condition:**

☐ Chiropractic ☐ Acupuncture ☐ Physical Therapy ☐ Massage Therapy ☐ Injection:

## PERSONAL MEDICAL HISTORY

**General symptoms:**

☐ Cancer
Type(s):
Date Diagnosed: / /

☐ Anemia ☐ Dermatitis ☐ Drug/alcohol abuse ☐ Fatigue
☐ Herpes/Shingles ☐ History of fever/chills ☐ IV drug use ☐ Psoriasis/skin condition
☐ Prolonged steroid use ☐ Sleeping difficulties ☐ SLE (Lupus)

**Cardiovascular:**

☐ Arteriosclerosis ☐ Bleeding disorders ☐ Blood clots ☐ Chest pain ☐ Congestive heart failure ☐ Deep vein thrombosis
☐ Heart attacks ☐ Heart disease ☐ High blood pressure ☐ Pacemaker ☐ Palpitations ☐ Pulmonary embolism

**Endocrine:**

☐ Adrenal disease ☐ Diabetes ☐ Goiter ☐ Low thyroid ☐ Parathyroid disease ☐ Pituitary disease

**Gastrointestinal:**

☐ Constipation ☐ Digestive problems ☐ Gall bladder problems ☐ GERD ☐ Heart burn ☐ Hepatitis
☐ High cholesterol ☐ Liver disease ☐ Nausea ☐ Ulcer/GI bleeding

**Genito-Urinary:**

☐ Inability to control bladder ☐ Increased urinary frequency ☐ Loss of sexual function
☐ Painful urination ☐ Kidney stones ☐ Prostate problems ☐ Urinary retention

**Gynecology:**

☐ Hot Flashes ☐ Menstrual cramps ☐ Miscarriage ☐ Pregnancy ☐ PMS
Date of last menstrual cycle: / /

**Eyes, Ears, Nose & Throat:**

☐ Blindness ☐ Blurred vision ☐ Cataracts ☐ Deafness/reduced hearing
☐ Glaucoma ☐ Ringing/buzzing in ears ☐ Sinus problems

**Musculoskeletal:**

☐ Arthritis ☐ Back pain ☐ Conditions aggravated by coughing, sneezing, or grunting
☐ Constant pain unrelated to movement ☐ Connective tissue disease ☐ Fibromyalgia
☐ Fractures ☐ Gout ☐ Herniated disc ☐ History of weakness ☐ Jaw problems ☐ Joint swelling
☐ Night pain unrelated to movement ☐ Osteoporosis ☐ Pinched nerve ☐ Rheumatoid arthritis ☐ Sciatica
☐ Scoliosis ☐ Sjogren's syndrome ☐ Tendonitis ☐ Osteoarthritis ☐ Whiplash injury

**Neuropsychological/Balance:**

☐ Burning, tingling, or numbness into the hips, legs, or feet ☐ Burning, tingling, or numbness into the shoulders, arms, or hands
☐ Bi-polar disorder ☐ Depression ☐ Dizziness ☐ Epilepsy/Seizure ☐ Headaches ☐ Migraines
☐ Multiple sclerosis ☐ Nervousness/Anxiety ☐ Parkinson's disease ☐ Poor balance ☐ Stroke ☐ Schizophrenia

**Respiratory:**

☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Pneumonia ☐ Shortness of breath ☐ Sleep apnea

## FAMILY MEDICAL HISTORY

**Problems that run in your family:**

☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart disease
☐ High blood pressure ☐ Seizures ☐ Stroke ☐ Spine disease

## PERSONAL MEDICAL HISTORY CONTINUED

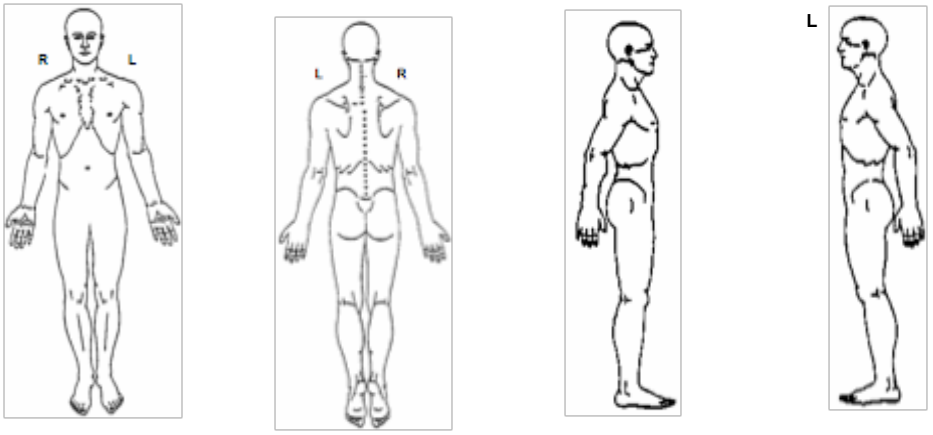
**Surgeries:**

| Year | Surgery |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:**

| Product | Reason | Dosage |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please mark your conditions, areas of concern and/or pain.**




**Allergies:**

## HEALTH HABITS

**Exercise:**

**How often do you exercise?**

☐ Never ☐ Rarely ☐ Occasionally ☐ Weekly ☐ Daily

**Type:** _____

**If you exercise, what is the intensity?**

☐ Light ☐ Moderate ☐ Strenuous

**Habits:**

**Do you drink alcohol?**

☐ Never ☐ Once a week ☐ Several times a week ☐ Once daily ☐ Several times per day

**Tobacco use:**

**Cigarettes:** ☐ Never ☐ Used in the past ☐ Less than ½ pack per day ☐ ½ pack per day ☐ 1 pack per day ☐ 2 packs per day ☐ More than 2 packs per day

**Chewing tobacco:** ☐ Never ☐ Used in the past ☐ Occasionally ☐ Often

**Cigars:** ☐ Never ☐ Used in the past ☐ Occasionally ☐ Often

**For how many years have you used tobacco products?** _____

**If you have quit smoking, when did you quit?**