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

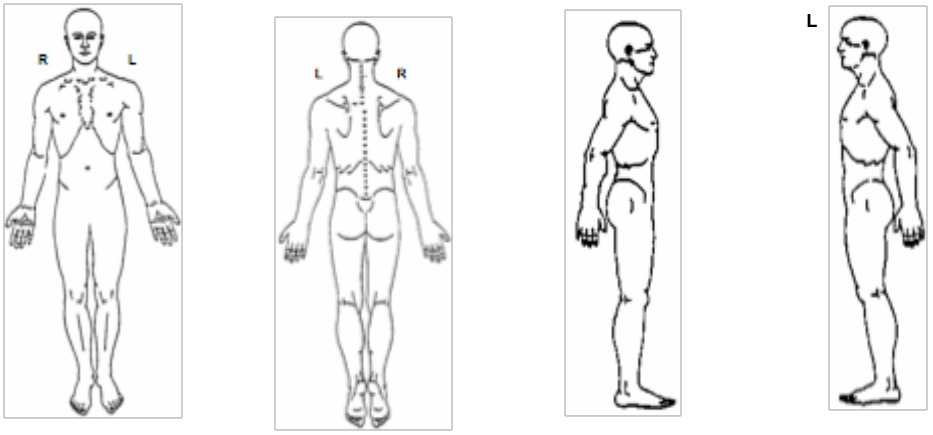
Surgeries:

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?