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Full name: _____ Date: _____
Gender: M F Date of birth: _____

CONTACT INFORMATION:

Full address:

Telephone: (home) _____ (work) _____ (mobile) _____

****EMAIL:**

How can we best reach you?

May we leave you phone messages / call to confirm & cancel appointments? Y N

Emergency contact: _____ Relationship: _____
Telephone: (home) _____ (work) _____ (mobile) _____

FAMILY

Marital status: ____ Single ____ Married ____ Divorced ____ Separated
____ Living with Partner ____ Widowed

Do you have any children? Y N

If yes, list age and gender: _____

Name of medical doctor: _____ Tel: (____) _____

Address: _____ Fax: (____) _____

Date of last visit to Medical Doctor: _____

Date last physical: _____

Are you under the care of any specialists? Y N

Name _____ Specialty: _____ Tel: (____) _____

Name _____ Specialty: _____ Tel: (____) _____

Name _____ Specialty: _____ Tel: (____) _____

How did you hear of this clinic/were referred by:

Evergreen Acupuncture & Oriental Medicine

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

MEDICAL HISTORY

Please list your health concerns in order of importance

Concern	Since	Concern	Since
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Have any of these issued changed or worsened over time? _____

What effect have these issues had on your life? _____

How would you describe your general state of health? _____

Please list any trauma, injury, illness, or accident (mental, emotional, physical)

Incident	Date	Long-term effects

Please list any surgical procedure you have undergone

Procedure	Date	Complications/Results

Please list any other forms of treatment that you have used and describe their effectiveness.

CHILDHOOD ILLNESSES & VACCINATIONS: (check all that apply):

- Chicken pox Measles Mumps Rubella (German measles)
 Roseola Mononucleosis Scarlet fever Tuberculosis
 Whooping Cough Impetigo Ear Infections Strep Throat
 Polio Rheumatic Fever Other

Were you vaccinated as a child? If so, any side effects?

Any additional vaccinations (i.e. Hepatitis A or B, "Flu shot", HPV vaccine, etc)?

MEDICATIONS / SUPPLEMENTS / DRUGS

Please list all current medications and supplements you take including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

Drug/Supplement	Used for	Date started	Dosage/Frequency

How often did you take antibiotics as a child? _____

In the last 5 years, how many courses of antibiotics have you taken? _____

Most recent course? _____

Which of the following have you used/do you currently use? Please include amount, frequency, duration of use.

Tobacco	Antacids
Alcohol	Sedatives
Recreational Drugs	Cortisone
Steroids	Coffee
Laxatives	Other

REVIEW OF SYMPTOMS

Please place a checkmark (✓) next to any of the following symptoms that you currently experience and a (P) next to any that you have had in the past

SKIN & HAIR

- Rashes
- Itching
- Eczema
- Psoriasis
- Boils/Cysts
- Acne
- Hives
- Warts
- Dryness
- Colour changes
- New/Changed moles
- Lumps
- Dandruff
- Hair loss
- Change in hair texture
- Nail changes
- Other

EYES

- Impaired vision
- Glasses/contacts
- Far-sighted
- Near-sighted
- Double vision
- Colour blindness
- Night blindness
- Sensitivity to sun
- Pain
- Redness
- Itching
- Dryness
- Discharge
- Blurring
- Excessive tearing
- Spots/Floaters
- Blind spot
- Glaucoma
- Cataracts
- Other

EARS

- Ringing
- Discharge
- Pain/Aches
- Deafness
- Infections
- Wax build-up
- Ear tubes
- Other

NOSE & SINUSES

- Allergies
- Loss of smell
- Post nasal drip
- Nosebleeds
- Dryness
- Sinus infections
- Sinus pain
- Nasal congestion
- Sleep apnea
- Snoring
- Nasal Polyps
- Other

MOUTH & THROAT

- Dental cavities
- Mercury fillings
- Gum problems
- Grinding/Clenching
- Ulcers/sores
- Loss of Taste
- Pain/Soreness
- Frequent Sore throat
- Hoarseness
- Tonsillitis
- Phlegm/Mucous
- Cold sores
- Enlarged glands
- Jaw pain/clicking
- Facial pain/tics
- Other

HEAD & NECK

- Headache
- Injury
- Lumps
- Swollen glands
- Swollen lymph nodes
- Goitre
- Pain/stiffness
- Other

RESPIRATORY

- Cough
- Sputum
- Coughing blood
- Wheezing
- Asthma
- Bronchitis
- Pneumonia
- Emphysema
- Tuberculosis
- Difficulty breathing
- Pain with breathing
- shortness of breath (SOB)
- SOB lying down
- SOB at night
- Other

CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Irregular heart beat
- Fast heart beat
- Slow heart beat
- Palpitations
- Murmurs
- Angina
- Chest pain
- Swelling of limbs
- Cold hands or feet
- Thrombophlebitis
- Blood clots
- Varicose veins
- Elevated cholesterol
- Past ECG test
- Other Heart tests
- Other

BLOOD & LYMPHATIC

- Anemia
- Easy bruising/bleeding
- Slow clotting
- Fatigue/weakness
- Pallor (paleness)
- Swollen lymph nodes
- Past transfusions
- Other

GASTROINTESTINAL

- Heartburn/acid reflux
- Indigestion
- Poor/change in appetite
- Large appetite
- Low appetite
- Poor/change in thirst
- Difficulty swallowing
- Abdominal pain/cramps
- Bloating
- Gas or belching
- Bad breath
- Diarrhea
- Constipation
- Incomplete bowel movements
- Nausea
- Vomiting
- Vomiting blood
- Spitting blood
- Chronic laxative use
- Rectal pain
- Rectal bleeding
- Rectal incontinence
- Hemorrhoids
- Blood in stool
- Black, tarry stools
- Undigested food in stool
- Mucous in stool
- Hernia
- Ulcer
- Candida
- Intestinal worms
- Liver disease
- Gall bladderstones/disease
- Jaundice
- Anal itching
- Anal fistula
- Anal fissures
- Diverticulitis
- Food allergies
- Anorexia nervosa
- Bulimia
- Crohn's disease
- Other

GENITOURINARY

- Frequent urination
- Pain/burning on urination
- Urgency to urinate
- Urinary incontinence
- Hesitancy with urination
- Waking at night to urinate
- Recurrent urinary tract Infections
- Kidney infection
- Kidney stones
- Blood in urine
- Low back pain
- Flank (side) pain
- Other

ENDOCRINE

- Excessive urination
- Excessive sweating
- Heat intolerance
- Cold intolerance
- Thyroid disease
- Excessive thirst
- Excessive hunger
- Diabetes
- Hypoglycemia
- Hormone Therapy
- Rapid weight gain
- Rapid weight loss
- Insomnia
- Other

MUSCULOSKELETAL

- Back pain
- Muscle spasms/cramps
- Muscle weakness
- Arthritis
- Tendonitis
- Jaw pain/stiffness
- Joint pain/stiffness
- Joint swelling
- Bursitis
- Fractures
- Osteoporosis
- Sciatica
- Other

NEUROLOGICAL

- Dizziness
- Seizures
- Fainting
- Paralysis
- Stroke
- Poor memory
- Loss of balance
- Concussion
- Numbness/Tingling

- Tremors
- Speech difficulty
- Poor coordination
- Confusion
- Dementia
- Learning difficulties
- Involuntary movements
- Other

FEMALE REPRODUCTIVE

- Heavy menses
- Light menses
- Irregular periods
- Painful periods
- Acne during period
- Mood swings during period
- Bloating during periods
- Bleeding between periods
- Menstrual blood clots
- Vaginal discharge
- Vaginal itching
- Vaginal sores
- Yeast infections/vaginitis
- Painful intercourse
- Low libido
- Other sexual difficulty
- Fibroids
- Ovarian cysts/PCOS
- Endometriosis
- Hysterectomy
- Menopause
- Difficulty conceiving/infertility
- Miscarriage
- Abnormal PAP
- Sexually transmitted disease
- Sexually active
- Birth control/Protection

Form: _____

Other

MALE REPRODUCTIVE

- Testicular masses
- Testicular pain
- Hernia
- Prostate problems
- Discharge or sores
- Low libido
- Erectile dysfunction
- Premature ejaculation
- Low sperm count
- Other sexual difficulty
- Sexually transmitted disease
- Sexually active
- Use regular protection

Form: _____

EMOTIONAL/PSYCHOSOCIAL

- Depression
- Anxiety
- Mood swings or Irritability
- Phobias
- Hyperactivity
- Aggression/Anger
- Alcohol/Drug Abuse
- Happy
- Inspired
- Think a lot/overthinking
- Sad

- Forgetful
- Grumpy
- Worry
- Lethargic
- Other

FAMILY HISTORY

Please indicate if any of your immediate family (parents, siblings, maternal & paternal grandparents) suffers from or has suffered from any of the following conditions.

Condition	Family Member(s)	Condition	Family Member(s)
Alcoholism/drug use		Asthma	
Colitis/IBS		Diabetes	
Kidney Disease		Overweight/Obesity	
Allergies/hay fever		Arthritis	
Depression/mental health		Heart disease	
Liver disease		Prostate cancer	
Breast cancer		Colon cancer	
High blood pressure		Hyper/hypothyroidism	
Stroke		Other cancer	

Any other conditions of concern in your family? _____

ALLERGIES, SENSITIVITIES, EXPOSURES

Please list any known or suspected allergies, sensitivities and/or intolerances.

Drugs	Food	Environmental/Chemical

Have you ever been exposed to toxic substances such as pesticides, herbicides, solvents, or sprays?

If yes, please give details:

Have you ever been exposed to heavy metals such as lead, mercury, arsenic, cadmium, or second hand smoke?

If yes, please give details:

Have you ever had to lower the regular dose of prescription, over-the-counter medication, homeopathic or herbal formula because you were too sensitive to the regular dose?

Do you avoid caffeine in the afternoon or altogether because it keeps you up at night?

Do you smell odors that others cannot? If so, which odors?

Do you have a sudden onset of symptoms (headaches, rashes, nausea, fatigue, shortness of breath, etc) when exposed to chemicals, mold, dust, pollen, or other environmental allergens? If so, please explain.

LIFESTYLE FACTORS

Energy

On a scale of 1-10, (10 = highest) rate your energy: /10 Rate your stress level: /10

What time of day is your energy the best? _____ worst? _____

What affects your energy? (↑ or ↓)

Exercise

Do you exercise regularly? Y N

What forms of exercise?

What duration/intensity?

Hobbies

What are your interests/hobbies?

How often do you enjoy them?

Sleep

How many hours of sleep do you get per night? _____ hrs

Difficulty falling asleep? Y N

Do you wake during the night? Y N

How often? _____

Do you feel rested on waking? Y N

Do you take naps? Y N

For how long? _____

DIET & DIGESTION

Height: _____ Current weight: _____ Desired weight if different? _____
 Max. weight? _____ when? _____ Min. weight? _____ when?

Have you gained or lost any weight in the past 6-12 months? Y N
 If so, how much? _____

Please recall what you eat/drink in a *typical* 24 hour period:

Breakfast	
Lunch	
Dinner	
Snacks	

Are there any foods you exclude from your diet? For what reason?

Please fill in the chart below using the following scale:

- F – frequency consume (daily or more)
- O – occasionally consume (a few times a week)
- I – Irregularly consume, generally less than once a week
- D – do not consume

Alcohol	Eat out	Juice	Seaweed
Baked goods	Eggs	Milk	Soda
Beef	Fast Food	Nut butters	Sweets
Beer	Fermented foods	Nuts/seeds	Herbal tea
Black tea	Bread	Fish	Organic foods
Cooks veggies	Raw veggies	Fried foods	Pork
Cheese	Fruit	Potato chips	Water
Chicken	Grains	Refined flour	Wine
Cigarettes	Green tea	Refined sugar	Seafood
Candy	Dairy		

Are there any foods that you crave specifically? (chocolate, sweets, hot, cold, salty, sour, rich/fatty, breads, spicy)
 At what times?

How much water do you drink daily?
 What is the primary source of your drinking water (bottled, filtered, tap, well, etc)?
 What other beverages do you drink, and how much?

How often do you urinate? Every ____ hr(s)
 How often do you have a bowel movement (per day or week)?

FEMALE (if applicable)

Age at menarche (first menses)? _____ Age at menopause (if reached)? _____

Number of days for typical menstrual flow? _____ Number of days in menstrual cycle? _____

Date of last menses? _____ Number of pregnancies? _____ Number of live births? _____

Menstrual blood:

Bright red () Red brown () Red () Dark colored () Heavy flow ()
Clots () Profuse flow () Scanty flow () Slow flow ()

Menopause:

Hot flashes () Osteoporosis () Mood swings () Night sweats ()
Dry vaginal mucosa () Hormone replacement therapy () Sore muscles () Other ()

Any history of miscarriage, abortion, c-section, breech birth, twins?

With any previous pregnancies, were there any difficulties or complications to pregnancy or delivery?

Is there any chance you are pregnant now? Y N
Are you currently lactating? Y N
Do you perform regular (monthly) self breast exams? Y N
Any history of breast lumps or masses?

Do you go for a yearly PAP test? Y N Last PAP test? _____
Any history of irregular PAP test (please explain)?

MALE (if applicable)

Do you go to a doctor or ND for an annual physical exam? Y N
Date of last physical exam: _____
Do you get regular screening lab tests? Y N
Last DRE (digital rectal exam)? _____
Any irregularities found?

ADDITIONAL

Is there any other information relevant to your health that has not been addressed?

*Thank you for taking the time to complete this intake form.
Its completion will help me to understand your whole health picture, and will assist me in providing you with the best care possible.*