Kalpana Patankar MD; M.Ac; Dipl. OM

New Patient Intake Form

Date _____/______/______

Name____

Phone Home____________________________________

Address____

Phone Cell______________________________________

City______________________ State________ Zip_____________

Work Phone______________________________________

Occupation____

Email____

Birthdate_____/_____/_____ Age_______ Height_____________ Weight_____________

Sex: □ Female □ Male

Marital Status □ Married □ Domestic Partner □ Divorced □ Widowed □ Separated □ Single

How did you learn about my practice?____

Emergency Contact? Name____

Phone #___________________________ Relationship____

Physician Name ____Phone #_______________________

Physician's address____

Have you had acupuncture before?

Have you taken Chinese herbal medicine before? ________________________

The reason for today's visit?

____

____

____

How long have you had this condition?_____________________

Have you had it in the past?__________________

If yes, (in the past) describe when____

What makes it better?

____

What makes it worse?

____

Is your condition… getting worse_________ getting better________ constant_________ comes and goes__________

Family History (Please circle what is pertinent)

Alcoholism, Allergies, Arthritis, Asthma, Cancer, Coronary artery disease, Diabetes, Epilepsy, Heart disease, High blood pressure, Kidney disease, Lung disease, Liver disease, Psych. problems Stroke, Other (please explain)

Survey of your Symptoms

Musculoskeletal

Neck pain/stiffness; Mid back pain/stiffness; Leg or calf cramping; Shoulder blade pain; Low back pain/stiffness; Ankle pain/stiffness; Shoulder joint pain/stiffness; Sacroiliac pain/stiffness; Weak ankles
Upper arm pain/stiffness; Hip joint pain/stiffness; Foot or toe pain/stiffness; Elbow pain/stiffness; Pain into thigh or upper leg; Numbness or tingling in feet; Wrist pain/stiffness; Pain into calf or lower leg; Muscle spasms; Hand or finger pain/stiffness; Weak legs; Muscle weakness; Numbness or tingling in hands; Knee pain/stiffness; Paralysis; Upper back pain/stiffness; Weak knees; Stiff all over

Is the problem helped by: ______ pressure ___________heat _____________cold______________ other________________________________

Is the problem aggravated by: ______ pressure ________heat _________cold______other____________________

Gastrointestinal

Constipation; Undigested food in stool; Blood in stool; Hiatal hernia; Hard stools; Black stools; Lower abdominal pain/ cramping; Nausea; Vomiting; Bowel movements feel incomplete; Hemorrhoids; Upper abdominal pain/cramping; Belching; Frequent laxative use; Colitis; Stomach acidity; Ulcer; Diarrhea; Diverticulitis; Indigestion; Loose stools; Parasites; Gurgling noise in stomach; Mucus in stool

Erratic bowel movements; Abdominal bloating; Bad breath; Poor appetite; Foul smelling stools; Gas (flatulence); Excessive appetite

How often do you have a bowel movement?_____________

Cardiovascular

High blood pressure; Angina or chest pain; Varicose veins; Cold hands; Low blood pressure; Coronary heart disease; Bruise easily; Cold feet; Blackouts or fainting; High cholesterol.

Skin and Hair

Rashes; Herpes Zoster (shingles); Recent change in mole; Fungus on skin; Hives; Boils; Warts; Fungus under nails; itching; Pimples or acne; Dry Skin; Weak or brittle nails; Eczema; Ulcerations or sores; Moist feet; Loss of hair; Psoriasis; Recent moles; Moist palms; Dandruff; Any numb areas? Y/N

Where____

Eyes

Nearsighted (myopia); Night blindness; Eye pain; Conjunctivitis; Farsighted (hyperopia); Sensitivity to light; Dry eyes; Use eyeglasses or contacts; Astigmatism; Blurred vision; Watery eyes; Blindness; Glaucoma; Floaters; Itchy eyes; Cataracts; Pressure behind eyes; Red eyes.

Sleep

Difficulty falling asleep and wired; Nightmares; Needs to take naps; Shallow sleep; Snoring; Sleep too much; Dream disturbed sleep; Difficulty waking in a.m.; Sleep too little; Wake at night –thinking; Wake up un-refreshed; Wake at night-mind empty, eyes open; Sleepy in afternoon; Sleep with an electric blanket

How many hours do you sleep in a 24 hour period____

Urinary and Genital

Scanty or small amount of urine; Decreased flow of urine; Sores on genitals; Dark urine; Flow does not stop quickly; Pain during intercourse; Strong smelling urine; Dribbling; Low sexual energy; Cloudy urine; Bed wetting; Excessive sexual energy; Profuse or large amount of urine; Pain or burning when urinating; Inability to achieve orgasm; Clear urine; Pain in bladder area; Prostate problems; Unable to hold urine; Blood in urine; Low sperm

count; Urgency to urinate; Bladder infection; Ejaculation during sleep; Frequent urination; Kidney infection; Premature ejaculation; Difficulty urinating; Kidney stones; Inability to maintain erection
How often do you urinate in 24 hours?_____________ How often do you wake to urinate at night?_________

Pregnancy and Gynecology

Number of pregnancies; ____Vaginal discharge: strong odor; Brownish vaginal discharge; Red light colored/pale blood; itchy vaginal discharge; Frothy & profuse discharge; Dark brown vaginal discharge; white/curd-like discharge; Light flow
Age at first menses_____ Cramping after period starts; Clots; Ovarian cysts; Painful periods; Cramping before period starts; Uterine fibroids; Endometriosis; Abnormal pap
Date of last menses:__/__/___ Low backache with period
Duration of flow; Spotting between periods; Pelvic inflammatory disease; Breast cysts or lumps;
Length of cycle______ Missed periods_______ Currently have an IUD
Age at start of menses; Premenstrual irritability; Previously had an IUD
Age menses stopped; Premenstrual emotional sensitivity; Current use of birth control pills; Premenstrual breast tenderness; Previous use of birth control pill;
Reason for using ______________________ Premenstrual bloating; Other birth control__________
Premenstrual fluid retention; Cannot maintain pregnancy; Reason for______________________ Premenstrual headache; Trying to become pregnant; Pregnant?
Have not yet begun menstruating; Premenstrual constipation; Infertility; Irregular cycle; Premenstrual diarrhea; Heavy flow; Hot flashes
Number of births; Premature births; Miscarriages; Abortions; Difficult deliveries; Caesarean sections; Age of children; Nursing; Nausea or morning sickness
Any other pregnancy or gynecological problems?_____________________________________
Date of last pap test________________

Respiratory

Chronic cough; Thin, watery phlegm; Pneumonia; Asthma: more difficult exhale?, Asthma: more difficult inhale?; Dry cough; Clear or white phlegm; Pain with deep breath; Tight rattling cough; Yellowish phlegm; Shortness of breath; Loose cough; Blood in phlegm; Emphysema; Thick, sticky phlegm; Bronchitis; Wheezing Head or chest cold; Night sweats; Anemia; Recent weight loss; Flu; Perspire easily w/o exertion; Always fatigued;

General

Weight gain; Recurrent fever; Rarely perspire; Fatigued easily; Often thirsty; Chills; Jaundice; Sudden drop in energy, weight loss.

Emotional

Depression; Mood swings; Frequent crying; Suicidal feelings; Manic episodes; Anxiety or fear; Frequent anger or Irritation, obsessiveness or compulsiveness; Indecisiveness; Tendency to repress emotions; Sadness or grief; Difficulty handling stress; Have you ever been emotionally, physically or sexually abused___________________

Have you ever been treated for emotional problems?____

Have you recently had any unusually stressful experiences (divorce, death of a loved one, bankruptcy, loss of a job, illness, injury, etc.)?____

Is there a constant stress in your life, at work, with your family, etc.____

Any other emotional problems?____

Feel welcome to add additional information

Signature_________________________ Date______________________