

Central Florida Preventive Medicine Patient Intake Form

Name _____ Date _____

Address _____

Home phone _____

Work Phone _____

Cell Phone _____

Email _____

Occupation _____

Birth Date _____

Height _____ Weight _____

Emergency contact

(name & phone)

Referred by _____

___ Single ___ Married ___ Divorced ___ Significant Other ___ Widowed

___ Caregiver for dependent ___ Children _____

Have you ever had acupuncture? _____ If yes, when? _____

For what condition? _____

Are you currently under the care of a physician? _____ If so, who, and for what condition(s)? _____

Main reason(s) for seeking consultation.

How long have you experienced symptoms? _____

Your condition is improved by

Your condition is aggravated by

List all current medications, prescribed or over the counter

List all current vitamins, herbs and other supplements

Significant illnesses, current or past. (please check all that apply)

- Cancer
- Diabetes
- Hepatitis
- Heart Disease
- Stroke
- Seizures
- HIV / AIDS
- Pneumonia
- Tuberculosis
- Multiple sclerosis
- Thyroid
- Asthma
- Stomach Ulcers
- Obesity
- Depression
- Shingles
- Chronic Fatigue
- Rheumatic Fever
- High Blood Pressure
- STD's
- Other _____

Please list any surgeries you've had including dates

Please list any Allergies

Major emotional or physical traumas you've experienced

Lifestyle (please check all that apply, and note frequency of use)

- Tobacco
- Alcohol
- Recreational drugs
- Caffeinated beverages

Do you exercise? _____ Please list types of activity and frequency:

Dietary preferences

- Vegetarian
- Raw foods diet
- Low fat diet
- High protein/low carb
- Dairy /milk /cheese
- Eggs
- Chicken
- Fish / seafood
- Red meat
- Artificial sweeteners
- Fast food/ burgers/fries
- Spicy / hot
- Sweet
- Sour
- Salty
- Cold drinks
- Hot drinks
- Ice chewing
- Extreme thirst
- Thirst with no desire to drink

General symptoms

- Fatigue
- Sweat without exertion
- Night sweats
- Fever / chills
- Dizziness / vertigo
- Bleed / bruise easily
- Low immunity
- Other _____

Digestion

- Extreme appetite
- No appetite
- Cravings
- Dieting
- Tired after eating
- Bloating
- Gas
- Acid regurgitation
- Heartburn/Ulcers
- GERD
- Nausea

- Vomiting
- Bulimia
- Anorexia
- Irritability or low energy between meals
- Other _____

How many meals per day? _____ How many snacks per day? _____

Intestinal

- Diarrhea
- Constipation
- Hemorrhoids
- Anal itching / burning
- Laxative use
- Bloody stool
- Mucous in stool
- Anal fissures
- Rectal prolapse
- Intestinal pain/cramping
- Incomplete evacuation
- IBS
- Colitis
- Crohn's Disease
- Gout
- Celiac Disease
- Gallstones
- Other _____

Sleep

- Falls asleep easily
- Lie in bed with eyes open
- Wake as specific times
- Wake repeatedly
- Wake frequently to urinate
- Vivid or Lucid Dreams
- Wake up not feeling rested
- Nightmares or Frightening dreams
- Need drugs or supplements to fall asleep

Head, Eyes, Ears, Nose and Throat

- Dry eyes
- Spots / flowery vision
- Blurred vision
- Poor vision
- Eye strain
- Night blindness

- Cataracts
 - Macular degeneration
 - Bleeding gums
 - TMJ
 - Sores on tongue or mouth
 - Dry mouth
 - Excess saliva
 - Sinus problems
 - Post-nasal drip
 - Sore throat
 - Headaches
 - Swollen glands
 - Difficulty swallowing
 - Earaches
 - Tinnitus / ringing
 - Deafness
 - Nosebleed
 - Other
-

Cardiovascular / respiratory

- Heart palpitations
- Chest pain
- Difficulty breathing
- High cholesterol
- Varicose veins
- Blood clots
- Swollen ankles
- Heart valve abnormality
- Shortness of breath
- Cold hands / feet
- Dry cough
- Wheezing
- Chest tightness
- Difficult inhalation
- Difficult exhalation
- Productive cough (color of phlegm?)

- Other _____

Skin / hair

- Dry skin
- Rashes / hives
- Eczema
- Psoriasis

- Pimples / acne
- Fungal infections
- Brittle nails
- Ridged nails
- Hair loss
- Dandruff
- Other _____

Musculoskeletal

- Spinal pain
- Joint pain
- Tendonitis
- Swelling
- Arthritis
- Limited range of motion
- Disc degeneration
- Osteoporosis
- Numbness
- Carpal tunnel
- Other _____

Neuropsychological

- Anxiety
- Irritability
- Insomnia
- Depression
- Easily stressed
- Poor memory
- Seasonal mood disorder
- Tics
- Tremors
- Death of someone close
- Job stress
- Recent divorce
- Currently in therapy
- Financial setback
- Other _____

Emotional stress scale

1 2 3 4 5 6 7 8 9 10
 no stress moderate extremely stressed

Rate your stress level regarding

Work _____

Health _____

Love _____

Money _____

Family _____
The future _____

Genito-urinary

- Frequent urination
- Loss of urine when laughing or sneezing
- Incomplete urination / retention
- Dribbling
- Burning urination
- Blood in urine
- Wake frequently to urinate
- Kidney stones
- Bedwetting
- Bladder Prolapse
- Decreased libido / sexual desire
- Other _____

Men only

- Enlarged prostate
- Prostate cancer
- Testicular cancer
- Testicular pain or swelling
- Erectile dysfunction
- Impotency
- STD's _____

Women only

Age menses began _____ Age menses ended (if applicable) _____

Date of last Ob/Gyn exam _____

Hysterectomy? partial full

- Hormone replacement therapy
- Live births
- Miscarriage
- Abortions
- Infertility
- Birth control pills
- Breast cancer
- Ovarian cysts
- Fibroids
- Endometriosis

- Candida / yeast
- Vaginal discharge
- Vaginal odor
- Vaginal sores
- Herpes
- Human Papilloma Virus positive
- Uterine prolapse
- STD history (chlamydia, PID, etc)
- Fibrocystic breast

Period lasts _____ days Usual number of days in cycle _____

Headaches ___ before menstrual cycle ___ during cycle ___ after cycle ___

- Pain at ovulation
- Cramps / low back pain
- Acne associated with period
- Constipation associated with period
- Diarrhea associated with period
- Depression or irritability with period
- Bleeding outside of normal menstrual cycle
- No period / skipped cycles
- Irregular cycle Menstrual flow
- Clotting
- Brownish
- Watery, thin and bright red
- Normal red
- Flooding and trickling
- Stop and start flow

If you have been evaluated for infertility, what was your diagnosis?

Payment and Cancellation Policies

Payment is by check, cash or credit card. Make checks payable to **Central Florida Preventive Medicine**. Full payment is expected at the time the services are rendered.

A **\$40** charge for the first check returned by the bank. If a second check is returned, subsequent payments must be money order or cash.

If you must cancel your appointment, please give 24hrs notice if it all possible. Exceptions will be made for medical emergencies. *A **\$50.** fee will be charged for all 'no-shows' or failure to cancel within 24 hours of appointment time.*

I, _____, certify that I have read and understood the statements above and agree to abide by them.

Signature: _____ Date: _____