Root Therapies

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New Patient Intake Form

Date:___________

Name ___________________________ Date of Birth____/____/____

Occupation_____________________________Address:_______________________________________

City_____________________State__________Zip____________Telephone_____________________

E-mail____

Do you wish to receive our E-newsletter? Yes □ No □

Another person we may contact in case of an emergency__________________________________

Phone _______________________ Relationship ____

How did you hear about us?____

Name & phone of Primary Care Physician____

Permission to contact Primary Care Physician: Yes □ No □

When was last complete medical exam?____

Services Requested Today (Check all you may be interested in):

Acupuncture □ Herbs □ Supplements □ B12 Injection □ Homeopathic Injection □

Primary Concern:

____

How long have you had this condition?________________ Was onset sudden □ gradual □

Pain scale of 0-10 (0 is none, 10 is highest) please circle: 1 2 3 4 5 6 7 8 9 10

Do you have a medical diagnosis ____

What other treatments have you received for this and/or other conditions?

____

Are you taking any medications? Please note all medications, vitamins, herbs, minerals you take, **AND THE REASONS** for taking them.____

____

Are you currently pregnant? Yes □ No □ Are you trying to get pregnant? Yes □ No □

Secondary Concerns:

____

Medical & Family History

Any surgery, illness accidents or birth trauma? Please list in chronological order and indicate length of illness or injury.

____

____

Family History:____

____

Please check if you have you had any of these in last three months

__ Insomnia	__Weight loss/gain	__Thirst	__ Poor balance
__ Poor appetite	__ Cravings	__Sweating easily	__ Localized weakness
__ Chills	__ Change in appetite	__ Bruising easily	__ Edema
__ Fever	__ Sudden energy drop	__ Tremors	__ Disturbed sleep

Other unusual or abnormal conditions you have noticed in your general health:

____

Diet and Food:

How is your appetite? ☐ Good ☐ Poor ☐ No appetite ☐ Hungry all the time

Any food cravings?____

Sleep and Emotions:

I have difficulty with: ☐ Falling asleep ☐ Staying asleep ☐ Disturbed sleep

Waking up at about ________am / pm

Do you use prescription or non-prescription substances? ☐ Anti-depressants ☐ Sleeping pills

Other____

Eyes, Ears, Nose, Throat & Head:

☐ Frequent Cold	☐ Motion sickness	☐ Poor vision	☐ Concussions
☐ Dizziness	☐ Ringing in ears (high/low)	☐ Dry eyes	☐ Dry mouth
☐ Sinus problems	☐ Earaches	☐ Cataracts	☐ Headache
☐ Frequent sore throat	☐ Hearing loss	☐ Night blindness	☐ Jaw clicks
☐ Bleeding gums	☐ Spots in front eyes	☐ Facial pain	☐ TMJ

Cardiovascular/ Respiratory:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Irregular heartbeat
- ☐ Poor circulation
- ☐ Cold hand & feet
- ☐ Varicose veins
- ☐ Neuropathy
- ☐ Swelling hand/ feet
- ☐ Excess phlegm (color_______)
- ☐ Asthma
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Pneumonia

Gastrointestinal:

- ☐ Belching
- ☐ Vomiting
- ☐ Nausea
- ☐ Acid regurgitation
- ☐ Gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Undigested food in stool
- ☐ Bad breath/ bad taste in mouth
- ☐ Hemorrhoids
- ☐ Hernia

Muscles, Joints & Bones:

- ☐ Neck pain
- ☐ Back pain
- ☐ Knee pain
- ☐ Shoulder pain
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Hand/wrist pain
- ☐ Bone pain
- ☐ Numbness
- ☐ Swollen joints
- ☐ Fibromyalgia
- ☐ Muscle weakness

Skin & Hair:

- ☐ Dry skin
- ☐ Skin rashes
- ☐ Acne
- ☐ Ulcerations
- ☐ Warts
- ☐ Hair loss
- ☐ Eczema
- ☐ Psoriasis
- ☐ Premature graying

Neuropsychology:

- ☐ Depression
- ☐ Easily stressed
- ☐ Poor memory
- ☐ Lack of coordination
- ☐ Anxiety
- ☐ Bad temper

Genitourinary & Reproductive:

- ☐ Painful urination
- ☐ Sores on genitals
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Premature ejaculation
- ☐ Decreases in flow

☐ Frequent urination ☐ Testicular pain ☐ Enlarged prostate

Do you wake to urinate?_________ If so, how often?_________per night. Any particular color?________

Female:

Number of days between cycles________________

Number of days of flow__________Color: Dark red ☐ Bright red ☐ Pink ☐ Brown ☐

Pregnant now/trying to become pregnant?_____Number pregnancies? _____Number deliveries_____

Are you using birth control? Yes ☐ No ☐ How long?_____________What type?___________

Pregnancy complications? Please describe:____

____

Menopause Date:____________Symptoms:____

Hormone replacement?___________Type?____

☐ Painful menses ☐ Miscarriages ☐ Clots

☐ Heavy/ Light menses ☐ PMS ☐ Vaginal discharge

☐ Irregular menses ☐ High/ low libido ☐ Infertility

I have read and understand the Welcome Letter and Financial Policy, and would like to be treated.

Date _________________________

Print Name____

Signature____

Practitioner Signature____