PACIFIC NATUROPATHIC
MEDICAL CENTER

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New Patient Form

(PLEASE PRINT LEGIBLY) Today's Date:_____

Last name	First name	M.I.	M / F Sex	Birthdate	Age

Address	City	State	Zip

( ) Phone	( ) Cell	Email

Referred by:_____

Have you ever had acupuncture? **Yes / No**

Name of primary health care provider and practice (M.D., Chiropractor, etc.)

Are you currently under the care of this health care provider? **Yes / No**

Are you currently taking any prescribed medications? If so, please list: **Yes / No**

Are you currently taking any vitamins, supplements, or herbs? If so, please list: **Yes / No**

Present health concerns (include diagnosis if applicable):

What makes it better?

What makes it worse?

Please rate your general energy level on scale of 1-10: 1 = exhausted & 10 = great: _____

What time of day do you feel best? _____ Worst? _____

Hobbies / Interests:

_____

_____

What are your **most commonly experienced** emotions? Please 'X'
Anger_____ Frustration_____ Worry_____ Sadness_____ Fear_____ Excitement_____ Joy_____

What emotions do you have a **difficult** time expressing? Please 'X'
Anger_____ Frustration_____ Worry_____ Sadness_____ Fear_____ Excitement_____ Joy_____

PAST HISTORY OF:

Adult/Childhood Illness:

_____

_____

Surgeries:

_____

_____

WOMEN

Age of first period:_____ Last pap:_____ Results:_____

Length of full monthly cycle:_____days Duration of flow:_____days Is cycle regular? **Yes / No**

Any spotting? **Yes / No** Pain? **Yes / No** PMS? **Yes / No** Vaginal discharge? **Yes / No** Other?_____

Pregnant? **Yes / No** Children? **Yes / No** Ages?_____ Birth control? **Yes / No** If yes, type?_____

MEN

History of impotence, premature ejaculation, fertility difficulties, discharge from penis, vasectomy, etc.

_____

_____

STDs (herpes, warts, etc.)?_____
Children? **Yes / No** Ages?_____

DIET
How much of each of the following do you consume daily?
Recreational drugs (i.e. marijuana):_____
Coffee / tea / caffeinated beverages:_____
Dairy products (milk, cheese, butter, yogurt, ice cream, etc.):_____
Meat / fish / poultry:_____
Breads / grains:_____
Cooked vegetables:_____
Raw fruits / raw vegetables:_____
Specific food / flavor cravings:_____
Typical day's menu (include content and time you normally eat)

YESTERDAY	Time	Content
Breakfast:		
Lunch:		
Dinner:		
Snacks:		

Exercise (type, duration, number of times per week):_____

Which of the following make you feel **bad/worse**? Please 'X'
Cold_____ Heat_____ Damp_____ Dry_____ Wind_____ Humidity_____ Fog_____

Which of the following make you feel **good/better**? Please 'X'
Cold_____ Heat_____ Damp_____ Dry_____ Wind_____ Humidity_____ Fog_____

Do you have any intolerance to heat or cold (food, drinks) or areas of the body that are hot or cold?

Please tell me about any previous treatments you have tried for your condition (Acupuncture, Homeopathy, Massage, Nutrition, M.D., etc.) and the results:

PLEASE CHECK ALL THAT APPLY:

General

( ) Bleed or Bruise Easily
( ) Always Sleepy
( ) Can't Fall Asleep
( ) Can't Stay Asleep
( ) Excess Dreaming
( ) Sweat Easily with Exertion
( ) Night Sweats
( ) Spontaneous Day Sweat
( ) Always Cold
( ) Always Hot
( ) Better with Cold
( ) Better with Heat
( ) Chills
( ) Feverish at Night
( ) Feverish During Day
( ) Fevers
( ) Heaviness of Body
( ) Heaviness of Limbs
( ) Hot Palms/Soles
( ) Memory Loss
( ) Poor Memory
( ) Forgetfulness
( ) Always Thirsty
( ) Thirsty for Hot
( ) Thirsty for Cold
( ) No Thirst
( ) Weight Gain
( ) Weight Loss

Cardiovascular

( ) Blood Clots
( ) Chest Pain
( ) Cold Hands/Feet
( ) Easily Fatigued
( ) Fainting
( ) Fullness
( ) High Blood Pressure
( ) Irregular Heart Beat
( ) Low Blood Pressure
( ) Palpitations
( ) Phlebitis
( ) Swelling of Hands/Feet

Ears

( ) DecreasedHearing
( ) Infection
( ) Ringing- High pitch
( ) Ringing- Low pitch

Genito-Urinary

( ) Blood in Urine
( ) Frequent Urination
( ) Kidney Stones
( ) Pain or Urination
( ) Unable to Hold Urine
( ) Urgency to Urinate

Eyes

( ) Blurred Vision
( ) Cataracts
( ) Dry Eyes
( ) Eye Inflammation
( ) Glasses/Contacts
( ) Poor Night Vision
( ) Poor Vision
( ) Red/Painful
( ) Redness/Dryness
( ) Spots/Floaters
( ) Visual Changes
( ) Blurry Vision
( ) Excessive Tearing
( ) Floaters

Head & Neck

( ) Concussions
( ) Dizziness
( ) Enlarged Lymph Glands
( ) Fainting
( ) Headaches
( ) Migraine
( ) Neck Stiffness

Gastro-Intestinal

( ) Bad Breath
( ) Belching
( ) Burning Rectum/Anus
( ) Constipation
( ) Diarrhea - Acute
( ) Diarrhea - Chronic
( ) Excessive Appetite
( ) Poor Appetite
( ) Gall Bladder Disorder
( ) Stool – Blood/Black
( ) Stool - Burning
( ) Stool - Difficult to pass
( ) Stool - Dry Stool
( ) Stool - Loose Stool
( ) Stool – Undigested food
( ) Gas
( ) Hemorrhoids
( ) Hernia – Inguinal/Umbillical
( ) Indigestion
( ) Nausea
( ) Pain or Cramps
( ) Rectal Pain
( ) Vomiting

Infection Screening

( ) Chlamydia
( ) Genital Warts
( ) Gonorrhea
( ) Hepatitis
( ) Hepatitis A/B/C
( ) Herpes: Genital
( ) Herpes: Oral
( ) HIV
( ) Syphilis
( ) TB

Musculo-Skeletal

( ) Upper Back Pain
( ) Joint Pain
( ) Low Back Pain
( ) Muscle Spasm, Twitching, Cramps
( ) Sore, Cold or Weak Knees
( ) Stiff Neck/Shoulders
( ) Weather Sensitivity

Neurological

( ) Concussion
( ) Numbness/Tingling of Limbs
( ) Pain
( ) Painful Gums
( ) Paralysis
( ) Seizures
( ) Tremors
( ) Numbness: Where?_____
( ) Poor Coordination

Respiratory

( ) Asthma
( ) Bronchitis
( ) Difficult to Inhale
( ) Difficulty Breathing
( ) Shortness of Breath
( ) Wheezing
( ) Frequent Colds
( ) Chronic Obstructive
( ) Pneumonia
( ) Cough
( ) Coughing Blood
( ) Production of Phlegm
( ) Clearing Throat Often

Skin, Hair & Nails

( ) Dryness
( ) Eczema
( ) Hives
( ) Itching
( ) Pimples
( ) Psoriasis
( ) Rashes
( ) Tumors, Lumps
( ) Dry/Dull Hair
( ) Hair Loss
( ) Premature Gray Hair
( ) Brittle Nails

Nose, Throat & Mouth

( ) Catch Cold Easily
( ) Dry Nose
( ) Hay Fever or Allergies
( ) Nose Bleeds
( ) Sinus Infections
( ) Discharge:
Color?_____
( ) Chronic Hoarseness
( ) Coughing Mucus:
Color?_____
( ) Difficulty Swallowing
( ) Frequent Sore Throat
( ) Recurring Sore Throats
( ) TMJ
( ) Voice:Hard to Project?
( ) Grinding Teeth
( ) Sores on Gums
( ) Sores on Lips
( ) Sores on Tongue
( ) Tooth Loss
( ) Bleeding Gums

Psychological

( ) Anxiety/Stress
( ) Depression
( ) Irritability
( ) Easily Startled
( ) Fear
( ) Grief/Sadness
( ) Hysteria
( ) Indecisiveness
( ) Irritable
( ) Can't "Stop Going"

I agree that the above information is accurate and true to my knowledge.

_____

Signature of patient **Date**