Heather Ruth, L.Ac.. CBP, Reiki 3A

New Patient Intake Form

Date: _____/_____/_____ Date of Birth: _____/_____/_____ Age: _____

Name: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone # to contact you: _____ ___ Cell ___ Home ___ Office

Alternate Phone #: _____

Marital Status: M S D W Height: _____ Weight: _____ Blood Type _____

Occupation: _____ Referred by: _____

Emergency contact name: _____ Phone#: _____

Have you had acupuncture / holistic care before? ___ Yes ___ No If so, when? _____

CONFIDENTIALITY: In the event this office needs to contact you:
May we leave a message for you with someone at your home phone number? _____ Yes _____ No
May we leave a message for you on your home voicemail? _____ Yes _____ No
May we send you an email? _____ Yes _____ No

REASON FOR VISIT TODAY: _____

_____

How long have you had the condition/symptoms? _____

Do you currently take any herbal supplements? ____ Yes (Please list) ____ No

Name	Dose	Frequency	Start Date (MM/YR)	Reason for Use

Do you currently take any vitamins/supplements? ____ Yes (Please list) ____ No

Name	Dose	Frequency	Start Date (MM/YR)	Reason for Use

Do you currently take any medications (prescription or over the counter)? ____ Yes (Please list) ____ No

Name	Dose	Frequency	Start Date (MM/YR)	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems? ____ Yes ____ No

Describe: _____

Have you had prolonged or regular use of: NSAIDS (Advil, Aleve, etc.), Motrin Aspirin Tylenol Allergy shots

Name	Dose	Frequency	Start Date (MM/YR)	Reason for Use

Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ____ Yes ____ No

Name	Dose	Frequency	Start Date (MM/YR)	Reason for Use

Antibiotics > 3 times/year ____ Yes ____ No

Name	Dose	Frequency	Start Date (MM/YR)	Reason for Use

Corticosteroids (prednisone, nasal inhalers) ____ Yes ____ No Seasonal? ____ Yes ____ No

Name	Dose	Frequency	Start Date (MM/YR)	Reason for Use

Hormonal (Progesterone, Estrogen, Testosterone) ____ Yes ____ No

Name	Dose	Frequency	Start Date (MM/YR)	Reason for Use

Do you use oral contraceptives? ____ Yes ____ No

Which brand? _____

Do you use over the counter creams or lotions of any kind? ____ Facial/Eye ____ Revitalizing ____ Skin moisturizers

Which brands: _____

Are you currently under the care of a physician? ___ Yes ___ No

If yes, explain. _____

Who is your physician? _____

Physician's Phone#: _____

Other concurrent therapies: _____
(Massage, chiropractic, hormonal, diabetes, etc.)

LIFESTYLE:

If you smoke: no. packs per week: _____ How long: _____ years Attempts to quit: _____

Previous smoker: no. packs per week: _____ How long: _____ years Attempts to quit: _____

Second hand smoke exposure: ___ work ___ home ___ social settings

Do you get regular flu shots? ___ Yes ___ No Date of last shot: _____

List other vaccinations:

Vaccinations	**Date of last shot**	**Frequency**
Malaria		
Typhoid		
Dengue Fever		
Polio		
Pneumonia		
Other		

SLEEP CYCLE:

Difficulty falling asleep? ___ Yes ___ No

No. of hours sleep per night? _____ Wake up in middle of night? ___ Yes ___ No

Snore? ___ Yes ___ No Type of sleep: (eg. restful or fitful) _____

Use of sleep aids? ___ Yes ___ No If yes, what type? _____

DAILY SCHEDULE:

No. of hours spent at work: _____ Occupation: _____

Stress level at work**:** (0 = no stress; 10 = most severe) _____

Time spent commuting to and from work: (one way) _____

Stress level during commute: (0 = no stress; 10 = most severe) _____

Stress level at home**:** (0 = no stress; 10 = most severe): _____

Overall energy level (rate on a scale from 1 to 10, 10 being the highest): _____

_____ Morning _____ Afternoon _____ Evening

Do you belong to a gym? _____ Yes _____ No No. of times per week at gym: _____

List exercises that you do and how frequently you do them. (Pilates, walk/run/gym equipment/sports etc.)

_____

_____

Do any of these significantly effect you –

____ cigarette smoke ____ perfumes/colognes ____ fragrance in hair sprays, gels, etc.

____ auto exhaust fumes other: _____

Are you exposed to harmful chemicals in your home or work environment, such as

____ herbicides ____ insecticides ____ pesticides ____ chemicals (cleaning)

____ dry cleaning; if so how often _____

____ organic solvents ____ heavy metals other: _____

List exposure information:

Chemical Name	Date	Length of exposure

Mold exposure ____ Yes ____ No Type of mold: _____

____ Home ____ Workplace Length of exposures: _____

Pets: ____ Dog ____ Cat Other: _____

Please check all that apply.

__ Poor Appetite
__ Heavy Appetite
__ Poor Sleep
__ Heavy Sleep
__ Poor Circulation
__ Shortness of Breath
__ Sweat easily
__ Muscle Cramps
__ Early Waking
__ Flushing
__ Dream disturbed sleep
__ Fever
__ Chills
__ Fatigue
__ Lack of Strength
__ Recent weight loss or gain
__ Cold hands or feet
__ Bleed or Bruise easily
__ No dream recall
__ Nightmares
__ Strongly like cold drinks
__ Strongly like hot drinks
__ Vertigo or dizziness
__ Peculiar taste in mouth
__ Night Sweats
__ Bodily Heaviness
__ Daytime sleepiness
__ Low body temperature
__ Difficulty falling asleep

Please explain above problems or list any significant others: _____

_____

_____

DIET:

Appetite: _____ low _____ high _____ regular

How many --

cups of coffee do you drink per day? _____ ounces: _____ creamer ___ Yes ___ No

artificial sweeteners ___ Yes ___ No

____ high-test ___ caffeinated ___ decaffeinated

Adverse reaction to caffeine? ____ Yes ____ No

When you drink caffeine do you feel:

____ Irritable ____ Wired ____ Aches & Pains Other: _____

cups of tea do you drink per day? _____ ounces: _____ creamer ___ Yes ___ No

artificial sweeteners ___ Yes ___ No

___ herbal ___ green ___ black

cups of soda do you drink per day? _____ ounces: _____ ___ sugar-free ___ regular

energy drinks per day? _____ High-test ____ caffeinated _____ decaffeinated ____

glasses of water do you drink per day? _____ ounces: _____

Alcohol: _____ Yes _____ No If yes, how often? _____

____ Beer ____ Wine ____ Liquor

Do you use artificial sweeteners? ___ Yes ___ No How often? _____

If yes, which ones? _____

Any food cravings for: ___ sweet ___ salty ___ spicy ___ bitter ___ greasy ___ fried

When and how often do the cravings occur? _____

Do you adversely react to (check all that apply):

____ monosodium glutamate (MSG) ____ Aspartame (NutraSweet) ____ Bananas

____ garlic ____ onion ____ cheese ____ citrus ____ chocolate

____ alcohol ____ red wine sulfites ____ sulfites/dried fruit ____ sulfites/salad bars

____preservatives (eg. sodium benzoate) other preservatives: _____

Eat meals on a regular basis:

breakfast: ___ Yes ___ No lunch: ___ Yes ___ No dinner: ___ Yes ___ No

No. of times eat out each week / which meals: _____

_____

Regular diet type:

___ Low Fat ___ Low Carbohydrate ___High Protein ___ Low Sodium ___ Metabolic

___ Diabetic ___ Dairy Free ___ Gluten Free ___ Soy Free ___ Vegetarian ___ Vegan

___ Organic (what percentage?) _____

Currently on a weight loss program? ___ Yes ___ No If yes, what type? _____

Please list any significant other issues not listed in section above:

_____

_____

AVERAGE DAILY MENU (do not alter your regular diet) (List - include what you drink and eat in each category)

	Day 1	Day 2	Day 3
Breakfast _____ AM			
Morning Snack _____ AM			
Lunch ____ PM			
Afternoon Snack ____ PM			
Dinner ____ PM			
Evening Snack ____ PM			
Beverages (include # of all beverages (coffee, tea, sodas/diet sodas, water, sports drinks, energy drinks, alcohol, milk, etc.)			

Preventive Tests and Date of LAST Test - *Check box if yes and provide date*

Test	Date	Yes	No	Reason
Full Physical Exam				
Blood Test				
Bone Density				
Colonoscopy				
Urine Test				
Stool Test				
Ultrasound				
EKG				
MRI				
CT Scan				
Radiograph				
Cardiac Stress Test				
Upper Endoscopy				
Upper GI Series				
Salivary Hormones				
Thyroid				
Diabetes				

SURGERIES

Surgery	Date	Yes	No	Reason
Appendectomy				
Hysterectomy +/- Ovaries				
Gall Bladder				
Hernia				
Tonsillectomy				
Dental Surgery				
Joint Replacement				
Knee				
Hip				
Heart Surgery–Bypass Valve				
Pacemaker				
Angioplasty or Stent				
Transplants				
Other				

PLEASE LIST AND DATE YOUR SIGNIFICANT INFECTIONS, TRAUMAS, AND ACCIDENTS IN YOUR LIFE.

Infections	Yes	No	Date	Treatment
Chicken Pox				
Mumps				
Measles				
Herpes				
Typhoid Fever				
Dengue Fever				
Malaria				
Venereal Disease				
Polio				
Rheumatic Fever				
Tuberculosis				
Other				
TRAUMAS /ACCIDENTS				
Auto accidents				
Hiking Accidents				
Boating Accidents				
Sports Injuries				
Other				

Concussion /Trauma	Yes	No	Date	Cause	Treatment

Have you been DIAGNOSED with any of the following DISEASES?

CARDIOVASCULAR

Condition	Date of onset	Treatment ongoing Yes/No	Type of Treatment
Heart Attack			
Stroke			
Elevated Cholesterol			
Elevated Triglycerides			
Arrhythmia (irregular heart rate)			
Hypertension (high blood pressure)			
Rheumatic Fever			
Mitral Valve Prolapse			
Anemia			
Arteriosclerosis			
High blood pressure			
Enlarged Aorta			
Other			

GASTROINTESTINAL

Condition	Date of onset	Treatment ongoing Yes/No	Type of Treatment
Irritable Bowel Syndrome			
Inflammatory Bowel Disease			
Crohn's			
Ulcerative Colitis			
Gastritis or Peptic Ulcer			
Ulcers			
GERD (reflux)			
Celiac Disease			
OTHER:			

METABOLIC/ENDOCRINE

Condition	Date of Onset	Treatment Ongoing? Yes / No	Type of Treatment
Type 1 Diabetes			
Type 2 Diabetes			
Insulin Resistance or Pre-Diabetes			
Hypoglycemia			
Metabolic Syndrome			
Hypothyroidism (low thyroid)			
Hyperthyroidism (overactive thyroid			
Hashimoto's Autoimmune Thyroid			
Polycystic Ovarian Syndrome (PCOS			
Infertility			
Weight Gain			
Weight Loss			
Frequent Weight Fluctuations			
Bulimia			
Anorexia			
Binge Eating Disorder			
Night Eating Syndrome			
Eating Disorder (non-specific)			

CANCER

Condition	Date of Onset	Surgery Yes/No	Treatment ongoing Yes/No	Type of Treatment
Lung				
Colon				
Prostate				
Breast				
Ovarian				
Skin				
Other:				

URINARY SYSTEMS

Condition	Age/Date Of Onset	Current Treatment Yes/No	Type of Treatment
Kidney Stones			
Kidney Infections			
Gout			
Interstitial Cystitis			
Frequent Urinary Tract Infections			
Frequent Yeast Infections			
Other			

INFLAMMATORY/AUTOIMMUNE

Condition	Age/Date Of Onset	Treatment ongoing Yes/No	Type of Treatment
Chronic Fatigue Syndrome			
Autoimmune Disease			
Rheumatoid Arthritis			
Lupus SLE			
Lymes			
Immune Deficiency Disease			
Herpes-Genital			
Herpes – Mouth			
Severe Infectious Disease			
Poor Immune Function			
Frequent Infections			
Other			

RESPIRATORY DISEASES

Condition	Age/Date of Onset	Treatment ongoing Yes/No	Type of Treatment
Asthma			
Bronchitis			
Chronic Sinusitis			
Emphysema			
Pneumonia			
Tuberculosis			
Sleep Apnea			
Whooping Cough			
Other			

SKIN DISEASES

Condition	Age/Date of Onset	Treatment ongoing Yes/No	Type of Treatment
Eczema			
Psoriasis			
Acne			
Melanoma			
Skin Cancer			
Other			

NEUROLOGIC/MOOD

Condition	Date of Onset	Treatment ongoing Yes/No	Type of Treatment
Anxiety			
Depression			
Panic Attacks			
Bipolar Disorder			
Migraines			
ADD/ADHD			
Autism			
Mild Cognitive Impairment			
Memory Problems			
Parkinson's Disease			
ALS			
Seizures			
Type:			
Epilepsy			
Paralysis			
Type:			
Other			

MUSCULOSKELETAL/PAIN

Condition	Date of Onset	Treatment ongoing Yes/No	Type of Treatment
Osteoarthritis			
Fibromyalgia			
Rheumatoid Arthritis			
Arthritis			
Chronic			
Other			

OBSTETRICS HISTORY *(FOR WOMEN ONLY)*

	Yes	No	Date of Onset	Date due
Currently Pregnant				

Previous Pregnancies	Yes	No	Number	Delivery / Procedure Date
Caesarean				
Vaginal Deliveries				
Breast Feeding (duration)				
Miscarriage				
Abortion *				

* You do not need to answer this inquiry

Complications	Yes	No	Date of Onset	Date End	Type of Treatment
Post Partum Depression					
Toxemia					
Gestational Diabetes					
Other					

MENSTRUAL HISTORY

Age at First Period _____ Menses Frequency: _____ No. of days: _____
Pain: ____ Yes ____ No Clotting: ____ Yes ____ No

Has your period ever skipped? _____ For how long?_____ Last Menstrual Period: _____

Hormonal Contraception	Yes	No	How long? Brand?
Birth control pills			
Patch			
Nuva Ring			
Contraception Devices			
Condom			
Diaphragm			
IUD			
Partner Vasectomy			
Abstinence			

Please check all that apply:

Premenstrual / PMS	Yes	No	No. days before cycle starts
Constipation			
Diarrhea			
Increased sleep			
Decreased sleep			
Bloating			
Breast Tenderness			
Fatigue			
Irritability			
Sweet cravings			
Salty cravings			
Other cravings			

Please check all that apply:

Menstrual	Yes	No	Comments
No periods			
Cramps			
Scanty Periods			
Heavy Periods			
Spotting Between			
Irregular			
Painful Period			
Vaginal discharge (color)			

Please check all that apply:

Condition / Symptom	Yes	No	Treatment ongoing Yes/No	Type of Treatment
Fibrocystic Breasts				
Breast lumps/cysts				
Breast Tenderness				
Endometriosis				
Fibroids				
Infertility				
Vaginal sores				
Vaginal odor				
Vaginal itch				
Vaginal pain with sex				
Hysterectomy				
Ovarian Cyst				
Venereal disease				
Other				

ANNUAL SCREENINGS

Test	Date	Yes	No	Reason / Treatment
Last Mammogram				
Normal				
Abnormal				
Breast Biopsy/Date				
Normal				
Abnormal				
BRCA Gene Test				
Positive				
Negative				
Last PAP Test				
Normal				
Abnormal				
Last Bone Density				
High				
Low				
Normal Range				
Other				

	Yes	No	Date of Onset	Reason
Menopause				
Age at onset:				
Peri-menopause				
Age at onset:				
Post-menopause				
Age at onset:				

Symptoms	Yes	No	Date of Onset	Reason
Hot Flashes				
Mood Swings				
Concentration				
Memory Issues				
Vaginal Dryness				
Decreased Libido				
Increased Libido				
Loss of Urinary control				

Use of hormone replacement therapy: ____ Yes ____ No Type of therapy: _____
Brand: _____ Dosage: _____

MALE DISORDERS

Date of your last PSA done _____ PSA Level: 0-2 2-4 4-10 >10
Have you had any of the following in the last year?

Condition	Date of Onset	Treatment ongoing Yes/No	Type of Treatment
Prostate Enlargement			
Prostate infection			
Prostate cancer			
Prostate “shots” (i.e.: Eligard)			
Change in Libido			
Impotence			
Difficulty Obtaining an Erection			
Difficulty Maintaining an Erection			
Decreased Frequency of Morning Erections			
Enlarged breasts			
Fluid discharge from nipples			
Nocturia			
Urination at night			
Frequent urination			
Urgency			
Hesitancy			
Change in Urinary Stream			
Loss of Control of Urine			
Discharge from penis			
Ejaculation problem			
Lumps in testicles			
Genital Pain			
Erectile dysfunction			
Sexual dysfunction			
Venereal disease			

GENERAL SYMPTOMS/CONDITIONS

HEAD, EYES, EARS, NOSE, AND THROAT

Please check all that apply within last 6 months.

__ Glasses or Contacts
__ Eye strain
__ Eye pain
__ Red eyes
__ Itchy eyes
__ Spots in Eyes
__ Poor vision
__ Blurred vision
__ Night blindness
__ Nose bleeds
__ Headaches
__ Conjunctivitis
__ Distorted sense of smell
__ Retina detachment
__ Vitreous detachment
__ Bleeding gums
__ Hearing aids
__ Glaucoma
__ Cataracts
__ Dry eyes
__ Grinding teeth
__ Teeth problems
__ Facial pain
__ Gum problems
__ Sores on lips or tongue
__ TMJ
__ Poor hearing
__ Migraines
__ Ear Pain
__ Ear ringing/buzzing
__ Hearing loss
__ Lid Margin redness
__ Dentures
__ Dry Mouth
__ Blindness
__ Excessive saliva
__ Sinus problems
__ Excessive Phlegm
List Color:_____
__ Recurring sore throat
__ Swollen glands
__ Lumps in throat
__ Enlarged thyroid
__ Sensitive to loud noises
__ Concussions How many: _____
__ Macular degeneration
__ Distorted sense of taste
__ Ear Fullness
__ Eye crusting
__ Partial plates

Please explain above problems or list any significant others: _____

_____

NAILS

__ Bitten
__ Fungus/fingers
__ Ridges
__ Thickening Toenails
__ Brittle
__ Fungus/toes
__ Soft
__ Other _____
__ Curve up
__ Pitting
__ Thickening Fingernails
__ Frayed
__ Ragged cuticles

RESPIRATORY

Please check all that apply.

__ Difficult breathing when lying down
__ Tight chest
__ Cough
__ Color of phlegm? _____
__ Pneumonia
__ Hoarseness
__ Snoring
__ Sore Throat
__ Wheezing
__ Hayfever
__ Winter Stuffiness
__ Nasal Stuffiness
__ Shortness of breath
__ Asthma/ wheezing
__ Dry or with phlegm
__Coughing blood
__ Bad breath
__ Nose Bleeds
__ Bad Odor in Nose
__ Post Nasal Drip
__ Cough-Dry
__ Sinus Fullness
__ Cough- productive
__ Sinus Infection

Other: _____

CARDIOVASCULAR

Please check all that apply.

__ High blood pressure
__ Low blood pressure
__ Chest pain/angina
__ Phlebitis
__ Heart Murmur
__ Tachycardia
__ Difficulty breathing
__ Blood clots
__ Atrial fibulation
__ Swollen ankles/feet
__ Palpitations
__ Irregular heartbeat/pulse
__ Fainting
__ Breathlessness
__ Varicose Veins

Other: _____

GASTROINTESTINAL

Please check all that apply.

__ Nausea
__ Vomiting
__ Acid Regurgitation
__ Gas
__ Hiccup
__ Bloating
__ Bad Breath
__ Diarrhea
__ Constipation
__ Black stools
__ Bloody stools
__ Mucous in stools
__ Intestinal pain or cramping
__ Itchy anus
__ Burning anus
__ Rectal pain
__ Hemorrhoid
__ Anal Fissure
__ Laxatives
__ Bowel Movements:
Frequency: _____
Color: _____
Texture/ Form: _____
Odor: ___ Y ___ N

Other: _____

LYMPH NODES

__ Enlarged/Tender neck
__ Enlarged/tender Axilla
__ Enlarged/tender Groin

MUSCULOSKELETAL

Please check all that apply.

__ Neck/ Shoulder pain
__ Muscle pain
__ Rib pain
__ Back muscle spasm
__ Tension headache
__ Neck Muscle spasms
__ Chest Tightness
__ Foot Cramps
__ Tendonitis
__ Lower back pain
__ Leg pain
__ Limited range of motion
__Joint deformity
__Calf Cramps
__ TMJ
__ Joint Redness
__ Joint stiffness
__ Upper back pain
__ Joint pain Where: _____
__ Limited use
__ Muscle twitch around eyes
__ Muscle spasms
__ Muscle twitch Arms or legs
__ Muscle Stiffness
__ Muscle weakness

Other: _____

SKIN AND HAIR

Please check all that apply.

__ Rashes
__ Hives
__ Warts
__ Ulcerations
__ Eczema
__ Thin skin
__ Psoriasis
__ Fungus Infections
__ Painful scars
__ Itching
__ Easy bruising
__ Wounds slow to heal
__ Boils
__ Patchy dullness

__ Oily skin
__ Cellulite
__Athlete's foot
___ Dry skin
__ Lackluster skin
___ Splotchy
__ Bumps on back of upper arms
__ Eczema
__ Ears get red
__ Shingles
__ Face gets red

__ Lack of sweating
__ Acne on back
__ Acne on face
__ Acne on chest
__ Cark circles under eyes
__ Too much sweating
__ Strong body odor
__ Skin darkening
__ Jock Itch
__ Vitiligo

SKIN AND HAIR

__ Acne on shoulders __ Sensitivity to poison ivy/oak __ Sensitivity to bug bits

__ Change in hair/ skin texture
__ Dandruff __ Hair loss __ Oily hair ___ Dry hair __ Dry scalp __ Hair shedding

ITCHING SKIN

__ Skin in general __ Anus __ Arms __ Ear Canals
__ Eyes __ Feet __ Hands __ Legs
__ Nipples __ Nose __ Penis __ Roof of mouth
__ Scalp __ Throat

DRYNESS

__Eyes __ Feet (Crack or peel) __ Hands (Crack or peel)
__Mouth/throat __ Skin (crack or peel)

NEUROPSYCHOLOGICAL

Please check all that apply.

__ Seizures __ Numbness __ Tics __ Considered/ attempted suicide
__ Poor memory __ Depression __ Easily stressed __ Seeing a therapist
__ Irritability __ Anxiety __ Abuse survivor __Agoraphobia
__ Fearfulness __ Numbness __ Fainting __ Epilepsy
__ Paranoia __ Dizziness/spinning __ Light headedness
__ Tremor/trembling __ Tingling __ Panic Attacks __ Auditory hallucinations
__ Visual hallucinations __ Autism __ ADD/ADHD

DIFFICULTY:

__ Concentrating __ With Balance __ With Thinking __ With Judgment
__ With Speech __ With Memory

Other: _____

URINARY

Please check all that apply.

__ Pain/burning on urination __ Blood in urine __ Wake to urinate
__ Frequent urination __ Incomplete urination __ Kidney disease
__ Urgent urination __ Leaking/incontinence
__ Unable to hold urine __ Bedwetting __ Kidney stones
__ Hesitancy

Other: _____

FAMILY MEDICAL HISTORY – Fill in information and check all that apply

	Children	Mother	Father	Brother	Sister	Mother's Parents	Father's Parents	Aunts	Uncles
Age									
Cancers									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Heart Disease									
Hypertension									
Obesity									
Diabetes									
Stroke									
Arthritis									
Rheumatoid									
Psoriatic									
Celiac Disease									
Autoimmune									
Lupus									
Thyroid									
Vitiligo									
Lymes									
MultipleSclerosis									
Thyroid Disorder									
Asthma									
Allergies									
Environmental									
Food									
Psoriasis/Eczema									
Parkinsons									
Tremors									
Lou Gehrig's (ALS)									
Dementia									
Alzheimers									
Depression									
Bipolar									
ADD/ADHD									
Autism									
Substance Abuse									
Genetic Disorder									
Scoliosis									
Seizures									
Epileptic									
Other									