Kerri Myatt Acupuncture and Herbal Medicine, LLC

NEW PATIENT INTAKE

Name:_____ Date:____/____/_____

What is your <u>chief complaint</u>? _____

When did this condition begin? _____

What treatment(s) have you received already? _____

What other issues would you like to work on: (Please list in order of importance.)

1. _____
2. _____
3. _____

<u>Major Hospitalizations/Surgeries</u>

Year	Operation/Illness	Hospital

<u>Medical History</u> (Please check all that apply):

☐ Heart Disease
☐ Diabetes
☐ High Cholesterol
☐ High Blood Pressure
☐ Thyroid Disease or Other Autoimmune Disease/Condition
☐ GERD, IBS or Other Digestive Disorder/Condition
☐ Seizures
☐ Cancer
☐ Hepatitis
☐ HIV
☐ Substance Abuse
☐ Others – please list: _____

<u>Habits:</u> (Please fill out any or all that apply) (This is Protected Health Information)

Tobacco Use per DAY_____Age Started_____Age Quit_____
Alcohol Use per week_____Age Started_____Age Quit_____
Caffeine Use per DAY_____Age Started_____Age Quit_____
Marijuana Use per week_____Age Started_____Age Quit_____
Other (please list)

Family History
Please check all that apply and how you are related to the family member with that condition.

	Mother	Father	Sibling	Grandparent
Cancer				
Heart Disease				
Diabetes				
Asthma				
Allergies				
Hypertension				
Migraines				
Stroke				
Depression				
Other mental issue				
Thyroid Disease				
Lupus				
Arthritis				
IBS				
Other:				
Other:				

Diet/Nutrition

1. Do you follow a special diet? ☐ Yes ☐ No
If yes, how would you describe the diet? (ie Vegetarian, Vegan, Low Carb, etc.)
_____
2. What do you eat on a "typical" day?:
a) Breakfast: _____
b) Lunch: _____
c) Dinner: _____
d) Snacks: _____

Allergies (Please list):_____

_____

Exercise: hours/week: _____ Type of activity:_____

_____

Sleep Habits: hours/night: _____Can you fall asleep and/or stay asleep? ☐ Yes ☐ No

If No, explain: _____

YOUR GOALS: What would you like to achieve with Acupuncture/Oriental Medicine?

_____

_____

_____