Healing Arts of Capitol Hill

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Patient Intake Form

Please complete this form as thoroughly as possible; all answers are confidential.

GENERAL INFORMATION

Name _____ Gender ❑ M ❑ F Date _____

Address _____ City _____ State _____ Zip _____

Email _____

Phone: ❑ Home _____ ❑ Work _____ ❑ Cell _____
(please indicate preferred contact number)

Occupation _____ Employer _____

Date of Birth _____ Age _____ Height _____ Weight _____

❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Separated/Divorced

Emergency contact _____ Relation _____

Emergency contact number: Home _____ Cell _____

Name of physician _____ Phone number _____
(No contact will be made without your permission)

Your signature _____

GOALS — What health concerns would you like to address through treatment

_____

_____

_____

_____

LIFESTYLE HABITS

Alcohol (drinks per week) _____ Coffee/Tea (cups per day) _____ Soda (regular or diet) _____

Cigarettes (packs per day) _____ Drug use (recreational) _____

Exercise ❑ Yes ❑ No How often? _____

What kind of exercise? _____

FAMILY HISTORY — Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse/partner	children
Adopted						
Good health						
Alcohol or other drug use						
Depression or mental illness						
Allergies						
High blood pressure/heart disease/stroke						
Cancer or tumors						
Diabetes						
Seizures						
Hepatitis/other liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Blood or bleeding disorders/anemia						
Thyroid disorders						
Kidney disorders						
Deceased (age)	N/A					

MEDICAL If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

Year	Operation/Illness	Hospital or Treatment Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICINES Please list all medications, vitamins and/or food supplements you are currently taking:

Medications	Dosage	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins & Supplements	Dosage	For what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

CONDITIONS/SYMPTOMS — Please mark any condition you have experienced in the past or currently.

Temperature (Kidney)

past *current*

- ❑ ❑ Cold hands
- ❑ ❑ Cold fingers
- ❑ ❑ Cold feet
- ❑ ❑ Cold toes
- ❑ ❑ Sweaty hands
- ❑ ❑ Sweaty feet
- ❑ ❑ Hot overall
- ❑ ❑ Cold overall
- ❑ ❑ Afternoon flushes
- ❑ ❑ Night sweats
- ❑ ❑ Heat in the hands, feet, and chest
- ❑ ❑ Hot flashes
- ❑ ❑ Thirsty
- ❑ ❑ Perspire easily
- ❑ ❑ Lack of perspiration
- ❑ ❑ Take water to bed

Energy (Lung/Kidney)

past *current*

- ❑ ❑ Shortness of breath
- ❑ ❑ Difficulty keeping eyes open during day
- ❑ ❑ General weakness
- ❑ ❑ Easily catch colds
- ❑ ❑ Low energy
- ❑ ❑ Feel worse after exercise

Blood (Liver/Spleen/Heart)

past *current*

- ❑ ❑ Dizziness
- ❑ ❑ See floating black spots

Heart Function

past *current*

- ❑ ❑ Palpitations
- ❑ ❑ Anxiety
- ❑ ❑ Sores on the tip of the tongue
- ❑ ❑ Restlessness
- ❑ ❑ Mental confusion
- ❑ ❑ Chest pain traveling to shoulder
- ❑ ❑ Pacemaker
- ❑ ❑ Frequent dreams
- ❑ ❑ Wake unrefreshed

Lung Function

past *current*

- ❑ ❑ Nasal discharge, color:
- ❑ ❑ Cough
- ❑ ❑ Nose bleeds
- ❑ ❑ Sinus Congestion
- ❑ ❑ Dry mouth
- ❑ ❑ Dry throat
- ❑ ❑ Dry nose
- ❑ ❑ Dry skin
- ❑ ❑ Respiratory allergies, to what?
- ❑ ❑ Alternating chills & fever
- ❑ ❑ Sneezing
- ❑ ❑ Headache, location:
- ❑ ❑ Overall achy feeling
- ❑ ❑ Stiff neck
- ❑ ❑ Stiff shoulders
- ❑ ❑ Sore throat
- ❑ ❑ Difficulty breathing
- ❑ ❑ Sadness
- ❑ ❑ Melancholy

Spleen Function

past *current*

- ❑ ❑ Low appetite
- ❑ ❑ Abrupt weight gain
- ❑ ❑ Abrupt weight loss
- ❑ ❑ Abdominal bloating
- ❑ ❑ Abdominal gas
- ❑ ❑ Gurgling In stomach
- ❑ ❑ Fatigue after eating
- ❑ ❑ Prolapsed organs (diagnosed):
- ❑ ❑ Easily bruised
- ❑ ❑ Hemorrhoids
- ❑ ❑ Pensive
- ❑ ❑ Over-thinking
- ❑ ❑ Worry

Spleen, Stomach, Large Intestine Function

past *current*

- ❑ ❑ Loose stool
- ❑ ❑ Constipated
- ❑ ❑ Incomplete evacuation
- ❑ ❑ Diarrhea
- ❑ ❑ Blood In stools
- ❑ ❑ Mucous In stools
- ❑ ❑ Undigested food in stools

Dampness

past *current*

- ❑ ❑ General sensation of heaviness
- ❑ ❑ Mental heaviness
- ❑ ❑ Mental sluggishness
- ❑ ❑ Mental fogginess
- ❑ ❑ Swollen hands
- ❑ ❑ Swollen feet
- ❑ ❑ Swollen joints
- ❑ ❑ Chest congestion
- ❑ ❑ Nausea
- ❑ ❑ Snoring

Stomach Function

past *current*

- ❑ ❑ Burning sensation after eating
- ❑ ❑ Large appetite
- ❑ ❑ Bad breath
- ❑ ❑ Mouth (canker) sores
- ❑ ❑ Bleeding, swollen or painful gums
- ❑ ❑ Heartburn
- ❑ ❑ Acid regurgitation
- ❑ ❑ Ulcer (diagnosed)
- ❑ ❑ Belching
- ❑ ❑ Hiccups
- ❑ ❑ Stomach pain
- ❑ ❑ Vomiting

Eyes (Liver Function)

past *current*

- ❑ ❑ Itchy
- ❑ ❑ Bloodshot
- ❑ ❑ Hot
- ❑ ❑ Dry
- ❑ ❑ Watery
- ❑ ❑ Gritty
- ❑ ❑ Blurry vision
- ❑ ❑ Decreased night vision
- ❑ ❑ Near-sighted
- ❑ ❑ Far-sighted

Liver/Gall Bladder Function

past current

- ❑ ❑ Alternation diarrhea & constipation
- ❑ ❑ Chest pain
- ❑ ❑ Tight sensation in chest
- ❑ ❑ Bitter taste In mouth
- ❑ ❑ Anger easily
- ❑ ❑ Frustration
- ❑ ❑ Depression
- ❑ ❑ Irritability
- ❑ ❑ Frequently unable to adapt to stress; cause of stress: _____
- ❑ ❑ Skin rashes
- ❑ ❑ Headache: at top of head
- ❑ ❑ Tingling sensation
- ❑ ❑ Numbness
- ❑ ❑ Muscle spasms
- ❑ ❑ Muscle twitching
- ❑ ❑ Muscle cramping
- ❑ ❑ Seizures
- ❑ ❑ Convulsions
- ❑ ❑ Lump in throat
- ❑ ❑ Neck tension
- ❑ ❑ Neck: limited range-of-motion
- ❑ ❑ Shoulder tension
- ❑ ❑ Shoulder: limited range-of-motion
- ❑ ❑ High-pitched ringing in ears
- ❑ ❑ Gall stones
- ❑ ❑ Sexually transmitted disease(s); specify: _____

Kidney/Urinary Bladder Function

past current

- ❑ ❑ Frequent cavities
- ❑ ❑ Easily broken bones
- ❑ ❑ Sore knees
- ❑ ❑ Weak knees
- ❑ ❑ Cold sensation in knees
- ❑ ❑ Low back pain
- ❑ ❑ Memory problems
- ❑ ❑ Wake frequently to urinate
- ❑ ❑ Low-pitched ringing in ears
- ❑ ❑ Kidney stones
- ❑ ❑ Bladder infections
- ❑ ❑ Lack of bladder control
- ❑ ❑ Fear
- ❑ ❑ Easily startled
- ❑ ❑ Excessive hair loss

Urination

past current

- ❑ ❑ Normal color
- ❑ ❑ Dark yellow
- ❑ ❑ Clear
- ❑ ❑ Reddish
- ❑ ❑ Cloudy
- ❑ ❑ Scanty
- ❑ ❑ Profuse
- ❑ ❑ Strong odor
- ❑ ❑ Blood
- ❑ ❑ Painful
- ❑ ❑ Discharge
- ❑ ❑ Difficult
- ❑ ❑ Urgent
- ❑ ❑ Frequent

Male — Genital

past current

- ❑ ❑ Impotence
- ❑ ❑ Premature ejaculation
- ❑ ❑ Nocturnal emission
- ❑ ❑ Pain/itching of genitalia
- ❑ ❑ Lumps in testicles
- ❑ ❑ Increased libido
- ❑ ❑ Decreased libido
- ❑ ❑ Other (describe) _____

Women — Gynecology

past current

- ❑ ❑ Menopause
- ❑ ❑ Irregular periods
- ❑ ❑ Menstrual cramps
- ❑ ❑ Excessive blood flow
- ❑ ❑ Menstrual blood clots
- ❑ ❑ Abnormal pap smear
- ❑ ❑ Vaginal infections
- ❑ ❑ Vaginal pain/itching
- ❑ ❑ Uterine fibroids
- ❑ ❑ Endometriosis
- ❑ ❑ Breast tenderness
- ❑ ❑ Breast lumps, cysts
- ❑ ❑ Increased libido
- ❑ ❑ Decreased libido
- ❑ ❑ Other (describe) _____ _____

Currently pregnant: trimester _____

Past pregnancies:

# of live births: _____

# of miscarriages _____

# of abortions _____

Other Information

_____

_____

_____

_____

_____

_____

Patient Signature _____ Date _____