Three Mountains Wellness, LLC

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New Patient Intake Form

Welcome to Three Mountains Wellness. Please fill out the following questions as completely as possible. Oriental Medicine has its own way of looking at the body, mind and spirit and uses different groupings of symptoms to make a diagnosis than Western medicine. As a result, little things that you may not think would be related to your primary health challenge, may actually be very important. If you don't know or are confused by a question, please answer with a question mark.

All responses will remain completely confidential.

Today's Date: _____

General Information

Name: _____ Age: _____ Date of Birth: _____/_____/_____
(*mm/dd/yyyy*)

Address: _____ Sex: M F

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Which phone would you like as your primary number? ☐ Cell ☐ Work ☐ Home
Would you like to receive appointment reminders as text messages to your cell phone? ☐ Yes ☐ No
Would you like to receive voicemail messages on your primary number? ☐ Yes ☐ No

Email: _____ Facebook: _____

Highest Educational Level Completed: _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

How would you describe the quality of your significant relationship? _____

Children / Ages:

_____ _____

_____ _____

_____ _____

Physician Information

Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Date of last medical examination: _____ Do you have a physician referral? ☐ Yes ☐ No

What was your diagnosis? _____

Please list any other health care providers that you use:

Name	Specialty	Phone

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Celll : _____ Work Phone: _____

General Physical Health & Nutrition Status

Height: _____ Present Weight: _____ Weight One Year Ago: _____ Ideal Weight: _____

Maximum Weight and When: _____ Minimum Weight (adult) and When: _____

Are you generally in good health or do you frequently feel ill? _____

What illnesses are you prone to (frequent colds, gastro-intestinal problems)? _____

Do you have any problems with your energy level? _____ If yes, please briefly describe: _____

Do you have any problems with sleep? _____ If yes, please briefly describe: _____

Which of the following are a part of your lifestyle?

X	Substance	Frequency		X	Substance	Frequency
	Alcohol				Occupational Hazards	
	Artificial Sweeteners				Painkillers	
	Coffee				Recreational Drug Use	
	Energy Drinks				Soft Drinks (soda)	
	Excessive Sugar or Salt				Steroids	
	Laxatives				Tobacco/Nicotine	

How often do you exercise and what type of exercise do you do? _____

_____

Do you have any difficulties with exercise? _____

How many meals do you eat in a day? _____ How many snacks? _____

Do you follow any particular diet? _____

How many 8 oz. glasses of water do you drink in a day? _____

On average, how many servings a day do you have of: Meats _____ Dairy and Eggs _____ Grains _____

Fruits_____ Vegetables _____ Fats _____

Do you believe that your diet has any impact on your complaints? ☐ Yes ☐ No

Are you concerned about your weight or appetite (too much or too little)? ☐ Yes ☐ No

Please record your intake of food and drink for the past three days. Indicate the date for each day of recall.

	Date 1:	**Date 2:**	**Date 3:**
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

If applicable, briefly describe any problems you think you have with your eating habits and appetite.

_____

_____

_____

Medication, Vitamins and Herbal Supplements

Please list all medications (prescription and over-the-counter), vitamins, herbs and supplements that you are taking.

Medication/Herb/Vitamin/Supplement	Dose	Frequency	How long taking this?

Please list any allergies and/or side effects you have experienced with any medications/herbs/supplements:

_____

_____

_____

Overall, in the past month, have you taken your prescription medications:

☐ Almost never ☐ Less than 50% of the time ☐ 50% of the time ☐ Routinely

Medical History

Please list all and note the year when they occurred or were first diagnosed.

X	Condition	Year		X	Condition	Year
	AIDS/HIV				Injuries	
	Alcoholism/ Substance abuse				Insomnia	
	Allergies				Intestinal Parasites	
	Anemia				Irritable Bowel Syndrome	
	Appendicitis				Joint Replacement	
	Arteriosclerosis				Kidney Stones and/or Kidney Disease	
	Asthma				Lupus	
	Bell's Palsy				Lyme Disease	
	Bipolar Disorder				Mood Disorder	
	Bleeding Disorder				Multiple Sclerosis	
	Blood Pressure (Low)				Osteoarthritis	
	Blood Pressure (High)				Osteoporosis	
	Cancer				Pacemaker	
	Chicken Pox/Shingles				Parkinson's Disease	
	COPD				Polio	
	Crohn's Disease/Colitis				Psoriasis	
	Chronic Fatigue Syndrome				PTSD (Post Traumatic Stress Disorder)	
	Depression				Reflux Esophagitis (GERD)	
	Diabetes				Rheumatoid Arthritis	
	Digestive Disorders				Schizophrenia	
	Eczema				Seizures and/or Epilepsy	
	Endometriosis				Sleep Disorder	
	Emphysema				Stroke	
	Epilepsy				Surgery (Please list all below)	
	Fatigue				Thyroid Disorder	
	Fibroids				Trauma (falls, accidents)	
	Fibromyalgia				Trigeminal Neuralgia	
	Gallstones				Tuberculosis	
	Gout				Ulcers	
	Heart Disease				Vascular Disease	
	Hepatitis Type:				Weight loss	
	Hernia				Weight gain	
	Hypoglycemia				Other	
	Infertility					

Please list all Major Traumas (mental, emotional and physical), Surgeries and Illnesses, the year when they occurred and any long-term effects.

How many times have you been treated with antibiotics? _____ For what conditions? _____

_____

Have you ever used probiotics after antibiotic use? ☐ Yes ☐ No

Do or have any of your family members (mother, father, siblings, maternal grandparent, paternal grandparents) suffer from:

X	Condition	Relationship
	Alcoholism	
	Allergies	
	Arteriosclerosis	
	Asthma	
	Arthritis	
	Auto-immune disease	
	Bleeding Disorder	
	Cancer	
	Diabetes	
	Eating Disorder	
	Enlarged Prostate	

X	Condition	Relationship
	Heart Disease	
	High Blood Pressure	
	Kidney Disease	
	Liver Disease	
	Mental Illness	
	Overweight/Obesity	
	Seizures / Epilepsy	
	Stroke	
	Substance Abuse	
	Other:	

General Emotional Health

Do you experience any of the following? Please indicate whether the **Freqency** is **O**ccasional, **F**requent or **C**onstant, and whether the Severity is **L**ow, **M**oderate or **S**evere.

Symptom	Frequency			Severity		
Anxious/Nervous	O	F	C	L	M	S
Binge Eating	O	F	C	L	M	S
Depression	O	F	C	L	M	S
Disorientation	O	F	C	L	M	S
Euphoria/ Too Much Energy	O	F	C	L	M	S
Extreme Lack of Emotion	O	F	C	L	M	S
Fatigue	O	F	C	L	M	S
Fearful	O	F	C	L	M	S
Feeling Manic	O	F	C	L	M	S
Feeling Overwhelmed	O	F	C	L	M	S
Feelings of Panic	O	F	C	L	M	S
Forgetfulness	O	F	C	L	M	S
Grief	O	F	C	L	M	S

Symptom	Frequency			Severity		
Impulsiveness	O	F	C	L	M	S
Insomnia	O	F	C	L	M	S
Irritability / Anger	O	F	C	L	M	S
Mood Swings	O	F	C	L	M	S
Nightmares	O	F	C	L	M	S
Poor Concentration	O	F	C	L	M	S
PTSD	O	F	C	L	M	S
Recurrent Thoughts / Pensive	O	F	C	L	M	S
Sadness	O	F	C	L	M	S
Worried	O	F	C	L	M	S
Other:	O	F	C	L	M	S
	O	F	C	L	M	S
	O	F	C	L	M	S

What is your most pressing emotional concern? _____

Do you believe your emotions interfere with the activities of daily living or that they are an obstacle to your achieving your goals? If so, how? _____

_____

Have you found that certain things (food sensitivities, light, noise, etc.) are emotional triggers? Please describe them:_____

_____

What is your current level of stress? _____

Do you think that stress, including recent major life changes, is contributing to your main complaints and/or negatively impacting any other aspect of your physical or mental health? If yes, how does stress affect you (headaches, gastrointestinal problems, edgy, etc.)? _____

_____

Describe Your Current Health Challenges

Please describe the reason for your visit today (Primary Complaint): _____

_____

_____

When did this start? _____ Was the onset: ☐ Sudden ☐ Gradual

What triggered this condition? _____

What other options have you tried to correct this problem? _____

_____

Did these/are these helping? _____

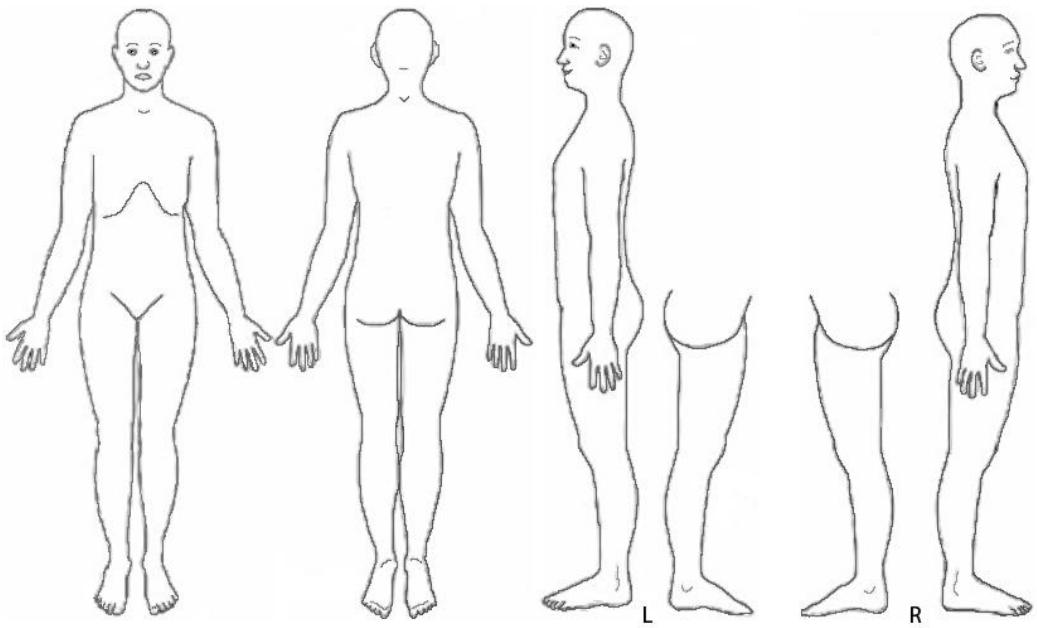
_____

Overall, is your condition: ☐ Getting Better ☐ Getting Worse ☐ Staying the same

Are there any other health concerns that you would like to address? _____

_____

Please shade in the areas on the diagram where you are experiencing symptoms.



Current Symptoms

Please fill this out carefully and list all symptoms, even if they don't seem to be connected to your primary health challenge. Please indicate whether the **Freqency** is **O**ccasional, **F**requent or **C**onstant, and whether the Severity is **L**ow, **M**oderate or **S**evere.

Symptom	Frequency			Severity		
Head and Face						
Dizziness	O	F	C	L	M	S
Headache	O	F	C	L	M	S
Head Injury	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Eyes						
Changes in Vision	O	F	C	L	M	S
Eyelid Twiitching	O	F	C	L	M	S
Floaters	O	F	C	L	M	S
Pain	O	F	C	L	M	S
Redness/Dryness	O	F	C	L	M	S
Tearing/Discharge	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Ears:						
Ear Pain / Infections	O	F	C	L	M	S
Loss of Hearing	O	F	C	L	M	S
Tinnitus	O	F	C	L	M	S
Vertigo	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Nose						
Impaired sense of smell	O	F	C	L	M	S
Sinus Trouble	O	F	C	L	M	S
Bleeding	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Mouth						
Dental Problems	O	F	C	L	M	S
Gum Problems	O	F	C	L	M	S
Teeth Grinding / TMJ	O	F	C	L	M	S
Unusual Tastes	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Throat						
Sore Throat	O	F	C	L	M	S
Hoarseness	O	F	C	L	M	S
Difficulty Swallowing	O	F	C	L	M	S
Dryness	O	F	C	L	M	S
Other:	O	F	C	L	M	S

Symptom	Frequency			Severity		
Respiration						
Difficulty Inhaling	O	F	C	L	M	S
Difficulty Exhaling	O	F	C	L	M	S
Pain or Tightness	O	F	C	L	M	S
Cough	O	F	C	L	M	S
Congestion	O	F	C	L	M	S
Shortness of Breath	O	F	C	L	M	S
Sputum	O	F	C	L	M	S
Voice Changes	O	F	C	L	M	S
Other	O	F	C	L	M	S
Heart and Chest						
High Blood Pressure	O	F	C	L	M	S
Palpitations	O	F	C	L	M	S
Chest Pain/Pressure	O	F	C	L	M	S
Edema	O	F	C	L	M	S
Difficulty Lying Down	O	F	C	L	M	S
Other:	O	F	C	L	M	S
Circulation						
Easy Bruising	O	F	C	L	M	S
Easy Bleeding	O	F	C	L	M	S
Cold Limbs – Hands	O	F	C	L	M	S
Cold Limbs - Feet	O	F	C	L	M	S
Reynaud's Syndrome	O	F	C	L	M	S
Other	O	F	C	L	M	S
Gastrointestinal						
Always Thirsty	O	F	C	L	M	S
Never Thirsty	O	F	C	L	M	S
Low Appetite	O	F	C	L	M	S
Cravings	O	F	C	L	M	S
Gluten intolerance	O	F	C	L	M	S
Gas/Bloating	O	F	C	L	M	S
Abdominal pain	O	F	C	L	M	S
Nausea	O	F	C	L	M	S
Diarrhea/Loose Stool	O	F	C	L	M	S
Constipation	O	F	C	L	M	S
Rectal Bleeding	O	F	C	L	M	S
Colon Problems	O	F	C	L	M	S
Other:	O	F	C	L	M	S

Symptom	Frequency	Severity
Urination		
Frequent	O F C	L M S
Difficult	O F C	L M S
Painful	O F C	L M S
Nocturnal	O F C	L M S
Bleeding	O F C	L M S
Other	O F C	L M S
Neurological		
Changes in Consciousness	O F C	L M S
Confusion	O F C	L M S
Difficulty Concentrating	O F C	L M S
Nervousness/Anxiety	O F C	L M S
Tremors	O F C	L M S
Numbness or Tingling	O F C	L M S
Lack of Coordination	O F C	L M S
Nerve Pain	O F C	L M S
Attention	O F C	L M S
Neurofatigue	O F C	L M S
Memory Loss	O F C	L M S
Gait disturbance	O F C	L M S
Paralysis	O F C	L M S
Forgetfulness	O F C	L M S
Other:	O F C	L M S

Symptom	Frequency	Severity
Skin		
Acne	O F C	L M S
Dryness	O F C	L M S
Moles that Change	O F C	L M S
Lumps	O F C	L M S
Excessive Sweating	O F C	L M S
Night Sweats	O F C	L M S
Rarely Sweat	O F C	L M S
Changes in hair	O F C	L M S
Rash and/or skin lesion	O F C	L M S
Wounds that won't heal	O F C	L M S
Changes in nails	O F C	L M S
Itching	O F C	L M S
Other:	O F C	L M S
Sleep		
Insomnia	O F C	L M S
Drowsiness	O F C	L M S
Excessive Dreaming	O F C	L M S
Waking Early	O F C	L M S
Other:	O F C	L M S
Musculoskeletal:		
Limited Movement	O F C	L M S
Stiffness	O F C	L M S
Weakness	O F C	L M S
Joint Clicking	O F C	L M S
Spasms or Cramps	O F C	L M S
Swelling	O F C	L M S
Pain	O F C	L M S
Other:	O F C	L M S

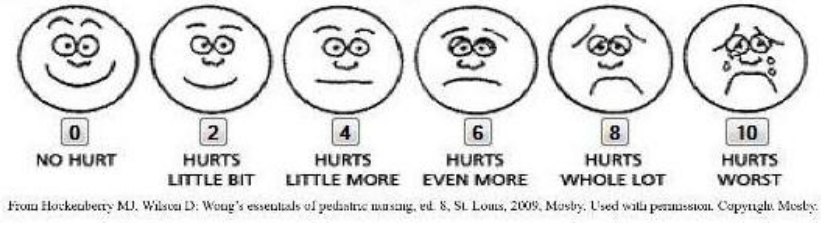
Other symptoms: _____

_____

Pain Evaluation

Please make sure that you have shaded in the areas where you are experiencing pain in the diagram on page 9.

Which face describes your level of pain?



How long have you had this pain? _____

When did your pain first begin, was it gradual? If not what triggered it? _____

Is your pain: ☐ Continuous ☐ Intermittent

If your pain is Intermittent, how often does it occur? ☐ Several times a day ☐ Once per day

☐ Several times a week ☐ Once per week ☐ Less than once per week ☐ Other:_____

How long does your pain last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐ Weeks

Is the pain worse at certain times of day? ☐ Yes ☐ No If so, when?_____

Below are a list of words that describe various types of pain, rate each words by placing an X in the column that best describes the intensity of each type of pain.

Type of pain	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-Burning				
Aching				

Type of Pain	None	Mild	Moderate	Severe
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

What makes your pain feel better? Please be specific. _____

What makes your pain feel worse? Please be specific. _____

How does your pain interfere with your normal activities or mood?_____

Do you have chest pain? ☐ Yes ☐ No Chest pressure? ☐ Yes ☐ No Heartburn? ☐ Yes ☐ No

Pain that radiates to other areas of the body (left arm, jaw, back, legs, etc.)? ☐ Yes ☐ No

Women's Health Issues

Are you currently sexually active? ☐ Yes ☐ No Do you use birth control? ☐ Yes ☐ No ☐ Sometimes

What form of birth control do you use? _____ Since: _____

Are you or could you be pregnant? _____ If yes, how far along are you? _____

Are you trying to become pregnant? _____ If yes, how long have you been trying? _____

Number of pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____

Age of first menses? _____ Date of last menstrual period: _____

Do you have problems with vaginal discharge? If yes, please describe: _____

Age at menopause, if applicable? _____ Are you using hormones? ☐ Yes ☐ No

How long between periods? ☐ Less than 28 days ☐ More than 28 days ☐ Varied ☐ Regular

How many days do your periods last? _____ Do you bleed between periods? ? ☐ Yes ☐ No

Are your periods uncomfortable: ☐ physically ☐ emotionally

Describe the flow of your menses: ☐ Heavy ☐ Light ☐ Very little

Do you have clots? _____ Early in the cycle? _____ Throughout? _____

What color is your menstrual blood? ☐ Bright Red ☐ Red ☐ Purple ☐ Brownish ☐ Pale

Do you experience any of the following pre-menstrual symptoms? ☐ Irritability ☐ Depression ☐ Crying

☐ Rage ☐ Nausea ☐ Breast Tenderness ☐ Weight gain ☐ Bloating ☐ Other: _____

☐ Cravings If yes, for what types of foods? _____

Do you have any difficulty with libido? ☐ Too low ☐ Too high

Are you having difficulty with: ☐ Changes in hair distribution ☐ Hot flashes ☐ Dryness

Have you ever had any gynecological surgeries or any abnormal findings on any tests? _____

Do you have a current or past history of herpes, venereal warts, gonorrhea, syphilis, Chlamydia, HIV/AIDS or other STD?

☐ Yes ☐ No If so, which ones? _____

Do you have any sexual/gynecological/obstetrical concerns or complaints? _____

_____

Men's Health Issues

Do you experience any of the following? Please indicate whether the **Freqency** is **O**ccasional, **F**requent or **C**onstant, and whether the **Severity** is **L**ow, **M**oderate or **S**evere.

Symptom	Frequency			Severity		
Urinary Frequency	O	F	C	L	M	S
Urging w/o passing urine	O	F	C	L	M	S
Waking during the night to urinate	O	F	C	L	M	S
Pain/burning	O	F	C	L	M	S
Trouble starting urine	O	F	C	L	M	S
Difficulty urinating completely	O	F	C	L	M	S
Cloudy urine	O	F	C	L	M	S
Red-tinged/blood in the urine	O	F	C	L	M	S
Foul smelling urine	O	F	C	L	M	S
Discharge	O	F	C	L	M	S
Pain or sores on penis	O	F	C	L	M	S
Hernias	O	F	C	L	M	S

Symptom	Frequency			Severity		
Testicular swelling	O	F	C	L	M	S
Testicular pain	O	F	C	L	M	S
Lumps on testicles, scrotum or penis	O	F	C	L	M	S
Fertility concerns	O	F	C	L	M	S
Inability to achieve or maintain an erection	O	F	C	L	M	S
Impotence	O	F	C	L	M	S
Premature ejaculation	O	F	C	L	M	S
Reduced libido	O	F	C	L	M	S
Excess libido	O	F	C	L	M	S
Other:	O	F	C	L	M	S

Please list all and note the year when they occurred or were first diagnosed.

X	Condition	Year
	BPH	
	Testicular Cancer	
	Penile Cancer	
	Surgery of Prostate or Genitals	
	Vasectomy	

X	Condition	Year
	Sexually Transmitted Diseases (herpes, vanereal warts, gonorrhea, syphilis, Chlamydia, chancre, HIV/AIDS	
	Other:	

Are you currently sexually active? ☐ Yes ☐ No Do you use contraception? ☐ Yes ☐ No ☐ Sometimes

Do you have any sexual problems or concerns? ☐ Yes ☐ No _____

Do you have regular prostate exams? ☐ Yes ☐ No Have any been abnormal? ☐ Yes ☐ No

Any other health concerns? _____

Oriental Medicine Experience

Have you ever received acupuncture before? ☐ Yes ☐ No

If yes, for what conditions and what was the outcome? _____

_____

_____

Did you work with an Oriental Medicine practitioner? ☐ Yes ☐ No

Please describe your goals, hopes and expectations for your treatment: _____

_____

How committed are you to making important changes? ☐ Little ☐ Moderate ☐ Very ☐ Don't Know

What potential obstacles do you foresee in addressing any lifestyle factors that are undermining your health or in adhering to therapeutic protocols? _____

_____

How did you hear about Three Mountains Wellness, LLC?

☐ Physician Referral ☐ Other Healthcare Provider Referral

☐ Family Member ☐ Friend ☐ Internet Search Engine: _____

☐ Yahoo Business ☐ Google ☐ CitySearch ☐ Mapquest ☐ Dex Yellow Pages

☐ Yellow Book Yellow Pages ☐ Other: _____

Thank you very much for taking the time to complete this thorough form. It will greatly assist in the formulation of an individualized protocol specific to your healthcare needs

I have provided correct and complete information to the best of my knowledge.

_____ _____

Patient's or Guardian's signature Date