Rowan Everard, LAc

Patient Intake Form

Today's date:
Preferred Name:
Pronoun:
Birth date:
What does the government/state/insurance have listed as your name:
What does the government/state/insurance have listed as your sex: M___ F___
Address: Street: City: State: Zip:
Phone number:
Emergency Contact: Phone: Relationship:

Insurance company name:	Insurance company phone number :
Member ID #:	Group or claim #:
Name of insurance policy holder:	Relationship of insured to patient:
Type of policy: Health___ Auto___ Worker's comp___	

Primary Physician:	Referred By:
Main Problem:	
Onset:	
Other Concurrent Therapies:	
Occupation:	

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Do you have any of the following: Cervix___ Uterus___ Ovaries___ Testicles___ Prostate___

Past Medical History (include date)
Significant Illnesses: ___Cancer ___Diabetes ___High Blood Pressure ___Heart Disease ___Hepatitis ___Rheumatic Fever ___Thyroid Disease ___Seizures ___Other
*Surgeries:*_____
*Significant Trauma (auto accidents, falls, etc.)*_____
*Birth History (prolonged labor, forceps delivery, etc.)*_____
*Allergies (drugs, chemicals, foods)*_____
*Medicines taken within last two months (include vitamins, over the counter herbs, etc.)*_____
____
*Occupational Stresses (chemical, physical, psychological, etc.)*_____
*Exercise*_____

Habits Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other_____
Family Medical History ____Diabetes ____Cancer ___ High Blood Pressure ___ Heart Disease ___Stroke ___Seizures ___Asthma ___Allergies ___Alcoholism ___Other_____

Average Daily Diet
Morning *Afternoon* *Evening*

GENERAL

Poor appetite	Heavy appetite	Poor sleep	Heavy sleep
Insomnia	Fatigue	Tremors	Vertigo
Cold hands	Cold feet	Cold back	Cold abdomen
Fevers	Chills	Night sweats	Sweat easily
Cravings	Localized weakness	Poor coordination	Change in appetite
Sudden energy drop at _____(time)		Peculiar tastes/smells_____	
Strong thirst (cold/hot drinks) _____		Bleed or bruise easily (where) _____	

SKIN AND HAIR

Rashes	Ulcerations	Hives	Itching
Eczema	Pimples	Dandruff	Changes in hair/skin texture
Loss of hair	Purpura	Other hair or skin problems_____	

HEAD, EYES, EARS, NOSE AND THROAT

Dizziness	Concussions	Migraines	Glasses
Eye strain	Eye pain	Poor vision	Night blindness
Color blindness	Cataracts	Blurry vision	Earaches
Ringing in ears	Poor hearing	Nose bleeds	Sinus problems
Mucus	Dry throat	Dry mouth	Copious saliva
Teeth problems	Jaw clicks	Grinding teeth	Facial pain
Gum problems	Spots in eyes	Recurrent sore throats _____/month	
Sores on lips or tongue	Headaches (where and when)_____		
Other head or neck problems_____			

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CARDIOVASCULAR

High blood pressure	Low blood pressure	Chest pain	Irregular heartbeat
Dizziness	Fainting	Cold hands/feet	Swelling in hands/feet
Blood clots	Phlebitis	Difficulty breathing	Other_____

RESPIRATORY

Cough	Coughing blood	Asthma	Bronchitis
Pneumonia	Difficulty breathing when lying down		Tight chest
Production of phlegm (color) _____			

GASTROINTESTINAL

Nausea	Vomiting	Diarrhea	Bowel movements:
Gas	Belching	Black stools	_____Frequency
Bad breath	Rectal pain	Hemorrhoids	_____Color
Constipation	Bloody stools	Sensitive abdomen	_____Odor
Pain or cramps	Laxative use _____/week; type _____		_____Texture/form

GENITO-URINARY

Pain on urination	Frequent urination	Blood in urine	Urgency to urinate
Unable to hold urine	Kidney stones		Impotency
Wake up to urinate _____/night; time _____			Sexually transmitted infections

PREGNANCY AND GYNECOLOGY

Number pregnancies_____	Age at first menses_____	Flow _____	Vaginal discharge
Number births_____	Period (days)_____	Last PAP_____	Clots
Premature births_____	Duration_____	Menopause_____	Breast lumps
Miscarriages_____	Last menses_____	Breast lumps	Vaginal sores

Birth control: type and duration_____

Changes in body/psyche prior to menstruation_____

MUSCULSKELETAL

Neck pain	Muscle pains	Back pain (where)_____
Joint pain (where)_____		Other joint or bone problems_____

NEUROPSYCHOLOGICAL

Seizures	Areas of numbness	Poor memory	Concussion
Depression	Anxiety	Bad temper	Easily stressed
Treated for emotional problems_____			Considered/attempted suicide

Other neurological or psychological problems_____

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