

Lisa Grieves White, L.Ac.

Date: _____

Name: _____

Address: _____

Telephone Number: _____

Email address: _____

(Will not be shared)

Would you like to receive my email newsletter? (once per month) _____

How did you hear about my services? _____

Date of Birth: _____

Height: _____ Weight: _____

Married: Yes ___ No ___

Primary Care Physician _____

Telephone Number _____

Emergency contact person _____

Name _____ Relationship _____

Best Number to call _____

Your Occupation _____

Please List:

Current Prescription Medications, their purpose, and length of time taken

Herbs/Remedies, their purpose, and length of time taken

Vitamins/supplements

Known Allergies

Previous Surgeries

Date

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Please list any complications from the above surgeries

Previous Serious Illnesses

Date

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Childhood vaccinations

Adult vaccinations

List your present symptoms/complaints in order of importance to you

PATIENTS IN PAIN

Please describe:
Area of pain

When did pain start _____

Is pain dull_____ or sharp_____

If you have had a medical diagnosis, please describe

What makes pain lessen or stop?

Any numbness in:

Arms _____

Legs_____

Hands_____

Joints_____

Hips_____

Neck_____

Shoulders_____

Cold limbs_____

Dietary Information:

In general, what do you eat on a daily basis?

Breakfast (please list)

Lunch (please list)

Dinner (please list)

Snacks

What temperature of food and drinks make you feel most comfortable

Hot _____ Cold _____ Warm _____ Neutral _____

How often are you eating in a restaurant

1-3 times per week _____

4-7 times per week _____

Do you:

Drink Alcohol _____

Smoke Tobacco _____

Use recreational drugs _____

Please note any unusual or adverse reactions you have when eating or touching certain foods, beverages, etc.

Do you have a bowel movement every day?

Yes _____ No _____

Is there any unusual or strong odor, color or consistency

Yes _____ No _____

Does your fluid intake correspond with your fluid output in urine?

Yes _____ No _____

In general, is your urine

Clear _____

Cloudy _____

Do you sleep well?

Yes _____ No _____

If no, please explain

Do you experience any of the following:

Night sweating _____ How often _____

Nightmares _____ How often _____

Restless legs _____ How often _____

Restless Sleep _____ How often _____

On a scale of 1-5, with 1 at the low end, describe your level of stress:

At home 1 2 3 4 5

At work 1 2 3 4 5

At school 1 2 3 4 5

Do you experience:

Blurred Vision _____

Earache _____

Corrected Vision _____

Nasal obstruction (stuffy nose) _____

Nasal drainage/discharge _____

Loss of sense of smell _____

ringing in ears _____

sores on lips or tongue _____

Do you have respiratory problems?

Asthma _____ Date of diagnoses _____

Allergies _____

Persistent cough _____

Shortness of breath _____

Recurrent lung problems _____

Do you suffer from:

Chest Pain _____

High _____/Low _____ blood pressure

Irregular heart beat _____

Swelling of ankles/feet/hands _____

Check those that generally apply to you most of the time

Irritability _____

Anger _____

Sadness _____

Forgetfulness _____

Anxiety _____

Fear _____

For Men Only: Check those that apply to you

Genital Pain _____

Impotence _____

Genital sores _____

Lump in testicles _____

Penis discharge _____

Nocturnal emission _____

Low sexual energy _____

If you are male, congratulations ~ you are finished with this intake form!

Ladies, please continue on to the next page.

For Women Only: Check those that apply to you
Abnormal pap _____ Date _____ Outcome _____

Bleeding between periods _____
Irregular periods _____
Endometriosis _____
Painful periods _____
Breast lumps _____
Contraceptives _____
Sores on genitalia _____
Low sexual energy _____
Vaginal discharges _____ what is the color _____
Uterine prolapse _____
Pregnant _____
Are you still menstruating Yes____No____
If you are in menopause, list any problems or symptoms

How many days does your period normally last? _____
What is the quality of your menses:
Heavy _____
Medium _____
Light _____

Any clotting Yes____No____

Do you experience PMS Yes____No____

For office use only

Tongue

Pulses

Left _____

Right _____

Diagnosis _____

—

**Treatment
Plan** _____

—

**Treatment
Points/Modalities** _____

—

Prescriptions _____

—

Recommendations _____

—

Notes _____

—

—

