NEW PATIENT INTAKE FORM

Please answer the following questions as thoroughly and openly as you can. Thorough understanding of your symptoms, lifestyle, emotional and physical state are crucial for creating an accurate healing protocol to achieve your health goals. All information is confidential. Please email this form to karen@eleosherbals.com after completion so we can schedule your appointment.

DEMOGRAPHICS

Name:

Address:

City:

State: Zip Code:

Phone Numbers

Home: Work: Cell:

Email Address:

Emergency Contact Name:
Phone:

Primary Care Physician:
Phone:

Gender:

Date of Birth: Age:

Height: Weight:

What would you like me to help you with today?

Primary Concern

When did it start?

What makes it worse/better?

When is it worse/better? *(am/pm; weather conditions; stress; heat, cold, etc.)*

What treatments have you tried?

Secondary Concern

When did it start?

What makes it worse/better? When is it worse/better? (am/pm; weather conditions; stress; heat, cold, etc.)

What treatments have you tried?

What level of change to your living habits are you willing to make in order to improve your health? *Please indicate your preference with "0" being no commitment, "10" complete commitment.*

0 1 2 3 4 5 6 7 8 9 10

Do you tend to be COLD or HOT?

Do you tend to have COLD hands and feet?

Do you tend to be HOT especially in the afternoon?

Do you have any mucus secretions? (runny nose, eyes, vaginal discharge)

Are you frequently thirsty or never thirsty?

Do you have:

- ❑ Dry Nose
- ❑ Dry Skin
- ❑ Dry Hair
- ❑ Itching from dryness

Any spontaneous sweating during the day or at night?

Lack of sweat, even when hot?

PAIN

Do you have headaches?

How often?

What part of your head generally hurts?

- ❑ top/vertex
- ❑ one or both sides
- ❑ forehead
- ❑ occiput
- ❑ eye related
- ❑ sinus/allergy relative

How Severe

(1 = very mild; 10 = unbearable)
Quality of pain: sharp, stabbing, dull, moving and changing, fullness of chest, stuffy feeling in chest, difficulty breathing

What time of day?

Do you currently experience any other pain?

	Severity (1 = mild; 10 = unbearable)	What make it better / worse	Time of day	Quality of pain
Chest discomfort / pain				
Hypochondrium pain				
Stiff shoulders and neck				
Knee pain				
Other joint pain / stiffness				
Lower back pain				
Other				

Do you experience:

- ❑ Floaters
- ❑ Burning
- ❑ Itchy eyes

Do you have sinus stuffiness / congestion or pain?

Do you have dry throat?

Do you experience twitching of:

- ❑ Eyes
- ❑ Face
- ❑ Legs
- ❑ Feet

Do you have any itching? **Where?**

Do you have toe fungus *(thickened or yellowed nails)***?**

Do you experience dizziness? **How often?**

STOOL

How often do you have a bowel movement?

Do you experience loose stools early in the morning?

Are your stools:

- ❑ Loose
- ❑ Hard and dry
- ❑ Watery

Alternate loose/hard?

- ❑ Is it very smelly?
- ❑ Is shaped like:
- ❑ Small pebbles?
- ❑ Small pebbles and dry?
- ❑ Long thin like pencil?

Can you see pieces of food in the stools?

Can you see any mucus in stools?

Does it take a lot of effort to defecate?

Do you experience cramping after defecation?

URINATION

Do you urinate at night? **How many times?**

What is the color of your urine? **If other:**

Is it smelly?

Are you experiencing:

- ❑ Urinary urgency
- ❑ Incontinence
- ❑ Painful urination
- ❑ Other ____________________

Do you have a history of Kidney stones?

DIET/APPETITE/LIFE STYLE

Do you tend to be very hungry or of poor appetite?

Please check any of the items you consume on a regular basis and indicate how much and how often:

- ❑ Alcohol
- ❑ Coffee
- ❑ Caffeinated Tea
- ❑ Soda
- ❑ Sugar
- ❑ Aspartame/saccharin
- ❑ Splenda
- ❑ Fried foods
- ❑ Cigarettes
- ❑ Marijuana

What are your favorite foods?

What are your least favorite foods?

Are you:

- ❑ Vegan
- ❑ Vegetarian
- ❑ Meat eater

What % of your diet is raw fruits and vegetables?

What taste is in your mouth:

- ❑ Bitter
- ❑ Metallic
- ❑ Sweet
- ❑ Other ____________________

Do you crave:

- ❑ Salt
- ❑ Sugar
- ❑ Lemons
- ❑ Vinegar
- ❑ Hot and Spicy
- ❑ Dairy

Briefly describe your daily food regimen *(indicate time of day for each meal and environment):*

Breakfast:

Snacks:

Lunch:

Dinner:

Where do you generally shop for food?

How many meals you eat are home cooked from scratch (per day)?

Do you experience feelings of

❏ Bloating ❏ Belching ❏ Stomach Fullness

❏ Gas ❏ Hiccups ❏ Canker Sores

❏ Mouth Sores ❏ Bad Breath ❏ Sleepiness after meals

Do you have: ❏ Swollen Gums ❏ Bleeding Gums

What is the health of your teeth?
What do you generally drink? **Hot or Cold?**
How many ounces/mL a day?

How many hours do you sleep per night?
How many hours are ideal?
Bedtime **Normal wake up time**

Do you feel rested when you wake up?

Do you wake up during the night?
Why and what times?

What are your energy levels?

What do you do for exercise?
How many times a week?

How do you relax?

What makes you happy?

Do you feel stressed out? At home or work?

Do you enjoy your work?

What emotions do you experience on a regular basis:

❏ Fear ❏ Anxiety ❏ Anger ❏ Moodiness ❏ Depression
❏ Frustration ❏ Fidgety ❏ Irritation ❏ Forgetful ❏ Easily Distracted
❏ Resentment ❏ Agitation ❏ Grief ❏ Sadness
❏ Other ______________________________

How would you describe your overall emotional state?

Have you recently experienced a loss of hearing?
Tinnitus (ringing in ears)?

List any allergies:

List major surgeries, trauma, accidents, falls (include approx. age):

List prescription drugs you are taking and purpose of each:

List vitamins and supplements you are taking and purpose of each:

List major illnesses you have had (include approx. age):

List your parents’ and grandparents’ health issues, if known:

ADDITIONAL SYMPTOMS

Are you experiencing the following?

❑ Cough ❑ Dry ❑ With clear mucus ❑ with white mucus ❑ With yellow or green mucus

- ❑ Frequent colds/flu
- ❑ Difficulty inhaling
- ❑ Difficulty exhaling
- ❑ Shortness of breath
- ❑ Shallow breathing
- ❑ Stuffiness in chest
- ❑ Rashes
- ❑ Acne
- ❑ Dry Skin
- ❑ Eczema
- ❑ Varicose Veins
- ❑ Hair Loss
- ❑ Easy Bruising
- ❑ Hemorrhoids
- ❑ Feeling of Heaviness
- ❑ Palpitations
- ❑ Irregular heart beat
- ❑ High cholesterol
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Puffiness
- ❑ water retention/edema
- ❑ poor memory
- ❑ Low libido
- ❑ Infertility
- ❑ Other symptoms you would like to share:

Women Only

Are you pregnant?

How long is your menstrual cycle?

How long is your menses itself?

Is your menses regular?

Are you experiencing:

- ❑ Heavy bleeding?
- ❑ Scanty bleeding?
- ❑ No bleeding?
- ❑ Severe pain?

If experiencing pain, is the pain:

❑ Before or during period ❑ After period ❑ Stabbing

❑ Burning ❑ Relieved by Heat ❑ Worse with Heat

Is there a lot of clots in your flow?

Is the blood dark or light in color?

Have you ever experienced PMS?

If so, what are your symptoms

- ❑ Depression
- ❑ Insomnia
- ❑ Headaches
- ❑ Bloating
- ❑ Anger
- ❑ Nausea
- ❑ Other

Have you had:

- ❑ Ovarian Cysts
- ❑ Fibroids
- ❑ Breast Lumps
- ❑ Tumors

Are you experiencing excess vaginal discharge?

Color?

Number of Pregnancies:

Number of Miscarriages:

Number of Abortions:

PRACTITIONER ONLY

TONGUE (photo)

Body Color:	Pale	Red	Very red	Purple	Blue	Black coat
Coating:	Thick coat	No coat	White coat	Yellow coat		
Moisture:	Wet	Dry	Greasy			

Shape:

Thin	Swollen	Scalloped	Long	Short	Cracked	Trembling
Deviated	Spots	Curled up edges		Strawberry	Swollen sides	

Sublingual veins: ❑ Pale ❑ Red ❑ Purple

PULSES

Beats per minute:

Right wrist: Left wrist:

Lung: Heart:

Spleen: Liver:

Kidney Yang: Kidney Yin:

Anything that hasn't been discussed yet?

Do you have a strong aversion to the taste of licorice or peppermint?

Treatment Analysis:

Treatment Strategy:

Herbal Recommendation: