

Lindsay Kohn, L.Ac
 www.fiveelementaustin.com
 805.689.2739



Heritage Park Office Plaza
 4101 Medical Parkway, Suite #204
 Austin, TX 78756

Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name _____ Sex F M Date _____
 Date of birth _____ Age _____ Occupation _____
 Address _____ City _____ State _____ ZIP _____
 Main phone number _____ Other phone number _____
 E-mail address _____ Allow email contact Yes No
 Relationship status _____ Children _____ Family physician _____ Chiropractor _____
 Emergency contact name _____ Phone number _____
 How did you find out about us? Friends/relatives (Name) _____
 Direct mail Location Website Yellow pages Periodicals Other _____

Main problem(s)

What is/are your main problem(s)? _____
 What diagnosis, if any, have you received for this problem? _____
 When did this problem begin? _____ What are the causes of this problem? _____
 To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____
 What kind of treatment have you tried? _____
 What makes this problem worse? _____ What makes this problem better? _____
 Is there anybody in your family with the same/similar problems? _____
 Remarks and additional information: _____

Medical History (Please include the month/year when the event occurred or when the diagnosis was made)

Surgeries: _____ Hospitalization: _____
 Significant trauma: (auto accidents, sports injuries, etc) _____
 Allergies: (drugs, chemicals, foods, environmental): _____

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type?)			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or Anxiety			Other		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

Occupation: _____ Do you usually work indoors outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

Personal Data

Height _____ Weight now _____ Weight one year ago _____ Weight maximum _____ @Year _____

Do you smoke? Yes No What? _____ How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes: _____

Do you exercise regularly? Yes No Please describe your exercise program: _____

How many hours do you sleep in general? _____ What time do you usually go to bed? _____

Diet

How much coffee do you drink? _____ cups/day Colas? _____ number/day Tea? _____ cups/day Water? _____ glasses/day

What kind of alcoholic beverages do you drink, if any? _____ Average number of drinks/week? _____

Are you a vegetarian? Yes No Yes, but not so strict Do you eat a lot of spicy food? Yes No

Remarks and additional information (e.g. diet) _____

Please describe your average daily diet (Please be as specific as possible):

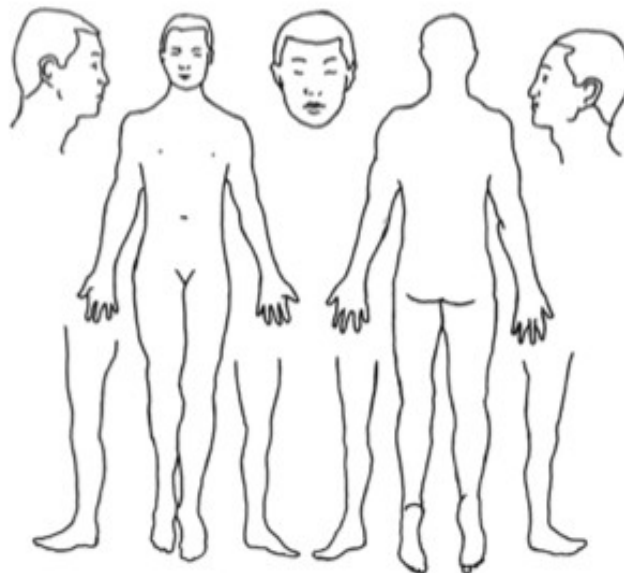
Morning _____

Afternoon _____

Evening _____

Snacks _____

Indicate painful or distressed areas:



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General

- | | | | | |
|---|---|---|---|--------------------------------------|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Poor balance | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Peculiar tastes | <input type="checkbox"/> Desire hot food | <input type="checkbox"/> Desire cold food | <input type="checkbox"/> Strong thirst (cold or hot drinks) | |
| <input type="checkbox"/> Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____ | | | | |

Skin & hair

- | | | | | |
|---------------------------------------|--------------------------------------|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Pimples | <input type="checkbox"/> Acne | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Purpura | <input type="checkbox"/> Change in hair or skin texture | | <input type="checkbox"/> Other _____ |

Musculoskeletal

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Joint disorders | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Pain/soreness in muscles | | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Neck tightness |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Joint sprain | <input type="checkbox"/> Other _____ | | | |

Head, eyes, ears, nose, and throat

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses/lens | <input type="checkbox"/> Eye strain |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Color blindness | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nose bleeding | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Other _____ |

Cardiovascular

- | | | | | |
|--|--|--|---|--------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Other _____ |

Respiratory

- | | | | | |
|------------------------------------|---|--|---|-------------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Production of phlegm (what color) _____ | | |

Gastrointestinal

- | | | | | |
|--------------------------------------|---------------------------------------|--|---|-------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Abdominal pain/cramps | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Parasites |

Chronic laxative use

Bowel movements: Frequency _____ Color _____ Odor _____ Texture _____

Neuro-psychological

- Loss of balance Lack of coordination Concussion Depression Anxiety
- Stress Bad temper Bi-polar

Genital-urinary

- Painful urination Frequent urination Blood in urine Urgency to urinate Kidney stones
- Unable to hold urine Dribbling Pause of flow Frequent urinary tract infection
- Genital pain Genital itching Genital rashes STD Other _____

Female

- Frequent vaginal infections Pelvic infection Endometriosis Fibroids
- Vaginal/genital discharge Ovarian cysts Irregular periods Clots
- Pain/cramps prior to/during periods Breast tenderness Breast lumps Hot flashes
- Moodiness related to periods Fertility problems

____ Number of pregnancies ____ Number of births ____ Miscarriages ____ Abortions
 ____ Premature births ____ C-sections ____ Difficult delivery

First date of last period _____ Age of first period _____ Duration of periods _____ days, cycle _____ days

Do you practice birth control? Yes No If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

Male

- Prostate problems Fertility problems Erectile dysfunction Ejaculation problems Discharge
- Frequent seminal emission Painful/swollen testicles Other _____

I have completed this form correctly to the best of my knowledge.

Signature: _____ Adult patient Parent or Guardian Spouse

Are there any other health issues you want to discuss with us?

Signature

Date