Cameron Clinic of Oriental Medicine
New Patient Intake Form- Life Vessel *today's date: ____________*

Name: **SS#** **Birthdate: / /** **Marital Status:** **Age:**
Address: **[] M [] F Ht. Wt.**
Home Phone: **Work Phone:** **Occupation:**   **Cell phone:** **email:**
Emergency Contact - Name and Phone:
Email address:
Allergies (medication, food, etc.)
Referred by/How did you hear about us?:
Reason for visit today? **Have you had acupuncture before? [] Yes [] No** **Chinese herbal medicine? [] Yes [] No**
How long have you had this condition?
Is it getting worse? **Does it bother your: [] Sleep [] Work [] other What?**
What seemed to be the initial cause?
What seems to make it better?
What seems to make it worse?
Are you under the care of a physician now? []Yes [] No If yes, for what?
Who is your physician? **Phone:**
What treatments are you getting for this condition? (physical therapy, massage, yoga, aromotherapy, etc.)
Current Medications: **Current Nutritional or Herbal supplements:**

Family Medical History:

[] Heart disease[] Diabetes [] Cancer [] High Blood Pressure
[] Stroke [] Asthma [] Seizures [] Alcoholism
________________ _____________ ___________ _____________________

Your Past Medical History

[] AIDS/HIV	[] Diabetes	[] Multiple sclerosis	[] Thyroid
[] Alcoholism	[] Emphysema	[] Mumps	[] TB
[] Allergies	[] Epilepsy	[] Pacemaker	[] Typhoid fever
[] Appendicitis	[] Goiter	[] Pneumonia	[] Ulcers
[] Asthma	[] Heart Disease	[] Seizures	[] _____________
[] Cancer	[] Hepatitis	[] Stroke	[] _____________
[] Chicken Pox	[] High Blood Pressure	[] ______________	[] _____________

List any hospitalizations you have had during the past 5 years:______________________________
____

Surgeries: (list) ____
____

Your Diet

Appetite: [] Low [] Normal [] High

[] Coffee [] Tea [] Thirst for water: #glass/day ______

[] Soft Drinks [] Salty Food

[] Sugar [] Stevia

[] Artificial Sweetener

Average daily menu:

Morning________________________________ Snack ________________________________

Snack ________________________________ Evening________________________________

Noon ________________________________ Snack ________________________________

[] Digestive enzymes. Brand __________________________________

I have trouble eating: [] milk [] dairy [] gluten [] meat [] shrimp [] soy [] salad

Other: ____

Has your digestion changed in the last six months? [] yes [] no

If yes, how?____

____

Your Lifestyle

[] Alcohol [] Marijuana [] Stress [] Tobacco [] Drugs [] Occupational Hazards

[] Exposure to chemicals [] Exposure to mold

Regular Exercise: Type: _____________________________________ How Often _____________

General Symptoms

[] Poor appetite	[] Poor sleep	[] Body feels heavy	[] Chills
[] Excess appetite	[] Sleep too much	[] Cold hands/feet	[] Night sweats
[] Strongly like cold drinks	[] Dream disturbed sleep	[] Poor circulation	[] Sweat easily
[] Strongly like hot drinks	[] Fatigue	[] Shortness of breath	[] Muscle cramps
[] Recent weight loss/gain	[] Lack of strength	[] Fever	[] Vertigo or dizziness
[] Bleed or bruise easily	[] Peculiar tastes (describe) _____________________________________		

Head, Eyes, Ears, Nose, Throat

[] Glasses	[] Night blindness	[] Sores on lips/tongue	[] Recurrent sore throat
[] Headaches	[] Glaucoma	[] Dry mouth	[] Swollen glands
[] Red eyes	[] Cataracts	[] Excessive saliva	[] Lumps in throat
[] Itchy eyes	[] Teeth problems	[] Sinus problems	[] Enlarged thyroid
[] Spots in eyes	[] Grinding teeth	[] Excessive phlegm	[] Nose bleeds
[] Poor vision	[] TMJ	Color of phlegm	[] Ringing in ears
[] Blurred vision	[] Facial pain	__________________	[] Poor hearing
[] Dry eyes	[] Gum problems	Other: ____	

[] I am sensitive to smells. Type _________________ [] I am sensitive to chemicals _______________

[] I have been exposed to chemicals, fertilizers, paints, hair dye, other: ___________________________

[] I am sensitive to mold [] I have mold in my house

Respiratory

[] Difficulty breathing when lying down	[] Tight chest	[] Cough	Color of phlegm
	[] Asthma/wheezing	Wet or Dry?_______________	____________________
[] Shortness of breath	[] Pneumonia	Thick or Thin?_____________	[] Cough blood

Cardiovascular

[] High blood pressure	[] Low blood pressure	[] Chest pain	[] Palpitations
[] Phlebitis	[] Blood clots	[] Fainting	[] Difficult breathing

[] Irregular heart beat Are you taking blood thinners or aspirin? [] Yes [] No

Gastrointestinal

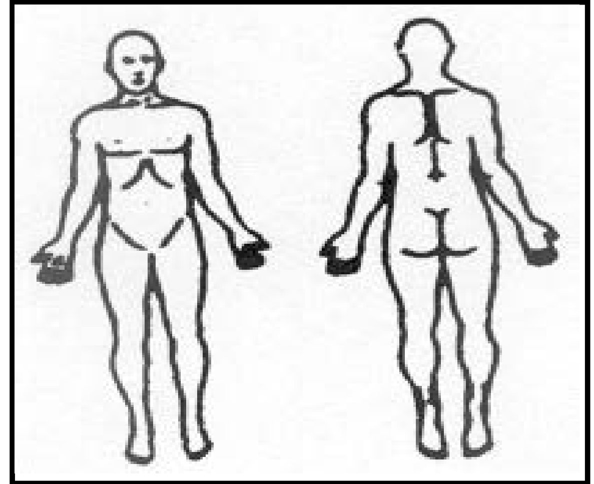
[] Nausea	[] Diarrhea	[] Intestinal pain or cramping	Bowel Movements
[] Vomiting	[] Constipation	[] Itchy anus	Frequency __________
[] Acid regurgitation	[] Use laxatives	[] Burning anus	Color _______________

[] Gas
[] Hiccups
[] Bloating
[] Bad breath
[] Black stools
[] Bloody stools
[] Mucus in stools
[] Rectal pain
[] Hemorrhoids
[] Anal fissures
Formed or loose______
Strong odor:[]Yes [] No

Musculoskeletal

[] Neck/Shoulder Pain
[] Muscle pain
[] Limited range of movement
[] Upper back pain
[] Low back pain
[] Sciatica
[] Numbness
[] Joint pain
[] Rib pain
[] Paralysis

Mark areas of pain on the diagram



Skin and Hair

[] Rashes
[] Hives
[] Ulcerations
[] Eczema
[] Psoriasis
[] Acne
[] Dandruff
[] Itching
[] Hair loss
[] Change in hair/skin texture
[] Fungal infections

Other hair or skin problems: ____

Neuropsychological

[] Seizures
[] Depression
[] Tics
[] Poor memory
[] Easily stressed
[] Abuse survivor
[] Irritability
[] Anxiety
[] Considered or attempted suicide
[] Seeing a therapist

Other: ____

Genitourinary

[] Pain on urination
[] Frequent urination
[] Urgent urination
[] Kidney stone
[] Blood in urine
[] Unable to hold urine
[] Incomplete urination
[] Venereal disease
[] Bedwetting
[] Wake to urinate
[] Increased libido
[] Decreased libido
[] Impotence
[] Premature ejaculation
[] Testicular self exam

Gynecology

Age menses began
____
Length of cycle
____
[] Date last period began ____________
Age of menopause _____________

Duration of Flow
____
[] Irregular periods
[] Painful periods
[] Clots
[] PMS

[] Vaginal discharge color ______________
[] Vaginal sores
[] Vaginal odors
[] Breast self exam
Date of last PAP exam __________________________

[] Breast lumps
[] # pregnancies____________
[] # live births _____________
[] # abortions ______________
[] # premature births ________

Life Vessel Disclaimer:

I understand that the questions on this form are being asked in order to better assess my current condition and their relationship to my well-being. I further understand that I am voluntarily agreeing to have a relaxation therapy session in the Life Vessel and that no medical claims or promises of healing have been given. Lastly, I acknowledge that the Life Vessel treatments do not supersede the recommendation of my personal physician nor are intended to replace the conventional standard of medical care.

Printed Name: ____
Signature: ____
Date: ________________________________