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Patient Intake Form©

Name: _____ Date _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone 1: _____ Phone 2: _____

Phone number where messages can be left for you: _____

Email address: _____

Age: _____ Date of birth: _____ Gender: _____

Your relationship status: _____ Occupation: _____

Employer name: _____ Hours worked per week: _____

Work address: _____

Emergency contact name: _____ Relationship to you: _____

Contact address: _____ Phone: _____

What are your health concerns? *Please list them in the order of importance for you today.*

1. _____
2. _____
3. _____
4. _____

What are your goals for treatment? *Please describe them.*

1. _____
2. _____

How motivated are you to receive help and make changes for your health? _____

Are you receiving health care somewhere else? *If yes, please list from whom and where their office is located.*

What health issues are you being treated for? _____

Do you have any concerns with our office sharing information with your other provider(s)? _____

Current Medications

Do you use any of the following? *Please check all the boxes that apply.*

- | | |
|--|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Anti-inflammatory medications | <input type="checkbox"/> Other psychiatric medications |
| <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Blood pressure medications |
| <input type="checkbox"/> Cholesterol lowering medications | <input type="checkbox"/> Hormones of any kind |
| <input type="checkbox"/> Stomach aids or digestive medications | <input type="checkbox"/> Sleeping Pills |

Please list any other prescription medications, over-the-counter medications, vitamins, herbs, and nutritional supplements you use and how frequently. Include dosage if you can.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Diet, Lifestyle, and Habits *Please describe your typical daily meals*

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Please describe what type of allergies or hypersensitivity reactions you notice:

Food: _____

Medications: _____

Chemicals: _____

Animals: _____

Do you use or identify with any of the following: *Please check all the boxes that apply.*

- | | | |
|---|--|--|
| <input type="checkbox"/> Fast food outlets | <input type="checkbox"/> Cravings for salty starches | <input type="checkbox"/> History of eating disorders |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Afternoon or evening cravings | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Sodas | <input type="checkbox"/> Reward yourself with food(s) | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Canned foods | <input type="checkbox"/> Cravings for comfort food(s) | <input type="checkbox"/> Marijuana |
| <input type="checkbox"/> Teas (caffeinated) | <input type="checkbox"/> Eat near bedtime or at night | <input type="checkbox"/> Other recreational drugs |
| <input type="checkbox"/> Salt or sugar your foods | <input type="checkbox"/> Irritable if not eating regularly | |
| <input type="checkbox"/> Cravings for sweets | <input type="checkbox"/> History of dieting | |

Diet, Lifestyle, and Habits (Continued)

Considering the past 6 months, please answer the following:

Describe how much and what type of exercise you performed _____

How many hours did you typically spend in front of computers or televisions during a day/week? _____

What areas in your life were the most common stressors? _____

What have been your hobbies or interests? _____

Describe your supportive relationships and/or communities/groups you participated in. _____

Did you attend any religious ceremony or perform any spiritually oriented practice? _____

If you wish, please tell more about any of these areas. _____

General

Height _____ Current weight _____ Weight 1 year ago? _____ Preferred weight _____

Last physical exam _____ History of trauma? _____ History of abuse? _____

Review of Systems

In this section, check the box if you have the symptom currently or if you have experienced it in the past 6 months.

Mental/Emotional

- Mood intensity or frequency concerns
- Mood swings
- Seasonal depression
- Depression
- Considered/attempted suicide
- Poor concentration
- Anxiety or nervousness
- Tension or chronic stress feelings
- Memory problems
- Easily stressed
- Sleep disruption or disturbance

Endocrine

- Hair loss
- Brittle nails
- Excessive thirst
- General fatigue
- Fatigue after meals
- Heat intolerance
- Cold intolerance
- Excessive hunger

Head

- Headaches
- Migraines
- Head injury
- Jaw pain/TMJ

Immune

- Chronic fatigue syndrome
- Swollen glands
- Reaction to vaccines
- Ongoing infections
- Slow wound healing
- Colds/flu more than once yearly
- Autoimmune disease
- History of autoimmune disease in family

Ears

- Impaired hearing
- Earaches
- Ringing
- Itching inside or outside
- Frequent popping

Review of Systems (Continued)

Nose and Sinuses

- Frequent head colds
- Stuffiness
- Sinus pain
- Nose bleeds
- Hay fever
- Loss of smell

Eyes

- Spots in vision
- Blurriness
- Color blindness
- Double vision
- Cataracts
- Eye pain/strain
- Uncomfortable tearing or dryness
- Glaucoma

Mouth and Throat

- Teeth grinding
- Frequent sore throat
- Gum bleeding/pain/disease
- Copious saliva
- Sore tongue/lips
- Hoarseness
- Jaw clicks

Neck

- Lumps
- Goiter/enlargement in front of throat
- Pain or stiffness

Peripheral Vascular

- Easy bleeding/bruising
- Deep leg pain
- Varicose veins
- Anemia
- Cold hands/feet

Neurological

- Seizures
- Muscle weakness
- Loss of memory
- Vertigo/dizziness
- Paralysis
- Numbness or tingling

Intestinal

- Trouble swallowing
- Change in thirst
- Change in appetite
- Nausea/vomiting
- Burning pain in stomach
- Heartburn
- Jaundice
- Gallbladder disease
- Liver disease
- Abdominal pain or cramps
- Excessive belching or excess gas
- Constipation
- Diarrhea
- Hemorrhoids
- Black stools
- Blood in stools
- Bowel movement (BM) daily

Musculoskeletal

- Joint pain or stiffness
- Broken bones
- Muscle spasms or cramps
- Arthritis
- Weakness
- Sciatica

Skin

- Rashes
- Itchiness
- Acne, boils
- Color changes
- Lumps
- Eczema
- Hives

Urinary

- Pain with urination
- Urgency
- Frequency at night
- History of frequent infections
- Unable to hold urine
- Kidney stones
- Splitting of stream

Review of Systems (Continued)

Respiratory

- Cough
- Asthma/wheezing
- Difficulty breathing
- Emphysema
- Pain on breathing
- Shortness of breath
- Lung congestion/sputum
- Bronchitis
- Pleurisy
- Pneumonia

Cardiovascular

- Heart disease
- High blood pressure
- Low blood pressure
- Blood clots
- Phlebitis
- Rheumatic fever
- Ankle swelling
- Angina/chest pain
- Heart murmurs
- Fainting

Reproduction/Sexuality

- Are you sexually active? _____
- Sexual orientation
(Please describe) _____
- Use of birth control
(What type) _____
- History of STDs _____
- Libido concerns _____

Female Reproduction

(Questions apply to lifetime, not just last 6 months)

- Age at first menses (first period) _____
- Age of last menses (if menopausal) _____
- Date of last annual exam/Pap _____
- Number of pregnancies _____
- Number of live births _____
- Number of miscarriages _____
- Usual length of cycle _____
- Duration of menstruation _____
- Bleeding/spotting between periods _____
- PMS
- Menopausal symptoms _____
- Genital herpes
- Pain with sexual activity

Male Reproduction

(Questions apply to lifetime, not just last 6 months)

- Hernias
- Prostate disease
- Impotence
- Premature ejaculation
- Testicular masses or pain
- Discharge or sores on penis
- Genital herpes

Please list any other health concerns you wish to address that have not been covered in this questionnaire:

Thank you for filling out this form. Please bring it with you to your appointment.

Dr. Garcia looks forward to working with you.

Signature: _____ Date: _____