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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: _____ Health Insurance: _____

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 and write the name in the space afterwards.*

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

Considering the past 6 months, please answer the following:

Describe what type of exercises you do and how frequently you did them.

How many hours would 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 participate in. _____

Did you attend any religious ceremony or perform any spiritually oriented practice? _____ *If you wish, please write about them.* _____

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
- Seasonal depression

Blood/Peripheral Vascular

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

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

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

Ears

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

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
- Glaucoma
- Uncomfortable tearing or dryness

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

Mouth and Throat

- Frequent sore throat
- Teeth grinding

Neck

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

Respiratory

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

Musculoskeletal (continued)

- Weakness
- Sciatica

Neurological

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

Cardiovascular

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

Skin

- Rashes/hives
- Itchiness
- Acne, boils
- Color changes
- Lumps
- Eczema

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

Sexuality

Are you sexually active _____

Sexual orientation (Please describe) _____

Use of birth control (What type) _____

History of STDs _____

Libido concerns _____

Urinary

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

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

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

How did you hear about our services? _____

Is there someone we can thank for your referral? _____

Your privacy is very important and our policy on protecting your confidentiality is available anytime upon request. Our office also uses electronic medical charts for record keeping and insurance billing. Please ask if you have any questions about these services and how you can access your medical file.

Dr. Garcia looks forward to working with you. Thank you for filling out this intake form. Please bring it with you to your appointment.

Your signature: _____ Date: _____