Integrated Center for Oriental Medicine

New Patient Preliminary Information Questionnaire

Patient:____
(first) (m.i.) (last)

Address: ____

City:______________________________ State:_____________ Zip code: _______________________

Phone: ____________________ ________________________ ________________________
(cell) (home) (work)

E-mail: _____________________________________

Occupation:_________________________________ Date of Birth: ______________________________

Circle one: Single Married Divorced Widowed Spouse's name:_____________________________

Emergency Contact:______________________________ Relation: _______________________________

Emergency Contact's Phone: _____________________________

Female: Are you pregnant?__________Number and Ages of Children: ____________________________

Date of Accident/Beginning of Illness:_________Location of Accident:___________________________

Have you lost time from work?_______Dates: ____

How did it occur? (circle one) Auto Collision On-the-Job Other: _______________________________

How did you hear about us? ____

All professional services rendered are charged to the patient and remain the patient's responsibility regardless of insurance coverage. Payment is due at the time services are rendered unless arrangements have been made in advance.

Please give cancellation notices 24 hours in advance to your scheduled appointment or a $95.00 fee for a missed appointment will be charged. Please initial here stating that you have read and understood this policy: _____________

Insurance Authorization (Please read and sign)
I hereby authorize the Integrated Center for Oriental Medicine to release all medical information required by my insurance company so that I may file for medical benefits. *I also state that the above information is correct to the best of my knowledge.*

____ ____________________
(Signature) (Date)

PATIENT HISTORY

NAME:____AGE:____________DATE______________

PRESENT WEIGHT:___________ WEIGHT 6 MNTHS AGO:___________PARA:___________GRAVIDA:__________

CHIEF COMPLAINT/PRESENT ILLNESS: ________________________

PAST OPERATIONS/ILLNESSES:

CURRENT MEDICATIONS:

PERSONAL PHYSICIANS:

FAMILY HISTORY:

FATHER
LIVING YES NO
AGE

MOTHER
LIVING YES NO
AGE

SISTERS/BROTHERS
HOW MANY?
AGES:

PREVIOUS ACCIDENTS:

SOCIAL HISTORY:

EXERCISE YES NO FREQUENCY_____________
ALCOHOL YES NO FREQUENCY_____________
TOBACCO YES NO FREQUENCY_____________

PLEASE CHECK IF ANY PROBLEMS IN THE FOLLOWING AREAS:								
H.E.N.T.	YES	NO	CARDIO-RESP.	YES	NO	G-U	YES	NO
HAIR			CHEST PAIN			FREQUENCY		
HEADACHE			SHORTNESS BREATH			URGENCY		
HEAD TRAUMA			COUGH			INCONTINENCE		
VISUAL DIST.			SPUTUM			BLOOD IN URINE		
EYE PAIN			HYPERTENSION			RETENTION		
DOUBLE VISION			NIGHT SWEATS			BURNING ON URIN.		
BLURRING			PALPITATION			STONES		
CONJUNCTIVITIS			EDEMA			IMPOTENCE		
DEAFNESS			BREASTS			MENSTRUAL PERIOD		
DIZZINESS			OTHER			AGE OF ONSET		
RINGING						DURATION		
TEETH			GASTRO-INTESTINAL			LMP		
SORE TONGUE						PAIN		
HOARSENESS			EATING HABITS			PAIN ON INTERCOURSE		
NECK PAIN			FOOD INTOLERANCE			DISCHARGE		
OTHER			GAS			OTHER		
			HEARTBURN					
GENERAL:			VOMITING			NEUROMUSCULAR		
			NAUSEA					
WORRIES			CONSTIPATION			NUMBNESS		
TENSION			DIARRHEA			TINGLING		
FAINTING			CATHARTIC HABIT			WEAKNESS		
INSOMNIA			ABDOMINAL PAIN			PARALYSIS		
WEAKNESS			CRAMPS			UNCONSCIOUSNESS		
FEVER			JAUNDICE			CONVULSIONS		
ARTHRITIS			RECTAL BLEEDING			CRAMPS		
SKIN RASH			RECTAL PAIN			ATAXIA		
PIGMENT			HERNIA			SPEECH		
ITCHING			OTHER			BACKACHE		
BRUISING						MEMORY		
						DROWSINESS		

Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

Name:______________________________ **Age:**______ **Sex:**________ **Date:**____________________

* Please circle the appropriate number "0 - 3" on all questions below. **0 as the least/never to 3 as the most/always.**

SECTION: GENERAL

- Does your child have any food sensitivities or allergies? (please list)
- List your child's 4 healthiest foods eaten regularly.
- List your child's 4 unhealthiest foods eaten regularly.
- How many times a week does your child eat candy? ______
- How many times a week does your child drink soda pop? _______
- Please list the top 4 foods your child craves regularly?
- List the medication(s) your child is currently prescribed and over the counter.
- Do you find it difficult as a parent to have your child on a special diet?

SECTION: A (K52)

- Does your child eat pasta, breads, and breaded foods? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? **0 1 2 3**
- Does your child eat dairy products? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? **0 1 2 3**

SECTION: B (K53)

- Does your child eat fried fish? **0 1 2 3**
- Does your child eat roasted nuts or seeds? **0 1 2 3**
- Is your child **missing** essential fatty acid rich foods in his/her diet? (for example: avocadoes, flax seeds, olives) *(mark "0" if present, "3" if missing)* **0 1 2 3**
- Does your child eat *fried* foods? **0 1 2 3**

SECTION: C (K34)

- Is your child's mental speed slow? **0 1 2 3**
- Does your child have difficulty with learning or memory? **0 1 2 3**
- Does your child have difficulty with balance and coordination? **0 1 2 3**

SECTION: D (K16)

- Does your child have stress? **0 1 2 3**
- Does your child **not** have enough sleep and rest? *(mark "3" if not enough)* **0 1 2 3**
- Does your child **not** have regular exercise? *(mark "3" if no exercise)* **0 1 2 3**
- Does your child feel overly worried and scared? **0 1 2 3**

SECTION: E (K16, K51)

- Does your child have temper tantrums? **0 1 2 3**
- Does your child exhibit wild behavior? **0 1 2 3**
- Does your child frequently yell or scream for unnecessary reasons? **0 1 2 3**
- Does your child have an **inability** to nap or sleep when physically exhausted? *(mark "3" if unable)* **0 1 2 3**
- Is your child overly talkative? **0 1 2 3**
- Does your child fidget and squirm when seated? **0 1 2 3**
- Does your child run and climb excessively when it is inappropriate? **0 1 2 3**
- Does your child have difficulty playing quietly or engaging in leisure activities? **0 1 2 3**

SECTION: F (K51)

- Does your child get excited easily? **0 1 2 3**
- Does your child have anxiousness and panic for minor reasons? **0 1 2 3**
- Does your child feel overwhelmed for minor reasons? **0 1 2 3**
- Does your child find it difficult to relax when she/he is awake? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION: G (K50)

- Does your child seem depressed? **0 1 2 3**
- Does your child have mood changes with overcast weather? **0 1 2 3**
- Does your child have symptoms of inner rage? **0 1 2 3**
- Does your child seem uninterested in games or hobbies? **0 1 2 3**
- Does your child have difficulty falling into deep restful sleep? **0 1 2 3**
- Does your child seem uninterested in friendships? **0 1 2 3**
- Does your child have symptoms of unprovoked anger? **0 1 2 3**
- Does your child seem uninterested in eating? **0 1 2 3**

SECTION: H (K49)

- Does your child have difficulty handling stress? **0 1 2 3**
- Does your child have anger and aggression while being challenged? **0 1 2 3**
- Does your child feel tired even after long sleeps? **0 1 2 3**
- Does your child tend to isolate from others? **0 1 2 3**
- Does your child get distracted easily? **0 1 2 3**
- Does your child have constant need and desire for candy and sugar? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION: I (K48)

- Does your child have difficulty with visual memory? **0 1 2 3**
- Does your child have difficulty remembering locations? **0 1 2 3**
- Does your child have fatigue or low endurance for learning activities? **0 1 2 3**
- Does your child have difficulty with attention or low attention span or endurance? **0 1 2 3**
- Does your child have slow or difficult speech? **0 1 2 3**
- Does your child have uncoordinated or slow movement? **0 1 2 3**

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only

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