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: _____

Female: Are you pregnant? _____ Number & Ages of children: _____

Emergency Contact: _____ Relation: _____

Emergency Contact's Phone: _____

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? _____

What other health care have you received for the problem(s) you would like for us to address?

_____

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 $135.00 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		

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

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

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Lowered gastrointestinal motility, constipation	0	1	2	3
Raised gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes	No		

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes			No
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Health Questionnaire (NTAF)

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 A

- Is your memory noticeably declining? **0 1 2 3**
- Are you having a hard time remembering names and phone numbers? **0 1 2 3**
- Is your ability to focus noticeably declining? **0 1 2 3**
- Has it become harder for you to learn things? **0 1 2 3**
- How often do you have a hard time remembering your appointments? **0 1 2 3**
- Is your temperament getting worse in general? **0 1 2 3**
- Are you losing your attention span endurance? **0 1 2 3**
- How often do you find yourself down or sad? **0 1 2 3**
- How often do you fatigue when driving compared to the past? **0 1 2 3**
- How often do you fatigue when reading compared to the past? **0 1 2 3**
- How often do you walk into rooms and forget why? **0 1 2 3**
- How often do you pick up your cell phone and forget why? **0 1 2 3**

SECTION B

- How high is your stress level? **0 1 2 3**
- How often do you feel that you have something that must be done? **0 1 2 3**
- Do you feel you never have time for yourself? **0 1 2 3**
- How often do you feel you are not getting enough sleep or rest? **0 1 2 3**
- Do you find it difficult to get regular exercise? **0 1 2 3**
- Do you feel uncared for by the people in your life? **0 1 2 3**
- Do you feel you are not accomplishing your life's purpose? **0 1 2 3**
- Is sharing your problems with someone difficult for you? **0 1 2 3**

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? **0 1 2 3**
- How often do you feel energized after eating? **0 1 2 3**
- How often do you have difficulty eating large meals in the morning? **0 1 2 3**
- How often does your energy level drop in the afternoon? **0 1 2 3**
- How often do you crave sugar and sweets in the afternoon? **0 1 2 3**
- How often do you wake up in the middle of the night? **0 1 2 3**
- How often do you have difficulty concentrating before eating? **0 1 2 3**
- How often do you depend on coffee to keep yourself going? **0 1 2 3**
- How often do you feel agitated, easily upset, and nervous between meals? **0 1 2 3**

SECTION C2

- Do you get fatigued after meals? **0 1 2 3**
- Do you crave sugar and sweets after meals? **0 1 2 3**
- Do you feel you need stimulants such as coffee after meals? **0 1 2 3**
- Do you have difficulty losing weight? **0 1 2 3**
- How much larger is your waist girth compared to your hip girth? **0 1 2 3**
- How often do you urinate? **0 1 2 3**
- Have your thirst and appetite been increased? **0 1 2 3**
- Do you have weight gain when under stress? **0 1 2 3**
- Do you have difficulty falling asleep? **0 1 2 3**

SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? **0 1 2 3**
- How often do you feel overwhelmed with ideas to manage? **0 1 2 3**
- How often do you have feelings of inner rage (anger)? **0 1 2 3**
- How often do you have feelings of paranoia? **0 1 2 3**
- How often do you feel sad or down for no reason? **0 1 2 3**
- How often do you feel like you are **not** enjoying life? **0 1 2 3**
- How often do you feel you lack artistic appreciation? **0 1 2 3**
- How often do you feel depressed in overcast weather? **0 1 2 3**
- How much are you losing your enthusiasm for your favorite activities? **0 1 2 3**
- How much are you losing enjoyment for your favorite foods? **0 1 2 3**
- How much are you losing your enjoyment of friendships and relationships? **0 1 2 3**
- How often do you have difficulty falling into deep restful sleep? **0 1 2 3**
- How often do you have feelings of dependency on others? **0 1 2 3**
- How often do you feel more susceptible to pain? **0 1 2 3**
- How often do you have feelings of unprovoked anger? **0 1 2 3**
- How much are you losing interest in life? **0 1 2 3**

SECTION 2 - D

- How often do you have feelings of hopelessness? **0 1 2 3**
- How often do you have self-destructive thoughts? **0 1 2 3**
- How often do you have an inability to handle stress? **0 1 2 3**
- How often do you have anger and aggression while under stress? **0 1 2 3**
- How often do you feel you are not rested even after long hours of sleep? **0 1 2 3**
- How often do you prefer to isolate yourself from others? **0 1 2 3**
- How often do you have unexplained lack of concern for family and friends? **0 1 2 3**
- How easily are you distracted from your tasks? **0 1 2 3**
- How often do you have an inability to finish tasks? **0 1 2 3**
- How often do you feel the need to consume caffeine to stay alert? **0 1 2 3**
- How often do you feel your libido has been decreased? **0 1 2 3**
- How often do you lose your temper for minor reasons? **0 1 2 3**
- How often do you have feelings of worthlessness? **0 1 2 3**

SECTION 3 - G

- How often do you feel anxious or panic for no reason? **0 1 2 3**
- How often do you have feelings of dread or impending doom? **0 1 2 3**
- How often do you feel knots in your stomach? **0 1 2 3**
- How often do you have feelings of being overwhelmed for no reason? **0 1 2 3**
- How often do you have feelings of guilt about everyday decisions? **0 1 2 3**
- How often does your mind feel restless? **0 1 2 3**
- How difficult is it to turn your mind off when you want to relax? **0 1 2 3**
- How often do you have disorganized attention? **0 1 2 3**
- How often do you worry about things you were not worried about before? **0 1 2 3**
- How often do you have feelings of inner tension and inner excitability? **0 1 2 3**

SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? **0 1 2 3**
- Do you feel your verbal memory is decreased? **0 1 2 3**
- Do you have memory lapses? **0 1 2 3**
- Has your creativity been decreased? **0 1 2 3**
- Has your comprehension been diminished? **0 1 2 3**
- Do you have difficulty calculating numbers? **0 1 2 3**
- Do you have difficulty recognizing objects & faces? **0 1 2 3**
- Do you feel like your opinion about yourself has changed? **0 1 2 3**
- Are you experiencing excessive urination? **0 1 2 3**
- Are you experiencing slower mental response? **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.

SMGEPQNTAF04(1009).INDD

Medication History

Please circle any of the following medication you have been or are currently taking.

Acetylcholine Receptor Antagonist – Antimuscarinic Agents
Atropine, Ipratopium, Scopolamine, Tiotropium

Acetylcholine Receptor Antagonist - Ganlionic Blockers
Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

Acetylcholinesterase Reactivators
Pralidoxime

Acetylcholine Receptor Antagonist - Neuromuscular Blockers
Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

Agonist Modulator of GABA Receptor (benzodiazpines)
Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSon, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax , Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazpines)
Ambien, Sonata, Lunesta, Imovane

Cholinesterase Inhibitors (irreversible)
Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

Cholinesterase Inhibitors (reversible)
Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticidses

Dopamine Reuptake Inhibitors
Wellbutrin (Bupropion)

Dopamine Receptor Agonists
Mirapex, Sifrol, Requip

D2 Dopamine Receptor Blockers (antipsychotics)
Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, luanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

GABA Antagonist Competitive binder
Flumazenil

Monoamine Oxidase Inhibitor (MAOI)
Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

Noradrenergic and Specific Sertonergic Antidepressants (NaSSaa)
Remeron, Zispin, Avanza, Norset, Remergil, Axit

Selective Serotonin Reuptake Inhibitor
Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil , Emocal, Serpam, Seropram, Cipralex, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

Selective Serotonin Reuptake Enhancers
Stablon, Coaxil, Tatinol

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

Tricylic Antidepresseants (TCAs)
Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

***Please refer to prescribing physician for nutritional interactions with any medications you maybe taking.**