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### Patient Intake Form

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

Full name \_\_\_\_\_ Sex  F  M Date \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Main phone number \_\_\_\_\_ Other phone number \_\_\_\_\_  
 E-mail address \_\_\_\_\_ Allow email contact  Yes  No  
 Relationship status \_\_\_\_\_ Children \_\_\_\_\_ Family physician \_\_\_\_\_ Chiropractor \_\_\_\_\_  
 Emergency contact name \_\_\_\_\_ Phone number \_\_\_\_\_  
 How did you find out about us?  Friends/relatives (Name) \_\_\_\_\_  
 Direct mail  Location  Website  Yellow pages  Periodicals  Other \_\_\_\_\_

#### Main problem(s)

What is/are your main problem(s)? \_\_\_\_\_  
 What diagnosis, if any, have you received for this problem? \_\_\_\_\_  
 When did this problem begin? \_\_\_\_\_ What are the causes of this problem? \_\_\_\_\_  
 To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? \_\_\_\_\_  
 What kind of treatment have you tried? \_\_\_\_\_  
 What makes this problem worse? \_\_\_\_\_ What makes this problem better? \_\_\_\_\_  
 Is there anybody in your family with the same/similar problems? \_\_\_\_\_  
 Remarks and additional information: \_\_\_\_\_

#### Medical History (Please include the month/year when the event occurred or when the diagnosis was made)

Surgeries: \_\_\_\_\_ Hospitalization: \_\_\_\_\_  
 Significant trauma: (auto accidents, sports injuries, etc) \_\_\_\_\_  
 Allergies: (drugs, chemicals, foods, environmental): \_\_\_\_\_

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type?)			Breathing problems			Tuberculosis		
Diabetes			Heart disease			High cholesterol		
Hepatitis			Digestive disorders			High blood pressure		
Thyroid disease			Venereal disease			Emotional disorders		
Seizures			Alcoholism			Anemia		
Arthritis			Depression or Anxiety			Other		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

\_\_\_\_\_

Occupation: \_\_\_\_\_ Do you usually work  indoors  outdoors?

Occupational stress (chemical, physical, psychological, etc): \_\_\_\_\_

**Personal Data**

Height \_\_\_\_\_ Weight now \_\_\_\_\_ Weight one year ago \_\_\_\_\_ Weight maximum \_\_\_\_\_ @Year \_\_\_\_\_

Do you smoke?  Yes  No What? \_\_\_\_\_ How many per day? \_\_\_\_\_ Since when? \_\_\_\_\_

Please describe any use of drugs for non-medical purposes: \_\_\_\_\_

Do you exercise regularly?  Yes  No Please describe your exercise program: \_\_\_\_\_

How many hours do you sleep in general? \_\_\_\_\_ What time do you usually go to bed? \_\_\_\_\_

**Diet**

How much coffee do you drink? \_\_\_\_\_ cups/day Colas? \_\_\_\_\_ number/day Tea? \_\_\_\_\_ cups/day Water? \_\_\_\_\_ glasses/day

What kind of alcoholic beverages do you drink, if any? \_\_\_\_\_ Average number of drinks/week? \_\_\_\_\_

Are you a vegetarian?  Yes  No  Yes, but not so strict Do you eat a lot of spicy food?  Yes  No

Remarks and additional information (e.g. diet) \_\_\_\_\_

Please describe your average daily diet (Please be as specific as possible):

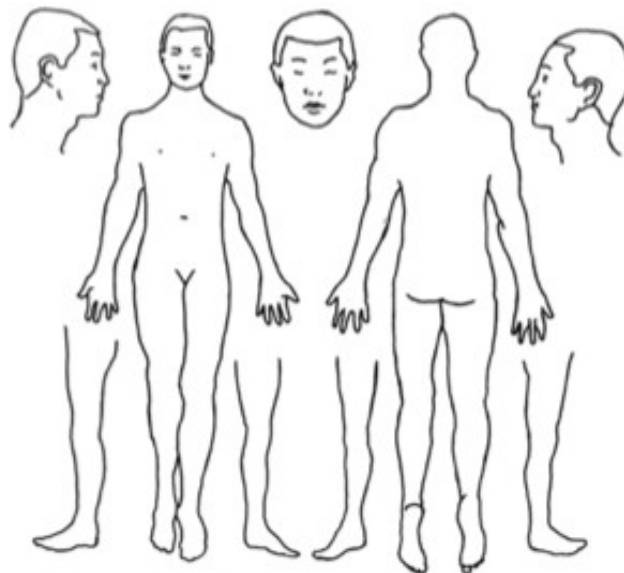
Morning \_\_\_\_\_

Afternoon \_\_\_\_\_

Evening \_\_\_\_\_

Snacks \_\_\_\_\_

**Indicate painful or distressed areas:**



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

**General**

- |   |   |   |   |                                      |
|---|---|---|---|--------------------------------------|
| <input type="checkbox"/> Poor appetite  | <input type="checkbox"/> Poor sleep             | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Fevers                             | <input type="checkbox"/> Chills      |
| <input type="checkbox"/> Night sweats   | <input type="checkbox"/> Sweat easily           | <input type="checkbox"/> Tremors            | <input type="checkbox"/> Change in appetite                 | <input type="checkbox"/> Cravings    |
| <input type="checkbox"/> Poor balance   | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Weight loss                        | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Peculiar tastes  | <input type="checkbox"/> Desire hot food        | <input type="checkbox"/> Desire cold food   | <input type="checkbox"/> Strong thirst (cold or hot drinks) |                                      |
| <input type="checkbox"/> Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____ |   |   |   |                                      |

**Skin & hair**

- |                                       |                                      |   |                                   |                                       |
|---------------------------------------|--------------------------------------|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes       | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives                          | <input type="checkbox"/> Itching  | <input type="checkbox"/> Eczema       |
| <input type="checkbox"/> Pimples      | <input type="checkbox"/> Acne        | <input type="checkbox"/> Dandruff                       | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Purpura     | <input type="checkbox"/> Change in hair or skin texture |                                   | <input type="checkbox"/> Other _____  |

**Musculoskeletal**

- |  |   |   |   |   |
|--|---|---|---|---|
| <input type="checkbox"/> Joint disorders | <input type="checkbox"/> Muscle weakness    | <input type="checkbox"/> Pain/soreness in muscles |   | <input type="checkbox"/> Tremors        |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Swelling of hands/feet   | <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Back pain      |
| <input type="checkbox"/> Hernia          | <input type="checkbox"/> Numbness           | <input type="checkbox"/> Tingling                 | <input type="checkbox"/> Paralysis        | <input type="checkbox"/> Neck tightness |
| <input type="checkbox"/> Neck pain       | <input type="checkbox"/> Shoulder pain      | <input type="checkbox"/> Hand/wrist pain          | <input type="checkbox"/> Hip pain         | <input type="checkbox"/> Knee pain      |
| <input type="checkbox"/> Joint sprain    | <input type="checkbox"/> Other _____        |   |   |   |

**Head, eyes, ears, nose, and throat**

- |   |  |   |  |   |
|---|--|---|--|---|
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Concussions     | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Glasses/lens          | <input type="checkbox"/> Eye strain     |
| <input type="checkbox"/> Eye pain               | <input type="checkbox"/> Color blindness | <input type="checkbox"/> Night blindness      | <input type="checkbox"/> Poor vision           | <input type="checkbox"/> Cataracts      |
| <input type="checkbox"/> Blurry vision          | <input type="checkbox"/> Earaches        | <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> Poor hearing          | <input type="checkbox"/> Sore throat    |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems  | <input type="checkbox"/> Nose bleeding        | <input type="checkbox"/> Grinding teeth        | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Facial pain            | <input type="checkbox"/> Jaw clicks      | <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Other _____    |

**Cardiovascular**

- |  |  |  |   |                                      |
|--|--|--|---|--------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Chest pain      | <input type="checkbox"/> Palpitation    | <input type="checkbox"/> Fainting    |
| <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Other _____ |

**Respiratory**

- |                                    |   |  |   |                                     |
|------------------------------------|---|--|---|-------------------------------------|
| <input type="checkbox"/> Cough     | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Wheezing                                | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chest pain     | <input type="checkbox"/> Production of phlegm (what color) _____ |   |                                     |

**Gastrointestinal**

- |                                      |                                       |  |   |                                     |
|--------------------------------------|---------------------------------------|--|---|-------------------------------------|
| <input type="checkbox"/> Nausea      | <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Constipation         | <input type="checkbox"/> Gas        |
| <input type="checkbox"/> Belching    | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stools       | <input type="checkbox"/> Indigestion          | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids  | <input type="checkbox"/> Abdominal pain/cramps | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Parasites  |

Chronic laxative use

Bowel movements: Frequency \_\_\_\_\_ Color \_\_\_\_\_ Odor \_\_\_\_\_ Texture \_\_\_\_\_

**Neuro-psychological**

- Loss of balance       Lack of coordination       Concussion       Depression       Anxiety
- Stress       Bad temper       Bi-polar

**Genital-urinary**

- Painful urination       Frequent urination       Blood in urine       Urgency to urinate       Kidney stones
- Unable to hold urine       Dribbling       Pause of flow       Frequent urinary tract infection
- Genital pain       Genital itching       Genital rashes       STD       Other \_\_\_\_\_

**Female**

- Frequent vaginal infections       Pelvic infection       Endometriosis       Fibroids
- Vaginal/genital discharge       Ovarian cysts       Irregular periods       Clots
- Pain/cramps prior to/during periods       Breast tenderness       Breast lumps       Hot flashes
- Moodiness related to periods       Fertility problems

\_\_\_\_ Number of pregnancies      \_\_\_\_ Number of births      \_\_\_\_ Miscarriages      \_\_\_\_ Abortions

\_\_\_\_ Premature births      \_\_\_\_ C-sections      \_\_\_\_ Difficult delivery

First date of last period \_\_\_\_\_ Age of first period \_\_\_\_\_ Duration of periods \_\_\_\_\_ days, cycle \_\_\_\_\_ days

Do you practice birth control?  Yes  No If yes, what type and for how long? \_\_\_\_\_

If you're on birth control pills, what are you taking and for how long? \_\_\_\_\_

**Male**

- Prostate problems       Fertility problems       Erectile dysfunction       Ejaculation problems       Discharge
- Frequent seminal emission       Painful/swollen testicles       Other \_\_\_\_\_

I have completed this form correctly to the best of my knowledge.

Signature: \_\_\_\_\_  Adult patient  Parent or Guardian  Spouse

Are there any other health issues you want to discuss with us?

Signature

Date

