New Patient Intake Form for Patients of Sarah Vosen, L.Ac. at Sheridan Park Chiropractic

Thank you for taking the time to reflect on your health and share this important information with me! I know that this form is long and you may find it challenging to fill out, just do your best. It's very helpful for me to understand what you've been through in the past, how you live your life now, and how all of the pieces come together to create the present day you with uncomfortable symptoms. It will also give us information about your constitution, which will help me guide you to feeling your best. Feel free to use the back of the page if you need more room.

Name:_____DOB:_____
Address:_____ Age:____
City, State, Zip:_____ Gender/pronouns:_____
Email:_____Relationship status:_____
Best number to reach you:_____
Can we leave you a message at this number? _____
Occupation:_____
Primary Physician:_____ # :_____
Emergency contact:_____Relationship to you:_____
Best #:_____
How did you hear about me? _____

Please list your health goals in order of their importance to you:
1)
2)
3)

Do you have any allergies that require you to carry an epi-pen? Please list.

List any serious diseases, injuries, surgeries, or hospitalizations you've had, and the year they occurred:

List any adverse reaction to medical treatment(allergic reaction to meds, fainting during a procedure, white coat syndrome, etc):

List all serious health conditions of your family (Mother, Father, Grandparents, Siblings, & Children):

Please list the names and ages of your partner, children, pets and any others you consider to be in your support system:

Do you have any physical pain? Circle Yes or No

Where is your pain? Check all that apply

- ❑ muscles
- ❑ joints
- ❑ fingers
- ❑ toes
- ❑ abdomen
- ❑ head
- ❑ neck
- ❑ arms
- ❑ legs
- ❑ genitals
- ❑ face
- ❑ feet
- ❑ back
- ❑ chest
- ❑ hands

Please list any prescribed and over the counter medications, including pain relievers:

Please list any supplements/herbs/vitamins you are taking:

Do you exercise? If so, what types and how often per week:

Do you see any other practitioners to support your health?
If yes, May I contact these providers to ensure coordination of care?
If yes, please list names and phone numbers for any you wish me to be in communication with:

Check any of the following that you do for work/life balance that helps you enjoy life:

- ❑ Take time off
- ❑ Spend time outside
- ❑ Have supportive friendships
- ❑ Read books
- ❑ Play games/sports
- ❑ Have a spiritual or religious practice
- ❑ Have a hobby
- ❑ Play an instrument
- ❑ Watch tv/movies
- ❑ Other:

Describe your typical daily diet, and when you eat them:

Time	**Meal**
	Breakfast:
	Lunch:
	Dinner:
	Snacks:

What are the foods that you don't eat because you don't feel well when you eat them?

What is your favorite food?
What is your most disliked food?
How many meals per week do you eat out?
Do you follow a particular philosophy for nutrition? (paleo, keto, vegetarian, vegan, etc)

Do you drink water and other liquids without caffeine and alcohol? How many ounces per day?

Do you drink coffee and/or caffeinated tea? How many cups per day?
Rate your energy level without having consumed caffeine(0-can't get up to 10-ready for anything)

Do you consume refined sugar regularly? In what form, and how much?

Do you drink alcohol? How many drinks per week?

Do you have any addictions/vices? To what and for how long?

Do you or have you in the past smoked tobacco cigarettes? How much and for how long?

Do you or have you used recreational drugs, including cannabis? How much and for how long?

Symptoms & Constitution

Wood Element(Liver/Gallbladder): write in box C=current(past 2 weeks), P=past, B=both

- ❑ Depression/Anger towards self
- ❑ Migraines
- ❑ Red, dry, itchy eyes
- ❑ Visual problems
- ❑ Dizziness
- ❑ Gallstones
- ❑ Lump in throat
- ❑ Clench teeth at pm
- ❑ Muscle cramps/twitching
- ❑ Neck & shoulder pain/tightness
- ❑ Soft/brittle nails
- ❑ Seizures/Tremors
- ❑ Cold feet/hands
- ❑ Bitter taste in mouth
- ❑ PMS/menstrual problems
- ❑ Tendonitis
- ❑ Lower rib cage pain
- ❑ Sour food cravings(pickles, citrus, kombucha)
- ❑ Tend to anger/ frustration
- ❑ Joint Pain
- ❑ Arthritis or Rheumatism
- ❑ Hepatitis/Liver disease
- ❑ Joint replacement
- ❑ Short-tempered/Irritable
- ❑ Restless legs
- ❑ Indecisiveness
- ❑ Headaches-Temples and/or top of head

Fire Element(Heart/Small Intestine):write in box C=current(past 2 weeks), P=past, B=both

- ❑ Heart Palpitations
- ❑ Rapid or Irregular Heartbeat
- ❑ Chest Pain
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Sleep Problems
- ❑ Vivid Dreams/Nightmare
- ❑ Easily Startled
- ❑ Dark Urine
- ❑ Red face
- ❑ Crave bitter flavors(like coffee, cocoa)
- ❑ Anxiety
- ❑ Poor Short-term Memory
- ❑ Bleeding disorder
- ❑ Blood disease
- ❑ Cardiovascular Disease
- ❑ Pacemaker
- ❑ Stroke
- ❑ Lack of Joy
- ❑ Stuttering/difficulty speaking
- ❑ Inability to follow through
- ❑ ADD/ADHD
- ❑ Love to talk and laugh
- ❑ Mouth & Tongue Sores

Earth Element (Spleen/Stomach): write in box C=current(past 2 weeks), P=past, B=both

- ❑ Limbs feel heavy

- ❑ Hard to get up in morning
- ❑ Muscles feel tired
- ❑ Swollen hands
- ❑ Swollen feet
- ❑ Easily bruised
- ❑ Bad breath
- ❑ Sweet taste in mouth
- ❑ Weak sense of taste
- ❑ Low appetite
- ❑ Excessive appetite
- ❑ Nausea
- ❑ Lack of thirst
- ❑ Excessive thirst
- ❑ Gas/Flatulence
- ❑ Vomiting/Belching/ Acid Reflux
- ❑ Hemorrhoids
- ❑ Organ prolapse(uterus, bladder)
- ❑ Chronic loose stools
- ❑ Abdominal pain
- ❑ Indigestion
- ❑ Brain foggy
- ❑ Tendency to gain weight
- ❑ Crave sweet flavors(sugar, fruit, etc)
- ❑ Overthinking/Worry
- ❑ Food sensitivities
- ❑ Type 1 Diabetes
- ❑ Type 2 Diabetes
- ❑ Disordered eating
- ❑ Stomach ulcer
- ❑ Thoughts on repeat
- ❑ Headaches-forehead
- ❑ Tired after meals
- ❑ Mentally spacy
- ❑ Vaginal yeast infections
- ❑ Obesity

Metal Element (Lung/Large Intestine): write in box C=current(past 2 weeks), P=past, B=both

- ❑ Chronic cough
- ❑ Nasal congestion
- ❑ Post-nasal drip
- ❑ Recurring sinus infections
- ❑ Itchy or sore throat
- ❑ Dry mouth/Nose/Throat
- ❑ Skin Rashes/Hives
- ❑ Snoring
- ❑ Shortness of breath
- ❑ Allergies
- ❑ Asthma
- ❑ Low immunity
- ❑ Catch colds easily
- ❑ Bronchitis
- ❑ Black or bloody stools
- ❑ Constipation
- ❑ IBS
- ❑ Diarrhea
- ❑ Colitis
- ❑ Crave pungent and/or spicy flavors(onion, garlic, horseradish)
- ❑ Stuck in grief
- ❑ Hold lots of guilt
- ❑ Difficulty letting go
- ❑ Emphysema
- ❑ Immune disorder
- ❑ Skin disease
- ❑ Tuberculosis
- ❑ Depression w/deep sadness
- ❑ Excessive sweating
- ❑ Don't sweat
- ❑ Repeat destructive patterns
- ❑ Overly judgemental of others

Water Element (Kidney/Bladder): write in box C=current(past 2 weeks), P=past, B=both

- ❑ Waking at night to urinate
- ❑ Bladder infections
- ❑ Incontinence
- ❑ Weak low back/knees
- ❑ Osteoporosis
- ❑ Feel cold easily
- ❑ Feel hot easily
- ❑ Low sex drive
- ❑ High sex drive
- ❑ Dark circles under eyes
- ❑ Thyroid problems
- ❑ Poor long-term memory
- ❑ Hair loss
- ❑ Gray hair young
- ❑ Hearing problems/Tinnitus
- ❑ Cavities
- ❑ Hot at night/Night sweats
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Infertility

- ❑ Crave salty foods
- ❑ Often fearful
- ❑ Lack of willpower
- ❑ Kidney disease
- ❑ Seizures/Epilepsy
- ❑ Phobias
- ❑ Easily frightened
- ❑ Headaches- base of skull
- ❑ Painful low back & knees
- ❑ Cheeks red
- ❑ Hot soles of feet & palms of hands
- ❑ Afternoon fevers
- ❑ Tired & wired
- ❑ Water retention
- ❑ Urgent BM in early am
- ❑ Frequent urination
- ❑ Hot flashes during day

Please list all diagnoses your have received, for chronic disease and acute illnesses:

If you have ever been diagnosed with cancer, please describe your treatment process:

Please describe your mental health:

Please describe your emotional health:

Please describe your spiritual health:

Please describe your sexual health:

Please describe your physical health:

What is the aspect of your life that stresses you out the most?

Have you gone through Menopause? If yes, what age? (skip the rest)

If you are someone who menstruates: Are you pregnant? Had miscarriages?
Do you have kids? How many-ages?
If yes, circle-Vaginal/ C-section/ Adoption/ Other? If no, do you want to?

Menses: age of menarche? Day 1 of last cycle? Avg # of days in cycle?
Days of bleeding? Color of blood: circle all experienced: dark red, fresh red, pink, brown, black, purple, clots.

Circle your PMS symptoms: easy to anger/frustration, crabby, sad/teary, breast tenderness, bloating, water retention, night sweats, fatigue, cravings_____, migraines, headaches, spotting, yeast infections/BV, other(fill in):

You made it! Thank you again for taking the time to share your health history with me so I can best support you in getting out of pain and feeling well! If you feel stirred up, please take a few deep breaths and feel your feet connected to the ground, and your body being supported by the chair. I look forward to meeting you and discussing your health with you soon. Take care!