REV. DOC. Lisa.
INTEGRAL HEALER

NEW CLIENT FORM

Successful care is possible only when the practitioner has a full understanding of the client - physically, mentally, emotionally and spiritually. Please fill out the following information to help determine the best treatment plan for you.

PERSONAL INFORMATION

Today's Date:_____

Name: _____ Gender:_____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Home Address:_____

City: _____ State: _____ Zip:_____

Contact Numbers: Cell: _____ Work: _____ Home: _____

Email Address (PRIVATE):_____

Preferred method for contact (i.e. cell, e-mail, etc):_____

Emergency Contact Name: _____ Phone: _____

Relationship of contact to you: _____

Type of work you do: _____ Employer/School: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Number of children: _____ Name of Physician:_____

Have you received acupuncture in the past?: ☐ Yes ☐ No

Have you taken Chinese herbal medication before? ☐ Yes ☐ No

How did you hear about Integral Healer?: _____

FOR OFFICE USE ONLY

MEDICAL HISTORY

Please indicate any illnesses you and/or a relative have had:

Cancer:	☐ You	☐ Relative		Emotional Disorders:	☐ You	☐ Relative	
Hepatitis:	☐ You	☐ Relative		Tuberculosis:	☐ You	☐ Relative	
High Blood Pressure:	☐ You	☐ Relative		High Cholesterol:	☐ You	☐ Relative	
Rheumatic Fever:	☐ You	☐ Relative		Diabetes:	☐ You	☐ Relative	
Heart Disease:	☐ You	☐ Relative		Seizures:	☐ You	☐ Relative	

Please list any medications and/or supplements you are currently taking:

1. Name: _____ Dosage: _____ Reason: _____

   How long? _____

2. Name: _____ Dosage: _____ Reason: _____

   How long? _____

3. Name: _____ Dosage: _____ Reason: _____

   How long? _____

4. Name: _____ Dosage: _____ Reason: _____

   How long? _____

5. Name: _____ Dosage: _____ Reason: _____

   How long? _____

6. Name: _____ Dosage: _____ Reason: _____

   How long? _____

7. Name: _____ Dosage: _____ Reason: _____

   How long? _____

8. Name: _____ Dosage: _____ Reason: _____

   How long? _____

Please indicate if any of the following applies to you:

☐ I have known allergies to:

_____

☐ I have a pacemaker ☐ I am taking coumadin, heparin, or warfarin (blood thinners)

☐ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

I currently have or have had:

☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes

Please list the health concerns that bring you here today:

_____

_____

_____

Please list all other treatment modalities that you have used for these concerns:

_____

_____

_____

Please list any other health issues you currently have:

_____

_____

_____

Please list any accidents, hospitalizations, and/or surgeries you've had, including dates:

_____

_____

_____

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FOR WOMEN

Age of first period: _____ Age of last period (if applicable): _____

Number of days between periods: _____ Number of days of flow: _____

Are you pregnant? ☐ Yes ☐ No Number of pregnancies: _____

Number of: Live Births: _____ Miscarriages: _____ Terminations: _____

Do you get Pap Smears annually? ☐ Yes ☐ No

Date of last gynecological exam: _____ Results: _____

Date of last mammogram: _____ Results: _____

Date of last bone density scan: _____ Results: _____

Please check any of the following that you have been diagnosed with:

☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID

Please check all of the symptoms that you experience before or during your menses:

☐ Cramps	☐ Increased Appetite	☐ Hot Flashes Night
☐ Back Pain	☐ Decreased Appetite	☐ Sweats
☐ Vaginal Discharge	☐ Increased Libido	☐ Headaches
☐ Vaginal Dryness	☐ Decreased Libido	☐ Breast Tenderness
☐ Constipation	☐ Insomnia	☐ Mood Swings
☐ Diarrhea	☐ Dizziness	☐ Bloating
☐ Nausea	☐ Light-Headedness	☐ Bearing-down Feeling

FOR MEN

Date of last prostate exam: _____ Results: _____

Please check the symptom or symptoms you have experienced:

☐ Frequent Nighttime Urination	☐ Delayed Stream	☐ Dribbling Urination
☐ Increased Libido	☐ Decreased Libido	☐ Testicular Pain
☐ Erectile Dysfunction	☐ Premature Ejaculation	☐ Impotence

SYMPTOM SURVEY (For Women and Men)

Please check the symptom or symptoms that you currently experience:

- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Knee Pain
- ☐ Chest Pain
- ☐ Lower Back Pain
- ☐ Hip Pain
- ☐ Carpal Tunnel Syndrome
- ☐ TMJ
- ☐ Excessive Appetite
- ☐ Lack of Appetite
- ☐ Fatigue
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Gas
- ☐ Indigestion
- ☐ Loose Stool/Diarrhea
- ☐ Bloating
- ☐ GI Ulcers
- ☐ Abdominal Pain
- ☐ Edema
- ☐ Insomnia
- ☐ Vivid Dreams
- ☐ Shortness of Breath
- ☐ Soft/Brittle Nails
- ☐ Mouth Sores
- ☐ Thinning Hair
- ☐ Easy Bruising
- ☐ Dizziness
- ☐ Dry Skin
- ☐ Intolerance to Cold
- ☐ Intolerance to Heat
- ☐ Ear Ringing/Tinnitus
- ☐ Kidney Stones
- ☐ Gall Stones
- ☐ Asthma
- ☐ Nasal Congestion
- ☐ Allergies
- ☐ Asthma
- ☐ Headaches
- ☐ Osteoporosis/Osteopenia
- ☐ Fears/Anxiety
- ☐ Poor Mood
- ☐ Depression
- ☐ Easily Angered/Irritated
- ☐ Mentally Restless
- ☐ Nervousness
- ☐ Inappropriate Laughter
- ☐ Difficulty Making Plans/Decisions
- ☐ Tendency to become obsessive in work
- ☐ Tendency to become obsessive in relationships
- ☐ OCD
- ☐ Eating Disorder
- ☐ Addiction
- ☐ Lump in Throat

Additional symptoms or pain? Please list them here:

LIFESTYLE

Please indicate the use and frequency of the following:

- ☐ Coffee/Black Tea — How much: _____
- ☐ Non-Medical Drugs — How much: _____
- ☐ Tobacco — How much: _____
- ☐ Alcohol — How much: _____

I consider myself to have an addictive personality: ☐ Yes ☐ No

Please describe your Heritage/Background (Asian, North American, South American, African American, Mediterranean, Australasian, Eastern European, others please specify):

_____

Please indicate how you feel about the following areas of your life:

Self:	☐ Great	☐ Good	☐ Fair	☐ Poor
Family:	☐ Great	☐ Good	☐ Fair	☐ Poor
Significant Other:	☐ Great	☐ Good	☐ Fair	☐ Poor
Sexuality:	☐ Great	☐ Good	☐ Fair	☐ Poor
Work:	☐ Great	☐ Good	☐ Fair	☐ Poor
Diet:	☐ Great	☐ Good	☐ Fair	☐ Poor
Exercise:	☐ Great	☐ Good	☐ Fair	☐ Poor
Spirituality:	☐ Great	☐ Good	☐ Fair	☐ Poor

Please note your spiritual/religious background and current practice/orientation.

If you like, note a reason or two you are seeking wellness support at this time.

Please note anything related to your mind, body or spirit you feel might be important to share: