hopper acupuncture & herbs

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NEW PATIENT INTAKE (All information will be kept confidential)

Date _____

Name _____ DOB _____ Age _____

Home Address _____

City _____ State _____ Zip _____

Email _____ Tel _____

Occupation _____ How Many Years _____

Height / Weight _____ _____ Gender M F T/GNC

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone No, _____

What is your primary health concern?

How long has it been bothering you? _____

Have you missed work because of it? ☐ Y ☐ N If so, how long? _____

What makes it feel better?

What makes it feel worse?

Have you been treated for this condition before?

Are you currently, or have you ever been, on medical disability? ☐ Y ☐ N

If yes, please elaborate: _____

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Wendy, age 7, sister _____

Have you recently traveled outside of the United States? Yes_____ No_____
If so, when and where? _____

Have you or your family recently experienced any major life changes? Yes_____ No_____
If yes, please comment: _____

Have you experienced any major losses in life? Yes_____ No_____
If so, please comment: _____

How important is religion (or spirituality) for you and your family's life?
a. _____ not at all important
b. _____ somewhat important
c. _____ extremely important

Current job: _____

How much time have you lost from work or school in the past year?
a. _____ 0-2 days
b. _____ 3 –14 days
c. _____ > 15 days

Previous jobs: _____

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:
Did you feel safe growing up?
Yes No

Have you been involved in abusive relationships in your life?
☐ Yes ☐ No

Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
☐ Yes ☐ No

Do you currently feel safe in your home?
☐ Yes ☐ No

Do you feel safe, respected and valued in your current relationship?
☐ Yes ☐ No

Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?

☐ Yes ☐ No

Would you feel safer discussing any of these issues privately?

☐ Yes ☐ No

ILLNESSES		WHEN	COMMENTS
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn's Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		

INJURIES		WHEN	COMMENTS
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		

DIAGNOSTIC STUDIES		WHEN	COMMENTS
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		

al. Chest X-ray
am. Colonoscopy
an. EKG
ao. Liver scan
ap. Neck X-ray
aq. NMR/MRI
ar. Sigmoidoscopy
as. Upper GI Series
at. Other (describe)

OPERATIONS	WHEN	COMMENTS
au. Appendectomy		
av. Dental Surgery		
aw. Gall Bladder		
ax. Hernia		
ay. Hysterectomy		
az. Tonsillectomy		
ba. Other (describe)		
bb. Other (describe)		

HOSPITALIZATIONS	WHEN	WHY
a.		
b.		
c.		
d.		
e.		

CURRENT MEDICATIONS. Include over-the-counter/non-prescription drugs.

	Medication Name	Date started	Dosage
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Are you allergic to any medications? Yes____ No____
If yes, please list: _____
_____
_____

Please list all vitamins, minerals, and other nutritional supplements that you are taking now.
Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date started	Dosage

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Were you a full term baby? Yes_____ No_____ Don't Know_____. Breast Fed? Yes_____ No_____

As a child did you eat a lot of sugar and/or candy? Yes_____ No_____

As a child, were there any foods that you had to avoid as a child? Yes_____ No_____

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)

_____

_____

What is a typical breakfast for you?

What is a typical lunch for you?

What is a typical dinner for you?

How much of the following do you consume each week?

Candy	Never	1-3x/week	3-7x/week	Multiple x/day
Cheese	Never	1-3x/week	3-7x/week	Multiple x/day
Chocolate	Never	1-3x/week	3-7x/week	Multiple x/day
Cups of coffee containing caffeine	Never	1-3x/week	3-7x/week	Multiple x/day
Cups of decaffeinated coffee or tea	Never	1-3x/week	3-7x/week	Multiple x/day
Cups of hot chocolate	Never	1-3x/week	3-7x/week	Multiple x/day
Cups of tea containing caffeine	Never	1-3x/week	3-7x/week	Multiple x/day

Are you on a special diet? Yes_____ No_____

_____ ovo-lacto _____ vegetarian _____ candida

_____ diabetic _____ vegan _____ paleo

_____ dairy restricted _____ blood type diet other (describe): _____

Is there anything special about your diet that we should know? Yes_____ No_____

If yes, please explain: _____

_____

Do you feel much worse when you eat a lot of:

high fat foods refined sugar (junk food)

high protein foods fried foods

high carbohydrate foods (breads, pastas, potatoes)
1 or 2 alcoholic drinks
other _____

Do you feel much better when you eat a lot of:

high fat foods
high protein foods
high carbohydrate foods (breads, pastas, potatoes)
refined sugar (junk food)
fried foods
1 or 2 alcoholic drinks
other _____

Have you ever had a food that you craved or "binged" on over a period of time? Yes____ No____
If yes, what food(s)?

Do you have a personal history of eating disorders? Yes____ No____
If yes, please elaborate: _____

Please fill in the chart below with information about your bowel movements:

a. Frequency
__ More than 3x/day
__ 1-3x/day
__ 4-6x/week
__ 2-3x/week
__ 1 or fewer x/week

b. Color
__ Medium brown
__ Very dark or black
__ Greenish
__ Bright red blood is visible
__ Greyish-white
__ Varies

c. Consistency
__ Yellow, light brown
__ Greasy, shiny appearance
__ Difficult to pass
__ Thin, long or narrow
__ Loose but not watery
__ Soft and well formed
__ Often float
Diarrhea
Small and hard
Alternating between hard and loose/watery

Intestinal gas:
Daily
Occasionally
Excessive
Present with pain
Foul smelling
Little odor

How often do you drink alcohol?

___ Never have had alcohol
___ Average 1-3 drinks per week
___ Average 4-6 drinks per week
___ Average 7-10 drinks per week
___ Average >10 drinks per week
____ No longer drinking alcohol

Have you ever had a problem with alcohol? Yes____ No____
If yes, please indicate time period (month/year): from _____ to _____.
Have you ever struggled with drug abuse? Yes____ No____
If yes, which drug(s)? _____
If yes, please indicate time period (month/year): from _____ to _____.
If yes, are in a 12-step program? Yes____ No____
Have you ever smoked cigarettes? Yes____ No____
If yes, number of years as a nicotine user _____ Amount per day _____. Year quit _____.
If yes, what type of nicotine have you used?

_____Cigarette _____ Smokeless _____Cigar _____Pipe _____Patch/Gum

Are you exposed to second hand smoke regularly? Yes____ No____

Do you have mercury amalgam fillings? Yes____ No____

Do you have any artificial joints or implants? Yes____ No____

Have you, to your knowledge, been exposed to toxic metals in your job or at home?
Yes____ No____ If yes, which one(s)? lead cadmium arsenic mercury aluminum

Do strong odors affect you? Yes____ No____

How well have things been going for you?

a.	In your job/school	Very Well	Fair	Poorly	Very Poorly	Does not apply
b.	In your social life	Very Well	Fair	Poorly	Very Poorly	Does not apply
c.	In your sex life	Very Well	Fair	Poorly	Very Poorly	Does not apply
d.	With your outlook	Very Well	Fair	Poorly	Very Poorly	Does not apply
e.	With partner/spouse	Very Well	Fair	Poorly	Very Poorly	Does not apply
f.	With your children	Very Well	Fair	Poorly	Very Poorly	Does not apply
g.	With your parents	Very Well	Fair	Poorly	Very Poorly	Does not apply

Have you ever had psychotherapy or counseling? Yes____ No____
Currently? _____ Previously? _____ If previously, from _____ to _____.
What kind? _____
Comments: _____

Are you currently, or have you ever been, married? Yes____ No____
If so, when were you married to your current partner? _____
Spouse's occupation _____ Any previous marriages? _____

Hobbies and leisure activities: _____

Do you exercise regularly? Yes____ No____
If so, how many times a week?_____ When you exercise, how long is each session?_____

What type of exercise is it? _____

All of the information on this form has been answered correctly to the best of my knowledge:

Signature: _____ Date: _____

If patient is under the age of 18 they must be accompanied by a parent or legal guardian for the entirety of the treatment.
If you are a parent or legal guardian accompanying a minor, please sign below:

Signature: _____ Date: _____