Susan Monaco, L.Ac.
New Patient In-Take Form

Contact Information (Please Print) Date:_____

Name (first & last):_____

Address: _____ Apt #:_____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Home Phone: _____ Cell Phone: _____

In Emergency Notify: Name: _____ Phone: _____

You were referred by: _____

General Information

Date of birth: ____/____/_____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Marital Status: _____

Reason(s) for your visit: _____

_____

To what extent does this condition interfere with your daily activity (work, exercise, sleep, sex, etc.)?

_____

When did this condition begin? (be specific) _____

If you have seen a medical doctor, what is your diagnosis? _____

What kind of treatments/therapies have you tried? _____

Past Medical History – Please note type and dates:

❑ Cancer	❑ Diabetes	❑ Pacemaker	❑ Thyroid Disease
❑ HIV/AIDS	❑High Blood Pressure	❑ Rheumatic Fever	❑ Alcoholism/Addiction
❑ Hepatitis	❑ Heart Disease	❑ STI (aka STD)	❑ Other: _____

Surgeries (type & date): _____

Significant Dental Work: _____

Significant Trauma (physical, emotional, sexual, etc.): _____

Allergies (drugs, chemicals, foods, etc.): _____

Stress (occupational, chemical, physical, psychological): _____

Birth History (prolonged labor, forceps, premature, etc.): _____

Family Medical History

❑Cancer	❑High Blood Pressure	❑Stroke	❑Psychiatric Disorder
❑Diabetes	❑Heart Disease	❑Alcoholism/Addiction	❑Other:_____

Lifestyle

Do you have a regular exercise program? Please describe: _____

_____

Are you, or have you been, on a restricted diet (vegetarian, vegan, gluten-free, low-carb, etc.)? Please describe:

_____

Please describe your average daily diet (include liquids)

Morning (3AM-11AM) _____

Afternoon (11AM- 3PM) _____

Evening (3PM-Bedtime) _____

What medications and/or supplements are you currently taking? _____

_____

Do you regularly consume the following substances:

❑ Coffee/tea	❑ Alcohol	❑ Stimulants (amphetamine, meth, cocaine, etc.)	❑ Opiates (hydrocodone, oxycodone, heroin, etc.)
❑Soda	❑ Marijuana		❑ Other: _____
❑Tobacco	❑ Sleeping aids		

Current Health Condition (please circle symptoms which are frequent/severe, underline symptoms which are infrequent/mild)

Energy, Immunity, and Metabolism

Fatigue	Catch colds easily	Allergies	Feeling hot/flushed
Energy drops	Slow wound healing	Sweat easily	Chills
General weakness	Chronic infections	Night sweats	Recent weight loss/gain

How would you describe your overall health? _____ Overall energy level? _____

Head, Eye, Ear, Nose, and Throat

Headache/Migraine	Photosensitivity	Sinus problems	Sore throat
Dizziness/Vertigo	Eye strain/pain	Nasal congestion	Hoarseness
Blurry vision	Ear ringing	Nose bleeds	Swollen glands
Floaters	Earaches	Snoring	Teeth grinding/TMJ

Respiratory and Cardiovascular

Asthma/Wheezing	Cough	Palpitations	Varicose veins
Shortness of breath	Chest tightness	High blood pressure	Fainting
Phlegm	Chest pain	High cholesterol	Edema

Gastrointestinal

Low appetite	Heartburn/Acid reflux	Gas	Diarrhea
Excessive appetite	Ulcers	Stomach growling	Constipation
Bad breath	Belching/Hiccough	Abdominal pain	Hemorrhoids
Nausea/Vomiting	Bloating	Gallbladder stones	Other: _____

Bowel Movements

Frequency: _____	Mucus in stool	Incomplete feeling	White/chalky stool
Undigested food	Thin/skinny stool	Painful	Green stool
Blood in stool	Small/bitty stool	Unusually strong odor	Yellow stool

Consistency: ❑ Well-formed ❑ Dry ❑ Hard ❑ Loose ❑ Soft ❑ Greasy/Oily ❑ Alternates

Genitourinary

Pain/burning on urination	Frequent urination	Dribbling urination	Kidney stones
Urinary urgency	Waking at night to urinate	Profuse urination	Urinary tract infections
Incontinence		Retention of urine	Bed wetting

Skin, Hair, and Nails

Easy bruising	Sores	Dandruff	Wrinkles
Acne	Itching	Hair loss	Stretch marks
Rashes	Dry skin/scalp	Weak/brittle nails	Cellulite

Neuromuscular

Seizures	Loss of balance	Paralysis	Poor memory
Lack of coordination	Muscle spasm/tic	Numbness/tingling	Poor concentration

Sleep

Trouble falling asleep	Excessive dreaming	Sleep talking/walking	Bedtime? _____
Trouble staying asleep	Nightmares/night terrors	Tired upon waking	Wake-up? _____

Emotions

Mood swings	Nervousness	Frequent worrying	Irritability/Anger
Depression	Anxiety/panic attacks	Obsessive/Compulsive	Mania/elevated mood
Sadness	Fear	Frustration	Fits of laughter

Please describe your level of happiness: _____

Men Only

Prostate disease	Low sex drive	Premature ejaculation	Poor sperm motility
Testicular pain/swelling	Impotence	Nocturnal emissions	Irregular morphology
Hernia	Excessive sex drive	Low sperm count	Other: _____

Women Only

Infertility	Spotting between periods	Hot flashes	Pain during intercourse
Abnormal vaginal discharge	Breast lumps	Low sex drive	Vaginal dryness
Abnormal pap smear	Nipple discharge	Difficulty reaching orgasm	Other:_____

Do you experience any of the following associated with your period?

Water retention	Weepiness	Food cravings	Heavy bleeding
Breast tenderness/swelling	Migraines/Headache	Changes in bowel movements	Scanty bleeding
Mood swings	Acne	Abdominal cramps	Clots
Irritability	Nose bleeds	Lower back pain	Other:_____

First day of last menstrual period: _____ At what age did you get your first period? _____

Duration of menstrual cycle (in days): _____ Duration of menstrual period (in days): _____

Are your cycles regular? ❑Yes ❑No Is there any chance you are pregnant now? ❑Yes ❑No

Are you currently using birth control? ❑Yes ❑No What type and for how long?_____

Number of pregnancies: _____ Number of miscarriages: _____

Number of live births: _____ Number of abortions: _____

Have you experienced menopause? ❑Yes ❑No When? _____

If you are experiencing menopausal symptoms, please describe: _____

_____

_____

Signature *Date*