Points of Healing: Miriam Delosantos L.Ac., Dipl. OM, PA-C
2929 Loma Vista Rd Ste D, Ventura, CA 93003
805-290-1252 | www.pointsofhealing.com

NEW PATIENT INTAKE

NAME _____ **DATE** _____

I. Major Symptoms: Please list in order of importance what symptoms are of concern to you.

(most concerning to least, along with the duration of the symptom)

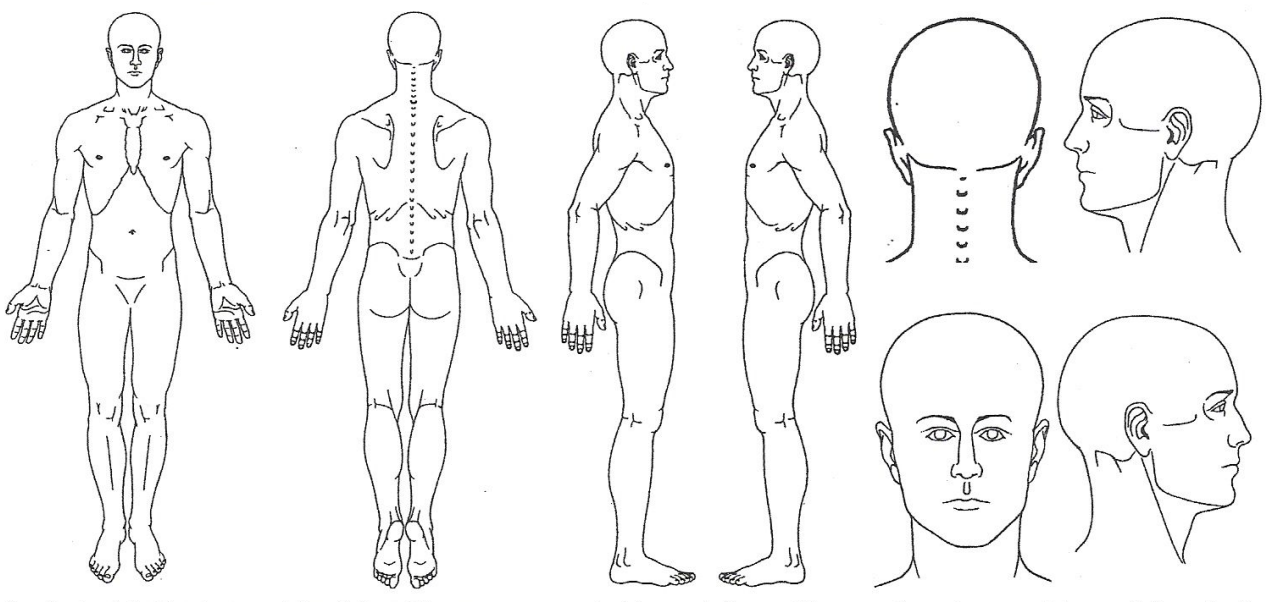
1. _____

2. _____

3. _____

4. _____

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? **Y / N**
If yes, using the models above to indicate the location of the discomfort by drawing the letter/symbol that best describes the feeling:

X	**P**	**D**	**N**
(sharp/stabbing)	(pins & needles)	(dull/aching)	(numbness)

FOR MEN:

1. Do you have any bothersome urinary symptoms? [ ] Yes [ ] No

If yes, describe:_____

2. Check all that apply:

[ ] Erectile dysfunction	[ ] Difficulty with orgasm	[ ] Pain or swelling of the testicles	[ ] Difficult/incomplete urination
[ ] Impotence/erectile dysfunction	[ ] Premature ejaculation	[ ] Feeling of coldness or numbness in genitalia	[ ] Pain/Swelling of testicles
[ ] Enlarged prostate	[ ] Testicular cancer	[ ] Excessively high libido	[ ] Low libido

3. Do you get up at night to urinate? [ ] Yes [ ] No

If so, how often? _____

4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

_____

5. Have you sought medical intervention for these problems? If so, when?

_____

6. What treatments have you tried for these problems and how successful have they been?

_____

_____

7. Please provide us with any other information that you think is relevant for us to know:

_____

_____

_____

_____

_____

FOR WOMEN:

1. Are you pregnant now? [ ]Yes [ ]No [ ]Unsure

2. Indicate number of occurrences:

Live Births _____ Pregnancies_____ Miscarriages _____ Abortions _____

3. Age: First period _____ Menopause (if applicable) _____ Hysterectomy (if applicable) _____

4. Date: Last Pap Smear _____ /_____ Last Mammogram _____ / _____

5. Any History of an Abnormal Pap Smear? [ ] Yes [ ] No

If so, what / when? _____

6. Is your menses cycle regular? [ ] Yes [ ] No

a) Average number of days of flow _____

b) The flow is: [ ] Normal _____days

[ ] Heavy _____days

[ ] Light _____days

c) The color is: [ ] Pink [ ] Light Red [ ] Red [ ] Dark Red [ ] Purple

[ ] Light Brown [ ] Brown

7. Do you have the following menstruation related signs/symptoms?

[ ] Difficulty with orgasm	[ ] Cramps	[ ] PMS	[ ] Heavy vaginal discharge between periods
[ ] Pain with intercourse	[ ] Bleeding after intercourse	[ ] Bleeding between periods	[ ] Blood clots
[ ] Nausea	[ ] Breast distention	[ ] Vaginal discharge	[ ] Low libido

8. Please provide us with any other gynecological information that you think is relevant for us to know: (Contraceptive use, PMS, ovarian cysts, endometriosis, painful periods, etc).:

_____

_____

_____

_____

_____

_____

II. Medical History (please check all that apply):

	Date Diagnosed		**Date Diagnosed**
Diabetes	___ / ___ / ___	High Cholesterol	___ / ___ / ___
High Blood Pressure	___ / ___ / ___	Low Blood Pressure	___ / ___ / ___
Thyroid Disease	___ / ___ / ___	Seizures	___ / ___ / ___
Cancer	___ / ___ / ___	Hepatitis	___ / ___ / ___
HIV	___ / ___ / ___	Others	___ / ___ / ___

III. Surgical History

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

IV. Family History

Please check all that apply and state how you are related to the family member with that condition:

	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent	Other (describe): _____
Heart disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Hypertension	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Asthma	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Allergies	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Migraines	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Other mental illness	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Substance abuse	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Osteoporosis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Glaucoma	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

V. Medications / Supplements

Medications you are <u>currently</u> taking (please include prescription medicine, supplements, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies (to medications, chemicals or foods):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VI. Nutrition

1. Do you follow a special diet? [ ] Yes [ ] No

If yes, how would you describe the diet? (ie Vegetarian, Vegan, Low Carb, etc.)

_____

2. What do you eat on a "typical" day?

_____

a) Breakfast

_____

b) Lunch

_____

c) Dinner

_____

d) Snacks

_____

e) Foods you tend to crave:

_____

f) Foods you dislike:

_____

g) Appetite: [ ] small [ ] medium [ ] large

h) Do you crave any of the following? [ ] sweet [ ] salty [ ] spicy [ ] bitter [ ] sour

VII. Social History

1. How much do you use of the following per day?

a) Coffee, tea, soft drinks:

_____

b) Alcohol:

_____

c) Cigarettes, cigars, other tobacco:

_____

d) Recreational drugs:

_____

2. Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No

3. Have you ever had a problem with *dependency* on other drugs? [ ] Yes [ ] No

4. If yes which and when?

_____

5. Do you have a known history of any exposure to *toxic* substances? [ ] Yes [ ] No

6. If so, please list which and when you first noticed symptoms?

_____

7. In the past year, how many days have been significantly affected by your health? _____

8. How many days did you feel generally poor? _____

9. How many times were you in the hospital? _____

10. Please describe your current exercise regimen:

Hours per week: _____ Activities: _____ [ ] No Exercise

11. How many hours of sleep do you usually get per night during the week? _____

Do you have any of the following? (circle) Insomnia, Excessive Sleeping, Heavy Dreaming, Nightmares

Do you feel you sleep well at night? [ ] Yes [ ] No

Do you awaken feeling rested? [ ] Yes [ ] No

What is your energy level during the day? (circle) *low* 1 2 3 4 5 6 7 8 9 10 *high*

13. Who would you describe as your source of primary social support? (relationship to you)

_____

_____

_____

_____

VIII. Other Information

For the following questions please answer yes or no:

Do you worry a lot? [ ] Yes [ ] No

Do you have many fears? [ ] Yes [ ] No

Do you consider yourself happy? [ ] Yes [ ] No

Do you get angry easily? [ ] Yes [ ] No

Do you have a feeling of loss or grief? [ ] Yes [ ] No

Do you have difficulty making decisions? [ ] Yes [ ] No

Do you have difficulty or dislike making plans? [ ] Yes [ ] No

Do you crave excitement like bungee jumping, sky diving, or roller coasters? [ ] Yes [ ] No

Do you have strong opinions of what is right and wrong? [ ] Yes [ ] No

Do you feel as though you are not in control of your life? [ ] Yes [ ] No

Do you have difficulty letting go of emotional attachments? [ ] Yes [ ] No

For the following questions please rank on a scale of 1 through 10 (10 highest):

Is your work environment stressful? (1 2 3 4 5 6 7 8 9 10)

Is your family life stressful? (1 2 3 4 5 6 7 8 9 10)

Are you content with your life as it is? (1 2 3 4 5 6 7 8 9 10)

Have you been treated for emotional issues? [ ] Yes [ ] No

Have you ever considered or attempted suicide? [ ] Yes [ ] No

Do you have any other neurological or psychological problem? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:

_____

_____

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYMPTOMS AND CONDITIONS FOR THE PAST 90 DAYS (please check any that apply)

GENERAL

Past	Current	Condition
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other: _____

SKIN & HAIR

Past	Current	Condition
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

HECK & NECK

Past	Current	Condition
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other: _____

EARS

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: _____

EYES

Past	Current	Condition
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Other: _____

NOSE, THROAT, MOUTH

Past	Current	Condition
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

CARDIOVASCULAR

Past	Current	Condition
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: _____

RESPIRATORY

Past	Current	Condition
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: _____

GASTRO-INTESTINAL

Past	Current	Condition
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Stools
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas
[ ]	[ ]	Other: _____

GENITO-URINARY

Past	Current	Condition
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain or urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Other: _____

MALE

Past	Current	Condition
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other: _____

FEMALE

Past	Current	Condition
[ ]	[ ]	Frequent urinary tract infections
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Genital lesions / discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Other: _____

NEUROLOGICAL

Past	Current	Condition
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: _____

PSYCHOLOGICAL

Past	Current	Condition
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other: _____

INFECTION SCREENING

Past	Current	Condition
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

MUSCULAR-SKELETAL

Past	Current	Condition
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain

points of healing