Karen Tan, ND, MAcOM, LAc.
1150 South King Street, Suite 905, Honolulu, HI 96814
808.591.8778

Adult Intake Form

Name: ____ Date: ________________

Address: ____

City: ___________________________ State: ___________ Zip: ______________________

Phone # (home): _________________(cell):________________ (work): ________________

Email address: ____

Age: _____Date of Birth: ___/___/_____ Gender: F/M Education:_________________________

Married:____ Separated:___ Divorced:____ Widowed:____ Single:____ Partnership:_____

Live with: Spouse:___ Partner:____ Parents:____ Children:____ Friends:____ Alone:____

Occupation: ____ Hours per week: ________

Employer Name and Address: ____

____

How did you hear about this clinic? ____

Has any other family member already been a patient at this clinic? __________________

Emergency contact: ___________________________ Relationship: _________________

Phone: ____________________ Address: ____________________________________

____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

CONTEXT OF CARE REVIEW

What *three* expectations do you have from *this* visit to our clinic?

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

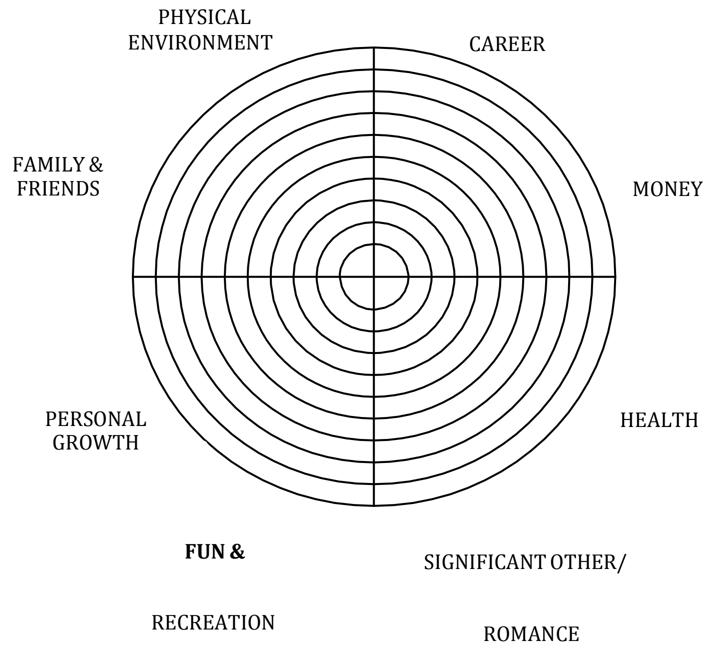
Karen Tan, ND, MAcOM, LAc.
320 Ward Ave, Suite 105, Honolulu, HI 96814   808.591.8778

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



Are you currently receiving healthcare?Yes/No

If yes, where and from whom? ____

If no, when and where did you last receive medical or health care? ____________________

____

What was the reason? ____

What are your most important health problems? List as many as you can in order of importance.

1) ____
2) ____
3) ____
4) ____
5) ____
6) ____
7) ____

Do you have any known contagious diseases at this time? Yes / No

If yes, what? ____

Karen Tan, ND, MAcOM, LAc.
320 Ward Ave, Suite 105, Honolulu, HI 96814 808.591.8778

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay fever	Hives	

Any other relevant family history? ____
What is your family heritage? ____

CHILDHOOD ILLNESSES

Birth city & state: ___________________________ Birth time: _________ Birth weight:_________

Please circle whether you had any of the following as a child:

Rheumatic fever	Diphtheria	Scarlet fever	Chicken
German Measles	Measles	Mumps	

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____________________________ year ________ _____________________________ year ________
_____________________________ year ________ _____________________________ year ________
_____________________________ year ________ _____________________________ year ________

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? ____

Any foods? ____

Any environmentals or chemicals? ____

-

Karen Tan, ND, MAcOM, LAc.
320 Ward Ave, Suite 105, Honolulu, HI 96814   808.591.8778

CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping Pills	Thyroid
Birth Control Pills	Hormone Replacement		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

1) ______________________ 5) ______________________

2) ______________________ 6) ______________________

3) ______________________ 7) ______________________

4) ______________________ 8) ______________________

GENERAL

Height: ______________ Weight: ______________ Weight one year ago: ____________

Maximum Weight: ____________________ When: ______________________

When during the day is your energy the best? ______________ Worst? ____________

Main interests and hobbies: ____

Exercise: Y / N If so, what kind and how often: ______________________________

Watch TV: Y / N If so, how many hours? ______ Read: Y / N If so, how many hours? ______

Do you have a religious or spiritual practice? Y / N If so, what kind? __________________

TYPICAL FOOD INTAKE

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To drink: ____

Karen Tan, ND, MAcOM, LAc.
320 Ward Ave, Suite 105, Honolulu, HI 96814 808.591.8778

FOR THE FOLLOWING, PLEASE CIRCLE:

Y=yes/condition you have now **N**=no/never had P= problem in the past **S**=sometimes a problem

GENERAL

- Do you sleep well? Y N P S
- Average 6-8 hours? Y N P S
- Awake rested? Y N P S
- Have a supportive relationship? Y N P S
- Have a history of abuse? Y N P S
- Experienced a major trauma? Y N P S
- Use recreational drugs? Y N P S
- Treated for drug dependence? Y N P S
- Use alcoholic beverages Y N P S
- Use tobacco? Y N P S
- If yes ,in the past, how many years ____________
- How many packs per day? ____________
- Do you enjoy your work? Y N P S
- Take vacations? Y N P S
- Spend time outside? Y N P S
- Eat three meals a day? Y N P S
- Do you go on diets often? Y N P S
- Do you eat out often? Y N P S
- Do you drink coffee? Y N P S
- Drink black/green tea? Y N P S
- Drink soda? Y N P S
- Do you eat refined sugar? Y N P S
- Do you add salt to your food? Y N P S

ENDOCRINE

- Hypothyroid? Y N P S
- Hypoglycemia? Y N P S
- Excessive thirst? Y N P S
- Fatigue? Y N P S
- Heat or cold intolerance? Y N P S
- Hyperthyroid? Y N P S
- Diabetes? Y N P S
- Excessive hunger? Y N P S
- Seasonal depression? Y N P S
- Difficulty exercising? Y N P S

IMMUNE

- Reactions to immunizations? Y N P S
- Chronically swollen glands? Y N P S
- Slow wound healing? Y N P S
- Chronic fatigue syndrome? Y N P S
- Chronic infections? Y N P S
- Night sweats? Y N P S

NEUROLOGIC

- Seizures? Y N P S
- Muscle weakness? Y N P S
- Loss of memory? Y N P S
- Vertigo or dizziness? Y N P S
- Paralysis? Y N P S
- Numbness or tingling? Y N P S
- Easily stressed? Y N P S
- Loss of balance? Y N P S

EARS

- Impaired hearing? Y N P S
- Ringing in ears? Y N P S
- Dizziness? Y N P S
- Ear aches? Y N P S

EYES

- Impaired vision? Y N P S
- Cataracts? Y N P S
- Glaucoma? Y N P S
- Spots in vision? Y N P S
- Color blindness? Y N P S
- Tearing or dryness? Y N P S
- Eye pain or strain? Y N P S

HEAD

- Headaches? Y N P S
- Migraines? Y N P S
- Head injury? Y N P S
- Jaw or TMJ problems? Y N P S

NOSE AND SINUS

- Frequent colds? Y N P S
- Stuffiness? Y N P S
- Sinus problems? Y N P S
- Nose bleeds? Y N P S
- Hayfever? Y N P S
- Loss of smell? Y N P S

NECK

- Lumps in neck? Y N P S
- Goiter? Y N P S
- Difficulty swallowing? Y N P S

MOUTH AND THROAT

- Frequent sore throat? Y N P S
- Copious saliva? Y N P S
- Sore tongue or lips? Y N P S
- Hoarseness? Y N P S
- Jaw clicks? Y N P S
- Teeth grinding? Y N P S
- Gum problems? Y N P S
- Dental cavities? Y N P S

SKIN

- Rashes? Y N P S
- Acne/boils? Y N P S
- Change in skin color? Y N P S
- Lumps or bumps on skin? Y N P S
- Eczema or hives? Y N P S
- Itching? Y N P S
- Perpetual hair loss? Y N P S

RESPIRATORY

- Cough? Y N P S
- Sputum? Y N P S
- Asthma? Y N P S
- Wheezing? Y N P S
- Bronchitis? Y N P S
- Coughing up blood? Y N P S
- Shortness of breath? Y N P S
- Shortness of breath when lying down? Y N P S
- Pain in breathing? Y N P S
- Emphysema? Y N P S

Tuberculosis?	Y	N	P	S

GASTROINTESTINAL

Trouble swallowing?	Y	N	P	S
Change in thirst?	Y	N	P	S
Change in appetite?	Y	N	P	S
Nausea/vomiting?	Y	N	P	S
Ulcer?	Y	N	P	S
Jaundice?	Y	N	P	S
Gall bladder disease?	Y	N	P	S
Liver disease?	Y	N	P	S
Hemorrhoids?	Y	N	P	S
Pancreatitis?	Y	N	P	S
Heartburn?	Y	N	P	S
Abdominal pain or cramps?	Y	N	P	S
Belching or passing gas?	Y	N	P	S
Constipation?	Y	N	P	S
Bowel movements: how often?	Y	N	P	S
Is this a change?	Y	N	P	S
Black stools?	Y	N	P	S
Blood in stools?	Y	N	P	S

MENTAL/EMOTIONAL

Treated for emotional problem?	Y	N	P	S
Depression?	Y	N	P	S
Anxiety or nervousness?	Y	N	P	S
Poor concentration?	Y	N	P	S
Do you have mood swings?	Y	N	P	S
Considered suicide?	Y	N	P	S
Attempted suicide?	Y	N	P	S
Tension?	Y	N	P	S
Memory problems?	Y	N	P	S

URINARY

Increased frequency of urination?	Y	N	P	S
Inability to hold urine?	Y	N	P	S
Pain in urination?	Y	N	P	S
Frequency at night?	Y	N	P	S
Frequent UTI's?	Y	N	P	S
Kidney stones?	Y	N	P	S

MUSCULOSKELETAL

Joint pain or stiffness?	Y	N	P	S
Arthritis?	Y	N	P	S
Broken bones?	Y	N	P	S
Weakness?	Y	N	P	S
Muscle spasms or cramps?	Y	N	P	S
Sciatica?	Y	N	P	S

BLOOD

Anemia?	Y	N	P	S
Easy bleeding or bruising?	Y	N	P	S
Cold hands/feet?	Y	N	P	S
Deep leg pain?	Y	N	P	S
Thrombophlebitis?	Y	N	P	S
Varicose veins?	Y	N	P	S

FEMALE REPRODUCTIVE

Age of first menses: ____________

Age of last menses (if menopausal): ____________

Length of cycle: ____________

Duration of menses: ____________

Are your cycles regular?	Y	N	P	S
Painful menses?	Y	N	P	S
Heavy or excessive flow?	Y	N	P	S
PMS?	Y	N	P	S

Symptoms? ____________

Bleeding between cycles?	Y	N	P	S
Clotting?	Y	N	P	S
Endometriosis?	Y	N	P	S
Ovarian cysts?	Y	N	P	S
Vaginal odor?	Y	N	P	S
Vaginal discharge?	Y	N	P	S

Date of last pap smear: ____________

Abnormal PAP?	Y	N	P	S
Cervical dysplasia?	Y	N	P	S
Are you sexually active?	Y	N	P	S

Sexual orientation: ____________

Birth control? Type: ____________

Pain during intercourse?	Y	N	P	S
Gonorrhea?	Y	N	P	S
Herpes?	Y	N	P	S
Chlamydia?	Y	N	P	S
Genital warts?	Y	N	P	S
Syphilis?	Y	N	P	S
Difficulty conceiving?	Y	N	P	S

Number of pregnancies: ____________

Number of live births: ____________

Number of miscarriages: ____________

Number of abortions: ____________

Do you do self breast exams?	Y	N	P	S
Breast pain/tenderness?	Y	N	P	S
Breast lumps?	Y	N	P	S
Nipple discharge?	Y	N	P	S
Menopausal symptoms?	Y	N	P	S

MALE REPRODUCTIVE

Are you sexually active?	Y	N	P	S

Sexual orientation: ____________

Birth control? Type: ____________

Discharge or sores?	Y	N	P	S
Chlamydia?	Y	N	P	S
Gonorrhea?	Y	N	P	S
Genital warts?	Y	N	P	S
Herpes?	Y	N	P	S
Syphilis?	Y	N	P	S
Hernias?	Y	N	P	S
Testicular masses?	Y	N	P	S
Testicular pain?	Y	N	P	S
Prostate disease?	Y	N	P	S
Impotence?	Y	N	P	S
Premature ejaculation?	Y	N	P	S