Center for INNOVATIVE MEDICINE

Adult Intake Form

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(808) 591-8778

PERSONAL INFORMATION

Full name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone # (Home): _____ **(Cell):** _____ **(Work):** _____

Email address: _____

Age: _____ **Date of Birth:** _____ **Gender:** _____ **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 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% ○ 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?

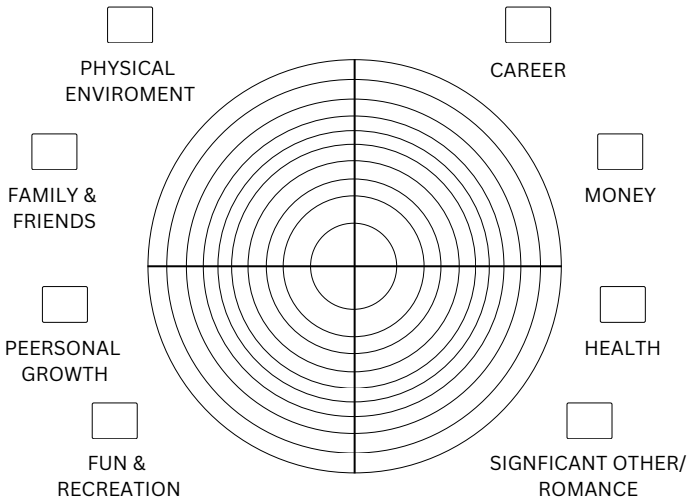
What do you love to do?

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 not, when and where did you last receive medical or health care? _____

If yes, where and from whom? _____

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? _____

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: _____

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

- ☐ **Rheumatic fever**
- ☐ **Diphtheria Scarlet fever**
- ☐ **Chicken pox**
- ☐ **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? _____

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**

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: **Yes** **No** If so, what kind and how often: _____

Watch TV: **Yes** **No** If so, how many hours? _____

Read: **Yes** **No** If so, how many hours? _____

Do you have a religious or spiritual practice? **Yes** **No** If so, how many hours? _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

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

SKIN

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: _____

Abdominal pain or cramps? (Y) (N) (P) (S)

Belching or passing gas? (Y) (N) (P) (S)

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)

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ACKNOWLEDGMENT & AGREEMENT OF TERMS

Our goal is to assist you in achieving improved health. We shall work with your body's inherent ability to heal encompassed in the laws of nature. This agreement clarifies our billing procedures. Please carefully read the statements below. Your signature designates your understanding and consent to these procedures. Please contact us with any questions, if necessary, prior to returning this form.

1. All accounts are due at the time of your visit. **Cash, check, MasterCard, and Visa** (not AMEX) are acceptable methods of payment.

2. It is your responsibility to determine whether or not your insurance company will reimburse you for your visit(s), and to what degree. We provide the proper paperwork, so that you may correspond with your insurance company directly.

3. Services and treatments not covered by your insurance carrier will still be your personal responsibility for payment to Dr Karen Tan.

4. The fee for an initial consultation, which includes a detailed history, physical exam, and a treatment program is **$425 + tax**. Return visits are **$170 + tax**. Initial Allergy Assessment is **$225 + tax**, subsequent allergy treatments are **$135 + tax**. These fees are subject to change without prior notice.

5. If you have HMAA or UHA, you will be responsible for the co-pay as well as the portion of the above stated fees that is not covered by your insurance. Please provide a copy of your insurance card and fill out the insurance claim form.

6. **Rescheduling & Cancellation Policy: A 24 hour notice is required** if you need to reschedule or cancel your scheduled appointment(s). If you change or cancel the appointment less than 24 hours of your scheduled appointment time, your credit card will be automatically charged for the visit.

Signature: _____ Date: _____

NO SHOW AND LATE CANCELLATION POLICY

Please see complete policy for more details. Clinic hours are Monday, Tuesday, Thursday and Saturdays. We are closed on Wednesdays and Fridays. A 24-hours business day notice for canceled or rescheduled appointments (e.g., notice of cancellation for a Monday appointment needs to be given on the Friday before) is necessary in order to avoid being charged. All cancellations need to be called into the clinic. If you are more than 30 minutes late, we will not be able to provide treatment and you will be charged for the treatment session.

Intial: _____ Yes, I have read the cancellation policy.

INFORMED CONSENT

In signing below, I acknowledge that **Karen Tan, ND, MAcOM, LAc**, has disclosed to me the following items concerning my treatment:

1. The care being provided is not a treatment for a specific disease, but preventative in nature and designed to improve my health or condition.

2. That she is not recommending I discontinue any other treatment or care being provided by any other health care professional.

3. That there is no guarantee or warranty, expressed or implied, concerning the outcome of any procedures.

4. That full disclosure of information has been made regarding my condition, the nature and character of the proposed treatment and/or procedure, the anticipated results, and the recognized serious possible risks, complications, if any, and anticipated benefits involved in the treatment and/or procedure, and in the recognized possible alternative forms of treatment, including non-treatment.

5. That I have had any questions answered to my satisfaction regarding my treatment, and I have agreed to the treatment and/or procedures that Dr. Tan will provide.

6. Should I experience any difficulties regarding my treatment, I am to contact Dr Tan as soon as possible, or proceed to the nearest emergency room.

7. We provide adjunctive, ongoing care. This means that care rendered by our physicians will not replace your need for a primary care physician. Our physicians subscribe to no hospital plans in the area, and therefore do not have admitting privileges.

Signature: _____ Date: _____

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