Dr. Molly Harbour Hutto, L.Ac, DACM, Dipl. OM

New Patient Intake Form

Patient Name_____Date/Time_____

Date of Birth: _____Phone: _____

Address: _____

How did you hear about us? _____

Insurance:

Carrier: _____Member #: _____

Are you primary insured? If not, who is? _____

What is their relationship to you/date of birth? _____

Provider Services # on back of card: _____

What is the primary reason for your visit?_____

_____

DIET, NUTRITION

- What do you not eat? _____
- What do you eat the most of? _____

_____

- What are your cravings? _____
- Does your energy drop or change after eating? Yes/No
- Temperature preferences of food & drink? _____
- Do you have any abnormal tastes in your mouth? _____
- Thirst: Thirsty/Normal/Never Thirsty Liquid Consumption? _____
- How often do you eat out?_____ How often do you eat fast food? _____

Other Comments:_____

_____

MEDICATIONS/SUPPLEMENTS/DRUGS

Please list all Prescription drugs and supplements here (please provide a separate sheet if they do not fit here):

Name	**Reason for Taking**	**How Long? (Dates)**
_____		
_____		
_____		

- Do you use recreational drugs? (Please Circle One) Now/Past/Never Which/How much? _____
- Do you smoke cigarettes or E-Cigarettes? (Please Circle One) Now/Past/Never How much? _____
- Do you consume alcohol? (Please Circle One) Now/Past/Never How much? _____
- Do you consume caffeine? (Please Circle One) Now/Past/Never How much? _____

ELIMINATION

URINATION – Please circle all that apply

Too frequent Not frequent enough Cloudy Urgent Dribbling Painful
Retention Scanty I urinate way more than I drink I urinate more than once at night

- Color: Clear/Light/Medium/Dark/Very Dark

STOOLS – Please circle all that apply

Stools are: formed loose dry Constipated Diarrhea Alternating
Undigested Food Painful before I feel tired after a BM Blood Mucus

- Frequency_____

Other Comments:_____

_____

SLEEP

- Do you fall asleep easily? Yes/No
- Do you stay asleep? Yes/No If no, how many times do you wake at night/what times? _____
- Do you remember your dreams? Yes/No
- Do you suffer from nightmares or dreams that are anxiety-ridden? Yes/No
- Do you wake feeling rested? Yes/No
- How many hours of sleep do you get at night? _____

ENERGY/EXERCISE

- General level of energy (1-10) _____
- Best time of day? _____Worst time of day? _____
- Do you exercise? Yes/No What type _____
- Frequency? _____
- How does exercise make you feel? _____

Other Comments:_____

_____

EMOTIONS

- How would you describe your general emotional state?_____
- Have you ever/do you currently experience depression/anxiety? _____

• How would you describe your emotional state as a youth? _____

Other Comments:_____

_____

EYES/EARS/TEETH/SKIN

• Do you suffer from headaches? Yes/No How frequently? _____

Please circle all that apply:

Dizziness Vertigo Ringing in ears Blurry vision

Red Eyes Dry eyes Itchy eyes Floaters Watery eyes

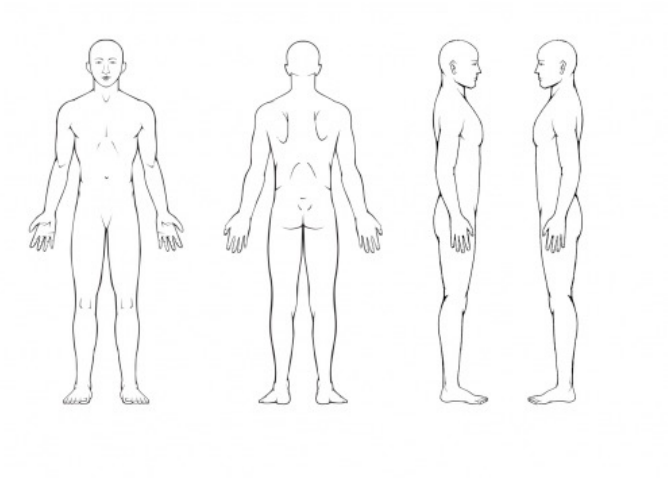
• Have you ever had a root canal? Yes/No

• Describe your dental health history: _____

• Do you suffer from bleeding gums? Yes/No Sensitive teeth? Yes/No Loose teeth as an adult? Yes/No

BODY PAIN

Please indicate on the following graphic where you experience pain:



Pain is worst with:

_____

_____

_____

Pain better with:

_____

_____

_____

Heat helps/aggravates Cold helps/aggravates

Movement helps/aggravates Rest helps/aggravates

Best time_____ Worst time_____

Other Comments:_____

_____

_____

GENDER SPECIFIC: *Please fill out all that is applicable to you.*

• Have any surgeries been performed on your reproductive organs? Please explain: _____

_____

Female:

• Menarche Age _____

• #days from day 1 of bleeding to day 1 of next cycle (usually 28-32 days) _____

• Color of menses _____

• Are clots present? Yes/No If yes, are they large or small? _____

- How many days of flow? _____ Do you experience cramping? Yes/No
- Do you experience mid-cycle pain (during ovulation)? Yes/No

- Do you experience breast tenderness? Yes/No Irritability Yes/No Fatigue Yes/No Bloating Yes/No
- Do you experience PMS symptoms prior to your menses? Yes/No How many days before? _____
- Do you experience excessive vaginal discharge? Yes/No
- Do you suffer from low libido? Yes/No
- Are you Menopausal or Peri-menopausal? Yes/No
- If yes, please circle all symptoms that apply to menopause for you: hot flashes/night sweats/insomnia

Please list all pregnancies and any pertinent details such as loss, difficult labors, C-Sections, trauma, etc:

_____

_____

_____

_____

_____

Other Comments:

_____

_____

_____

Male:

- Have you had your prostate checked? Yes/No Are there any concerns with the health of your prostate?

_____

- Do you suffer from low libido? Yes/No

Other Comments:

_____

_____

_____

By signing this form, you agree that all information is correct to the best of your knowledge. It will help the practitioner best meet your individual healthcare needs.

Patient Signature: _____ Date: _____