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3. On a Mac, Go to "print" and then instead of printing hit the "PDF" button instead (in the lower left corner) and then re-save it as a PDF and use that one to save onto your desktop and then send as an attachment.

On a PC, go to the File, Save as, then save the file to your computer as a PDF appending your name to the file name (File is AdultLongIntakeForm Save as AdultLongIntakeFormYourName). Email and print out this new file.

4. Even if you email it to me as a PDF, please also bring in the printed form just in case the PDF did not transmit properly.

If you are sick with a cold or the flu at the time of your initial appointment, Dr. Martin suggests that you reschedule for another day

Dr. Randy W. Martin, PhD, LAc, OMD, QME, CCH — Lic.#CA2265

*Doctor of Oriental Medicine - Classical Homeopathic Medicine - Qualified Medical Examiner
Chinese Herbs - Acupuncture - Nutritional Counseling - Metabolic Balancing*

Today's Date _____

First Name _____ Last _____ Middle _____

Address (no PO Box) _____ City _____

State _____ Zip Code _____ Home Phone _____ Work Phone _____

EMAIL # _____ Cell or Pager _____

Driver's License No. _____ SS# _____

Birthdate _____ Birth Place _____

Birth Time (if known) _____ Height _____ Weight _____

Employer's Name _____

Address _____

City _____ State _____ Zip Code _____

Who Should We Contact In Case of an Emergency? _____ Phone # _____

Whom may we thank for referring you to Dr. Martin? _____

Will your account be paid by cash/check _____ or by Insurance Coverage? _____

PLEASE READ AND SIGN ALL THREE STATEMENTS:

1. I understand that I am responsible for payment in full even if I have insurance. A compounded monthly late fee of 1% will be applied to any unpaid balance from 30 days of treatment. If the insurance company doesn't pay within 90 days of treatment, I agree that I will be responsible for payment in full.

2. I understand that I personally am responsible to pay for any missed appointments unless I cancel them at least 24 hours (48 hours for new patients) in advance of the appointment, unless other arrangements have been made.

3. I consent and authorize Dr. Martin to transmit any information to my insurance company as required or requested for Dr. Martin to receive insurance compensation in connection with my treatment.

I have read and agree to the above three statements:

Date _____ Patient's Signature _____

I ACCEPT. Please check this box in lieu of signature if you are submitting this form electronically indicating you agree to waive formal signature.

Marital Status: Single Married Separated Widow(er) Divorced
 Living with a romantic partner In a Committed Relationship and not living together
 Celibate (for how long? _____) Not interested in relationships at this time

What type of work do you do? _____ Enjoy your work? _____

Are you pregnant? _____ Have you ever considered suicide? _____ When _____

List your health concerns and how much each limits you in your life: (1=very little and 10=a lot/severe)

1. _____ 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
2. _____ 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
3. _____ 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
4. _____ 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
5. _____ 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
6. _____ 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Please indicate the types of treatment you are interested in receiving:

Homeopathy (Acute) Homeopathy (Constitutional) Acupuncture Herbs
 Vitamins Nutritional Counseling Energy Balancing Whichever works best

List any prescription medications you are currently taking: _____

List any vitamins, herbs, or homeopathic remedies you are currently taking: _____

List any past hospitalizations and/or operations and their approximate dates: _____

List injuries or accidents you have had: _____

Are you in any form of counseling? _____ Type/Frequency _____

Are you currently under the care of other doctors? _____

If so, please specify who and provide an address and phone below.

May I send them a note requesting we work as a team on healing your symptoms? _____

1. _____

2. _____

Are you a member of, or do you follow any particular spiritual, new age, or religious school of thought?

If so, please specify: _____

How often do you partake in any _____recreational drugs, _____tobacco, and/or _____alcohol?

Are you more _____introverted(shy) or _____extroverted(outgoing)?

Are you more _____cold or _____warm blooded?

Diet: Place a number for the approximately number of times you eat these foods EACH WEEK

(no cheating):

_____ Red Meat _____ Fish _____ Poultry _____ Milk _____ Coffee _____ Decaf

_____ Cheese _____ Soda _____ Diet soda _____ Candy _____ Pickles _____ Cookies/Cakes

_____ Salt your food? _____ Chocolate

What foods do you eat reguarly? _____

What foods do you **NOT** like? _____

If all foods were great for you nutritionally, **including junk foods**, what would taste good to you?

Do you follow any of these diets? _____Vegan _____ Pritikin _____ Macrobiotic _____ Vegetarian

_____ Junk Food _____ Zone Diet _____ Weight Watchers _____ Atkins _____ Other: _____

What exercise do you do and how often? _____

Do You Pray? _____ Type/Frequency _____ Do You Meditate? _____ Type/Frequency: _____

Do you enjoy exercising? _____ How many hours do you sleep? _____

How do you feel when you wake up? _____ Do you use a cell phone without a headset? _____

Do you sleep with an electric blanket? _____; or within 100 feet of high-power electric lines? _____

Do you remember your dreams? _____

Briefly describe any dreams that keep repeating or are disturbing to you :

What type of things or people "bug you"? _____

When you get stressed-out, what do you do to cope? _____

Have you _____, or your parents _____, or your grandparents _____, ever had any of the following:

_____ tuberculosis _____ gonorrhea _____ syphilis _____ HPV _____ Hepatitis (A-B-C?)

Please indicate all problems which have affected your relatives:

Mother _____

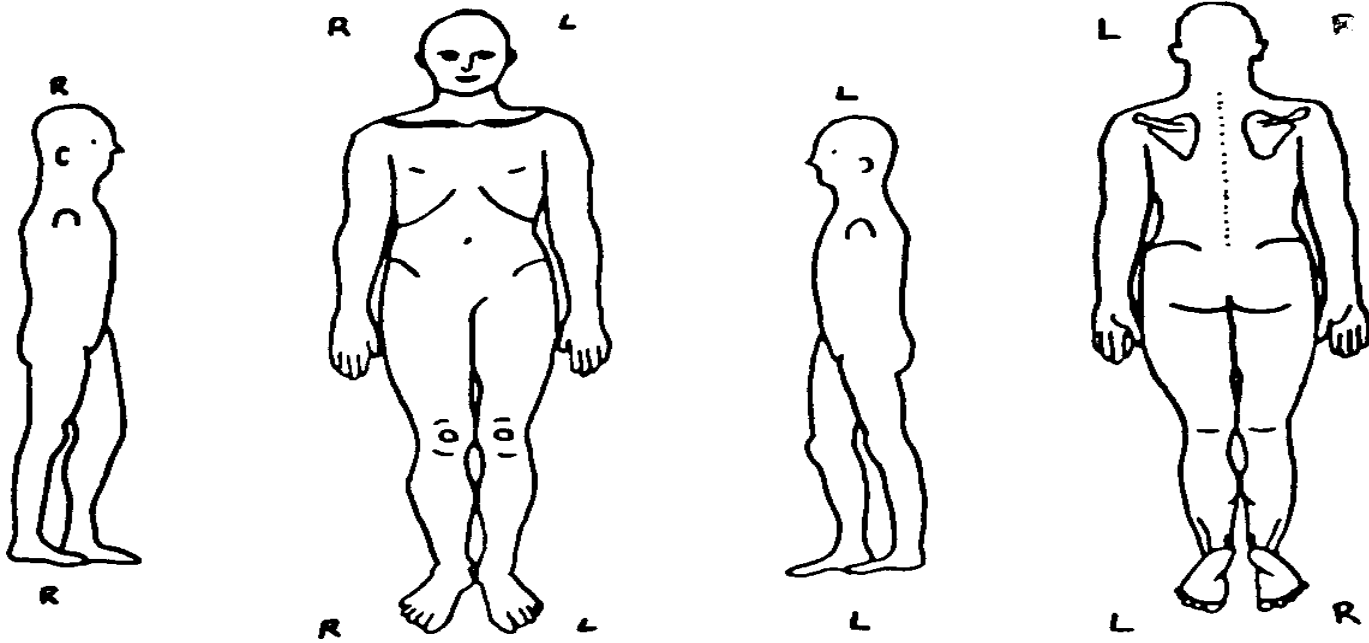
Father _____

Brother(s)/Sister(s) _____

Grandparents _____

Children _____

If you are in pain, please indicate exactly where the pain is on this chart:



Please check a "P" for PAST or "N" for NOW:

_____ Sweating for no reason _____ Spots before your eyes _____ Dizziness _____ Ringing in the ears

_____ Flatulence (gas): _____ before _____ during _____ after eating _____ Burping or heartburn

_____ Allergies: _____ airborne _____ food; Specify: _____

_____ Allergy to Drugs or Herbs or Vitamins? _____

_____ Bronchitis _____ Frequent colds _____ Asthma _____ Breast Fed as an Infant?

_____ Frequent use of antibiotics: For what problems? _____

_____ Pain during intercourse _____ Bad Breath _____ Heart Palpitations

Please check a "P" for past or "N" for now for the following symptoms:

_____ Herpes: _____ Lips (how often _____) _____ Genitals (how often _____) _____ Zoster

_____ Skin Problems: Specify _____ High Blood Pressure _____

_____ Moles or Warts: Where? _____

_____ Any moles or warts removed? _____ Where/When? _____

_____ Cancer: Where and status _____

_____ Hepatitis _____ Constipation _____ Diarrhea _____ Epstein Barr Virus

_____ Candiada albicans _____ Anxiety _____ Depression _____ Sadness or Grief

_____ Memory loss My Sex drive is: _____ Low _____ Medium _____ High

_____ Headaches: How often and what part of the head _____

_____ Fatigue: Is it Chronic? _____ or Current Only? _____ _____ Mood Swings: Food Related? _____

_____ Hemorrhoids: Bleeding? _____ _____ Cold hands _____ Cold Feet _____ Insomnia _____ Anemia

_____ PMS? _____ Moody _____ Sadness _____ Depression _____ Temper _____ Cravings _____ Cramps

_____ Breast Swelling _____ Headaches _____ Cramping _____ Menopause: _____

_____ How many pregnancies _____ Carried to term? _____ Abortions _____ Miscarriages

_____ Did you breast feed? If yes, for how long? _____

_____ Yeast; Color of Discharge _____; Amount, Consistency, or Pain of the Discharge _____

_____ Arthritis _____ Joint pain _____ Past head injury _____ Blackouts or Fainting _____ Epilepsy/Convulsions

_____ Fibroid or Cyst; Where? _____ _____ Breast Lumps _____ Teeth/Gum problems

_____ Bladder infections or Pain _____ Low Back Pain _____ Mid-Back Pain _____ Upper Back Pain

_____ Weak knees or Legs _____ Alcoholism _____ Drug Addiction

_____ Sexual Abuse _____ Emotionally Abused _____ Frequent ankle sprains

_____ Skin Rash? Where/When: _____

_____ Swelling? Where/When: _____

Please list any health problems you have had after which you NEVER FELT TOTALLY WELL:

Dr. Randy W. Martin, Ph.D., L.Ac., O.M.D., C.C.H., Q.M.E.

*Doctor of Oriental Medicine – Classical Homeopathic Medicine – Qualified Medical Examiner
Chinese Herbs – Acupuncture – Nutritional Counseling
Women’s Health – PMS – Menopause – Pain Control – Family Medicine – Allergies – Headaches
Fertility – Pregnancy – Sciatica – Low Back Pain – Neck & Shoulder Pain*

Dr. Martin makes an effort to not double book patients and to not keep patients waiting.

To make this possible, it’s important for each person to arrive at their appointment on time.

If because of an emergency you will be late, please inform the office so others will not be kept waiting.

If you need to cancel or reschedule your appointment, you will be charged the full fee unless you give 24 hours notice.

By signing below, you acknowledge and agree to this office policy.

Signature: _____

Print Name: _____

Date: _

By checking this box, I agree to these terms

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