1. Download PDF to your computer; do not fill out online or the information will not be saved

2. Open PDF and fill in the information

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 being 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:
Birthdate:	Birthplace:	Birth time (if known):
Address (no PO Box):		
City:	State:	Zip code:
Home phone:		Work phone:
Email:		Cell or pager:
Driver's license number:		SS#:
Height:	Weight:	
Employer's name:		
Employer's address:		
City:	State:	Zip:
Who should we contact incase of an emergency?		
Contact phone number:		
Whom may we thank for referring you to Dr. Martin?		
How will your account be paid? ☐ Cash ☐ Check ☐ 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

What type of work do you do?

List your health concerns and how much each limits you in your life: (1=very little to 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

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 currently under the care of other doctors? ☐ Yes ☐ No

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

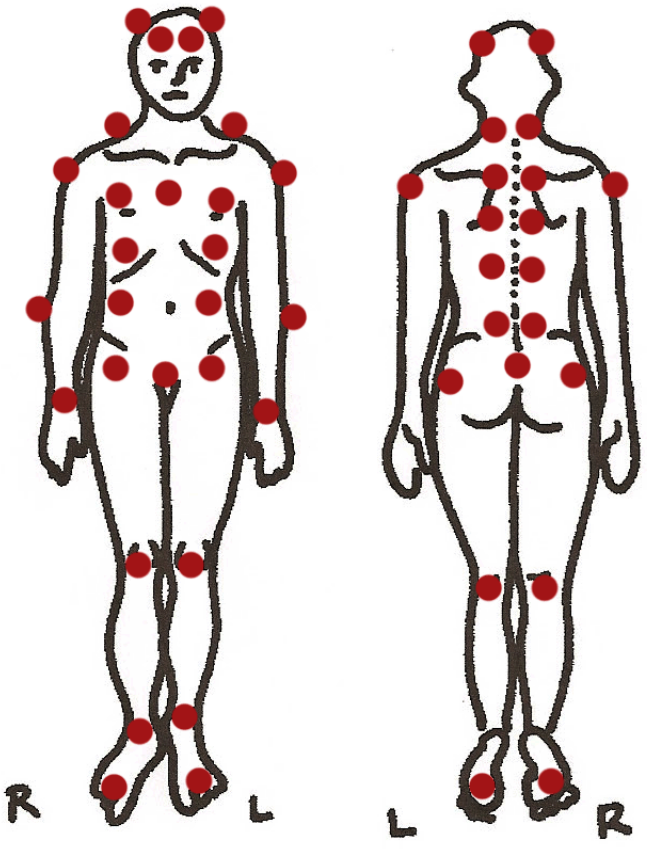
1.

2.

May I send them a note requesting we work as a team on healing your symptoms? ☐ Yes ☐ No

What exercise do you do and how often?

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



PLEASE CHECK ALL THAT APPLY:

MUSCULAR / SKELETAL HEALTH

☐ Low back pain ☐ Mid-back pain ☐ Upper back pain

☐ Frequent ankle sprains ☐ Arthritis ☐ Joint pain

HEART / BLOOD HEALTH

☐ High blood pressure ☐ Heart palpitations ☐ Anemia ☐ High blood cholesterol

GASTROINTESTINAL HEALTH

☐ Flatulance (gas): ☐ before eating ☐ during meals ☐ after eating

☐ Burping or heartburn ☐ Constipation ☐ Diarrhea ☐ Hemorrhoids: ☐ bleeding

GENITAL / URINARY HEALTH

My sex drive is: ☐ Low ☐ Medium ☐ High ☐ Bladder infections or pain

RESPIRATORY HEALTH

☐ Bronchitis ☐ Frequent colds ☐ Asthma

☐ Allergies: ☐ Airborne ☐ Food: specify: ☐ Drugs/herbs: specify:

SKIN HEALTH

☐ Skin problems: specify:

☐ Moles or warts: where?

☐ Moles or warts removed: where/when?

☐ Skin rash: where/when:

HEAD / EYE / EAR HEALTH

☐ Spots before your eyes ☐ Memory loss ☐ Dizziness ☐ Ringing in the ears

☐ Past head injury ☐ Blackouts or fainting ☐ Epilepsy / convulsions

☐ Headaches: specify how often and what part of the head:

SPECIFIC CONDITIONS

☐ Herpes: ☐ Lips: how often: ☐ Genitals: how often: ☐ Candiada albicans

☐ Epstein Barr virus ☐ Hepatitis ☐ Zoster ☐ Cancer: where and status:

GENERAL HEALTH ISSUES

☐ Weak knees or legs ☐ Sweating for no reason ☐ Cold hands ☐ Cold feet

☐ Swelling: specify where/when:

☐ Fatigue: ☐ Is it chronic? or ☐ Current only?

☐ Frequent use of antibiotics: for what problems?

WOMEN'S HEALTH

☐ PMS ☐ Moody ☐ Sadness ☐ Depression ☐ Temper ☐ Cravings ☐ Cramps

☐ Breast swelling ☐ Headaches ☐ Cramping ☐ Menopause:

☐ Yeast: ☐ Breast lumps ☐ Fibroid or cyst: where?

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

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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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12340 Santa Monica Blvd. #132 • West Los Angeles • CA 90025 • (310) 979-6495
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