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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 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, Ph.D., L.Ac., O.M.D. - Lic. #CF002265

*Doctor of Oriental Medicine - Classical Homeopathic Medicine
Chinese Herbs - Acupuncture - Nutritional Counseling*

Specializing in: Women's Health - Preventive & Holistic Medicine - Pain Control - Pediatrics - Allergies - Headaches

Today's Date _____

Patient's First Name _____ Last _____ Middle _____

Address _____ City _____

State _____ Zip Code _____ Home Phone _____ Parent's Work Phone _____

Parent's E-Mail: _____ Pager or Cell Number _____

Parent's Driver's License No. _____ SS# _____

Child's Birthdate _____ Birth Place _____

Birth Time (if known) _____ Birth Weight _____ Current Height _____ Weight _____

Parent's Name _____ Parent's Employer's Name _____

Employer's Address _____

City _____ State _____ Zip Code _____

Who Should We Contact In Case of an Emergency? _____

Phone Number of This Person? _____ Relationship _____

Who should we thank for referring you to Dr. Martin? _____

PLEASE READ AND SIGN:

1. I understand that I am still responsible for payment in full even if I have insurance coverage. A monthly late charge of 1% will be applied to any unpaid balance from 30 days of the treatment date.
2. I understand that I personally am responsible to pay for any missed appointments unless I cancel them at least 24 hours in advance of the appointment (48 hours in the case of new patient first appt.)
3. I give Dr. Martin permission to treat my child using Oriental medicine, nutritional supplements, acupuncture, and/or homeopathy.
4. 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 child's treatment.

My signature below indicates that I have have read and agree to the above:

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.

Page 2

The following information will be kept strictly confidential

Has your child ever received homeopathic and/or acupuncture treatment? _____

If so, when and where? _____

List the four (4) most important concerns you currently have about your child/teen's health:

1. _____ 2. _____
3. _____ 4. _____

Please indicate the types of treatment you are interested in your child/teen receiving:

_____ Homeopathy _____ Acupuncture _____ Herbs
_____ Nutritional Counseling and Diet _____ Whatever works best

List any prescription medications your child is currently taking: _____

List any vitamins, herbs, or homeopathic remedies he/she is currently taking: _____

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

List immunizations and reactions to the immunizations:

May I contact you child's other doctors so we can work as a team? _____ (please list address/phone)

1. _____

2. _____

Has your child ever been in any type of psychological counseling? _____ If so, when, and for how long? _____

How often do they cry? _____ Scream and Yell? _____

Yawning frequently? _____ Easily Startled? _____

Were they breast fed? _____ how long: _____ Finger Sucking? _____

Page 3

How long was the mother's labor? _____ Mother's Health Problems at Birth _____

List the complications in labor and delivery? _____

Any medical problems during the pregnancy? _____

Did mother smoke _____, drink _____, or take any drugs _____ during the pregnancy? _____

What was the mother's attitude during the pregnancy? _____

What was the father's attitude during the pregnancy? _____

Was the child planned? _____ Has the child experienced grief? _____

=====

Diet: Please check the items s/he eats and approximately how often each week:

_____ Red Meat _____ Fish _____ Poultry _____ Milk _____ Junk Food

_____ Other dairy products _____ Herbal Teas _____ Regular sodas _____ Chocolate

_____ Diet sodas _____ Candy _____ Cookies/Cakes _____ Pickles _____ Ice Cream

_____ Breast Fed Only _____ Breast Fed with Formula (type of formula): _____

What foods does s/he prefer? _____

What foods will s/he not eat? _____

Do you or your child follow any of these diets?

_____ Vegan _____ Pritikan _____ Macrobiotic _____ Vegetarian _____ Junk Food

=====

How many hours does s/he sleep? _____ How does s/he feel when waking up? _____

Does s/he sleep with many covers _____ or few _____? What position of sleep? _____

Are there nightmares? _____ Content _____

What things disturb your child? _____

What does s/he do when not getting their way? _____

=====

As the parent, have **you** _____, or **your** parents _____, or **your** grandparents _____, ever had:

_____ tuberculosis _____ gonorrhea _____ syphillis _____ cancer : where _____

_____ headaches _____ allergies _____ stomach problems _____ alcohol abuse

_____ moles and warts _____ asthma _____ been on anti-depression medications

_____ been smokers _____ bronchitis _____ skin rashes or hives _____ emotional abuse

Page 4

Please indicate problems which have affected you or your relatives:

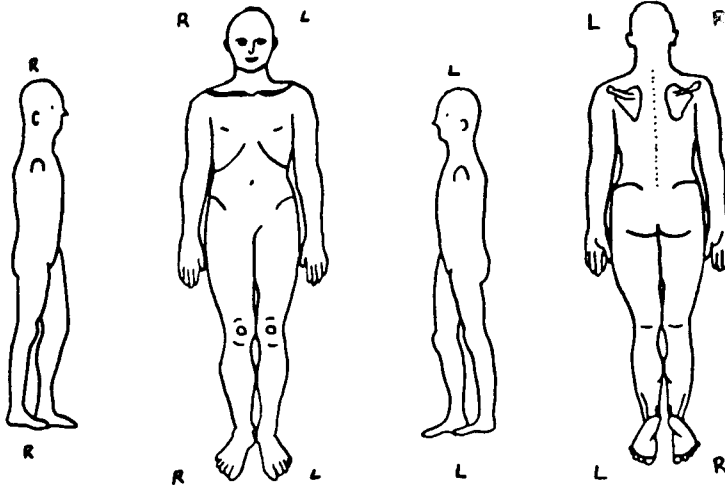
Child's Mother _____

Child's Father _____

Brother/Sister (of the child) _____

Child's Grandparents _____

If your child is in pain, please indicate exactly where the pain is on this chart:



Please check a "P" for past or "N" for now for any symptoms your child has had:

- Sweating for no reason; Where is the sweating? _____
 Flatulence (colic/gas): before during after eating
 Burping or heartburn Frequent colds/flu Ear Infections: side _____
 Allergies: airborne food; Specify: _____
 Bronchitis Asthma Any Physical Shock? _____
 Frequent use of antibiotics: For what problems? _____
 Herpes: Lips Genital Zoster
 Other Skin Problems: Specify _____; Skin Rashes? Where _____
 Moles or Warts: Where? _____
 Moles or warts removed? _____ Where/When? _____
 Cancer: Where and status _____
 Hepatitis Constipation Conjunctivitis
 Separation Anxiety Hides face in blankets Hot or Cold hands

Please check a "P" for past or "N" for now for any symptoms/problems the child has had:

- Diarrhea Candiada Thrush Cradle Cap
 Headaches: How often and what part of the head _____

___ Fatigue ___ Mood swings ___ Skin Rash ___ Joint pain ___ Head injury
___ Bed Wetting ___ Swelling: Where? _____ ___ Insomnia
___ Cyst; Where? _____ ___ Teeth/Gum problems ___ Bladder infections
___ Yeast infections ___ Anemia ___ Epilepsy/Convulsions ___ Sexual Abuse

=====
What was the health of your child at birth? _____

What is your child afraid of? _____

Is the child more: ___ outgoing, or ___ quiet and reserved. ___ Fear of Dogs?

If nursing, does the child prefer the: ___ right, or ___ left breast? ___ Fear of Heights?

What position does s/he sleep in? _____

Is the child exceptionally affectionate? _____ More toward men ___ or women ___?

If nursing, which foods does the **MOTHER** crave? _____

=====
Personality and Other Characteristics (please check):

___ Demanding ___ Irritable ___ Sweet
___ Controlling ___ Grinds Teeth ___ Big Appetite
___ Small Appetite ___ Irregular Appetite ___ Chews on Ice
___ Bed-wetting ___ Very thirsty ___ Craves cold drinks
___ Dislikes bathing ___ No thirst ___ Frequent Crying
___ Nosebleeds ___ Loner ___ Night person
___ People Person ___ Morning Person ___ Easy Going
___ Prefers Windows Open ___ Prefers Stuffy Room ___ Plays with other children easily
___ Likes the ocean ___ Chilly ___ Tire easily
___ Climbs into parents bed ___ Soddness ___ Parents argue

Please list any problems your child has had after which s/he has 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

17000 Ventura Blvd. #220 • Encino • CA 91316 • (818) 905-6171
12340 Santa Monica Blvd. #132 • West Los Angeles • CA 90025 • (310) 979-6495
23332 Valencia Blvd. • Valencia • CA 91355 • (661) 312-9868
Website: www.drrandymartin.com -- Email: Drrandymartin@gmail.com