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

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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 ______ syphillis _______ HPV ______Hepatitis (A-B-C?)

Please indicate all problems which have affected your relatives:

Mother ____

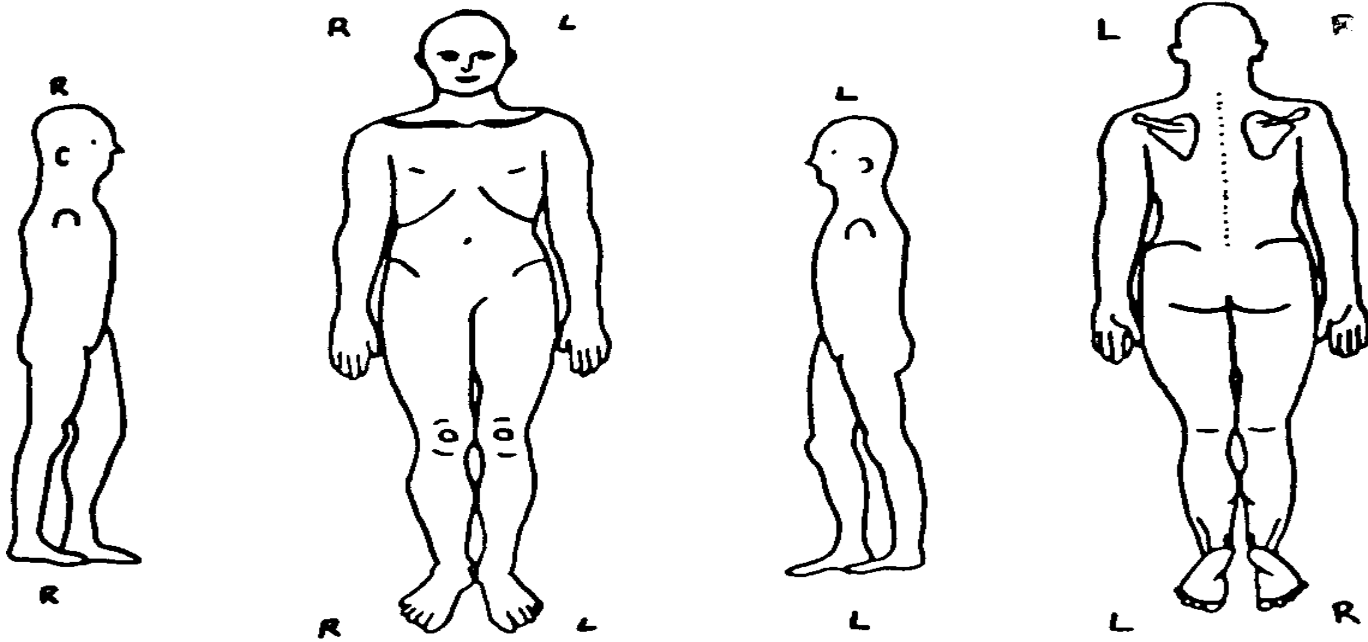
Father ____

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

_____Flatulance (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 sympoms:

_____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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