

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 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: _____

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.

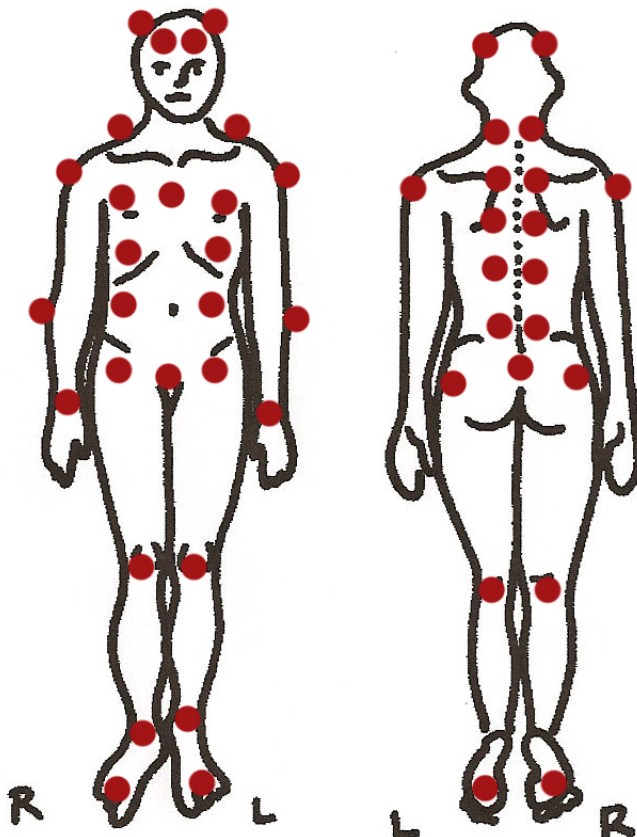
1.

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

- Flatulence (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*

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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