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, 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

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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.

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? _____

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 attittude during the pregnancy? _____

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

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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

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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? _____

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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

Please indicate problems which have affected you or your relatives:

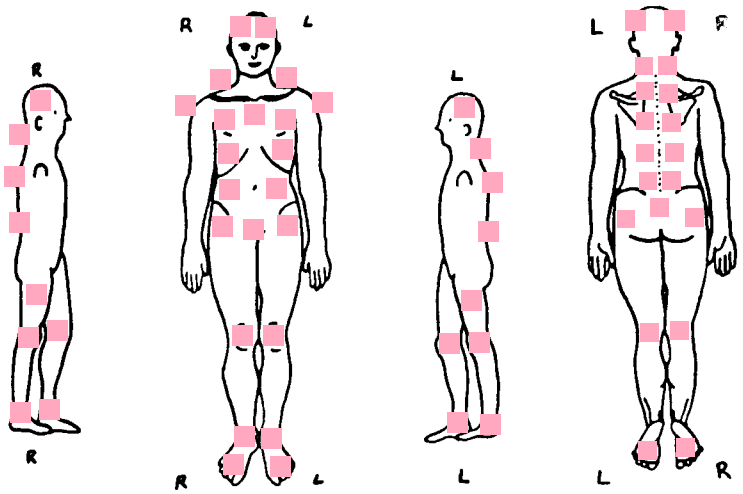
Child's Mother _____

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? _____

_____Flatulance (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

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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?_____

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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 _____ Saddness _____ 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

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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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