

Clinic Intake

Patient's name:

Date:

Age:

Sex: M/F

DOB:

C/C #1

O

P

Q

R

S

T

Past/current treatment for this complaint:

C/C #2

O

P

Q

R

S

T

Past/current treatment for this complaint:

C/C #3

O

P

Q

R

S

T

Past/current treatment for this complaint:

C/C continued on the back of this form: Y/N

Ten Questions:

Temp	hot	warm	neutral	cool	cold
HA	location: duration		describe pain: severity		how often:
Dizzy					
Dryness	hair	skin	eyes		
Ears	plugged	tinnitus	hearing loss		Sensitivity
Eyes	floaters redness		decreased night vision		dry/tearing
Nose	congested		dry		runny
Throat	plum pit		dry/scratchy		hoarse sore
Appetite			Cravings		
Digestion	gas nausea/vomiting		bloating/distention tastes		belching/acid reflux appetite

