Harry Hong Ph.D L.Ac.

PATIENT INTAKE

Patient Name: ____ Date: ______________

Last Name First Name

Address: ____

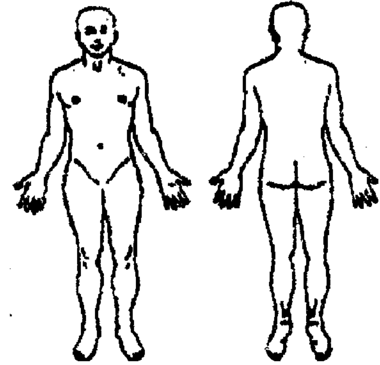
City State Zip

Phone: ________________ ________________ ________________

Home Cell Work

Occupation: ________________ SSN: ____________ Date of Birth: ______________

E-mail: ____



Please indicate pain location

Major Complaint: ________________________________

When did you first notice the problem? ____________________

What diagnostic studies have been done? ____________________

____

What treatment (medication, surgery) has been given? When? What results?

____

____

____

List OTHER complaints, how long have been having them, what treatment has been given?

1. ____

2. ____

3. ____

List surgeries you had in the past and when you had them: ____________________

____

____

List allergies you have (food, environmental and medication): ____________________

____

Circle diseases you have and indicate how long you have had it:

Diabetes______ Hypertension______ Heart disease______ Liver disease______

Arthritis______ Kidney disease______ Lung disease______ High Cholesterol ______ Others______

Are you often exposed to chemicals and toxic materials? (oil painting, cleaning material, pesticides,etc) ___
If yes, what are they?

Do you have amalgam (silver) filling in your teeth? _____ If yes, how many? ______

(Turn over)

After each meal, do you feel __tired, __bloated, __gassy, __heartburn, or __diarrhea? __yes __no
If yes, what food causes the discomfort?
__sugar (chocolate, candy, cake, etc) __fiber (raw fruits and vegetables, bran) __protein (meat, fish, etc)
__spicy food __salt __carbohydrate (bread, noodles, etc) __don't know

Do you crave certain food? __yes __no If yes, are these foods mainly composed of
__sugar (chocolate, candy, cake, etc) __fiber (raw fruits and vegetables, bran) __protein (meat, fish, etc)
__spicy food __salt __carbohydrate (bread, noodles, etc) __don't know

List five foods and snacks you eat everyday (list the items you eat most frequently first):

_____________ _____________ _____________ _____________ _____________

Do you have problem to __maintain or __loss weight? __yes __no
If having problem to loss weight, is it due to eat __ too much or __ not much but still gaining weight

Do you use the following items? If yes, indicate how much you have each day.
__(cup) coffee __(glass) alcohol __(pack) cigarette __(can) soft drink

How many glasses of water do you drink each day? ___ (8oz. glass)

Do you have problems with your urination? __yes __no
If yes, please indicate: __pain, __hot, __frequent, __leaky, __difficult or __________

Do you have a regular bowl movement (at least once a day)? __yes __no
If not, __diarrhea or __constipation. How many times do you have? __ times a day or __times a week

Do you have problems to sleep? __yes __no
If yes, ___ difficult to fall sleep, ___ wake up and can't sleep again, ___ feel not rested in the morning

Are you tired during the day? __yes __no. If yes, is it in the __morning, __afternoon, __before bed?

Is your body usually __ cold or __ hot? or __ **normal** ?

Rate your stress levels on a scale of 1-10 during the average week ___

Have you had any physical injuries such as car accident or falling down? _________________

Who referred you to see Dr. Harry Hong ? _______________ If from the web, which site? ______

Will you need a statement for the visit? ___ If yes, it is for __insurance or __ personal record ?

(Doctor Use Only)

Polarity: ___on ___off BP: ___________________ Heart Rate: ____________

Tongue: _________________ Pulse: _________________