New Patient Information
The Vitality Center, Ltd.
1842 S Broadway
Denver, CO 80210
720-900-4372

Patient Name: _____

Date of Birth: _____ **Age:** _____ **Gender:** _____

Single: _____ **Married:** _____ **Separated:** _____ **Divorced:** _____ **Widowed:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Occupation: _____ **Employer:** _____

Emergency Contact: _____

Phone #: _____ **Relationship:** _____

How did you hear about us?: _____

I understand that I am financially responsible for all charges for services rendered. Recommended services will be described to the patient prior to treatment. I understand that any outstanding account balances will be sent to collections after 90 days if payment has not been remitted.
An Oriental Medicine Practitioner is not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition that has been diagnosed by your doctor and is not an emergency situation, we will be happy to do so as long as the condition is in fact not an emergency situation and you understand and accept that our treatment regime may be different than what your doctor might have recommended. If the patient decides to alter their pharmaceutical regime in any way the patient must consult their doctor before doing so. I have read the above and I understand and accept these policies.

Patient Signature: _____ **Date:** _____

Primary Physician: _____

Other Physicians/Therapists: _____

Medication(s) you are currently taking:

Drug Name	Taking For	Taking Since

Supplements (vitamins, minerals, herbs, etc.): _____

_____

List all hospital stays, surgeries, or major illnesses that you have had since birth	Year Occurred

Test	Year	Test Results
☐ Physical	_____	_____
☐ Cholesterol	_____	_____
☐ Prostate	_____	_____
☐ Mammogram	_____	_____
☐ Pap Smear	_____	_____
☐ Blood	_____	_____
☐ HIV/STD	_____	_____

Please check if you have or had any of the following conditions

☐ Diabetes	☐ Syphilis	☐ Mumps	☐ Jaundice/Hepatitis
☐ Heart Disease	☐ CVA (Stroke)	☐ Rheumatic Fever	☐ Thyroid
☐ Asthma	☐ Pneumonia	☐ Emphysema	☐ Vein Condition
☐ Allergies	☐ Gonorrhea	☐ Bleeding Tendency	☐ Tuberculosis
☐ Meningitis	☐ Measles	☐ High Blood Pressure	☐ Chicken Pox
☐ Epilepsy	☐ HIV	☐ Nervous Disorder	☐ Polio
☐ Paralysis	☐ High Fever	☐ Mononucleosis	☐ Migraines
☐ Glaucoma	☐ Cancer	☐ Multiple Sclerosis	☐ Anxiety

Major Complaint(s) / What you are seeking treatment for:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Do these conditions affect your daily activities? ☐ **No** ☐ **Yes (Explain below)**

_____

Do these conditions affect your emotional health? ☐ **No** ☐ **Yes (Explain below)**

_____

Do these conditions affect your energy level? ☐ **No** ☐ **Yes (Explain below)**

_____

Have you ever been exposed to harmful chemicals? (paints, fumes, fuels, drugs/meds, etc.): _____

_____

_____

Have you ever experienced any physical injuries? (car accidents, broken bones, etc.): _____

_____

_____

Trauma has many forms and can range in severity and intensity from person to person. Trauma can be anything from neglect, divorce, death, physical abuse, sexual abuse, etc.

Have you experienced emotional or physical traumas?

☐ **No** ☐ **Yes**

Are you ok being asked about trauma?

☐ **No** ☐ **Yes**

Feel free to explain in as little or as much detail as you are comfortable with: _____

_____

_____

_____

Sleep Patterns

Do you have trouble falling asleep? ☐ **No** ☐ **Yes**

Do you have trouble staying asleep? ☐ **No** ☐ **Yes**

Do you wake refreshed? ☐ **No** ☐ **Yes**

Average hours of sleep a night: _____

Health History Questionnaire

Please check all the symptoms that you are currently experiencing or have experienced in the last 6 months.

Location of Pain: _____

Describe Your General Pain

What makes the pain better?

- ☐ Soft pressure
- ☐ Hard pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Rest
- ☐ Other: _____

What makes the pain worse?

- ☐ Soft pressure
- ☐ Hard pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Rest
- ☐ Other: _____

TOTAL BOXES CHECKED: _____

Pain Quality

- ☐ Sharp
- ☐ Fixed
- ☐ Burning
- ☐ Moving
- ☐ Cramping
- ☐ Aching
- ☐ Dull
- ☐ Other: _____

TOTAL BOXES CHECKED: _____

Lung & Kidney Function (Overall Temperature)

- ☐ Shortness of breath
- ☐ General weakness
- ☐ Daily chronic fatigue & malaise
- ☐ Low energy
- ☐ Difficulty keeping eyes open (daytime)
- ☐ Easily catch colds
- ☐ Feel worse after exercise

TOTAL BOXES CHECKED: _____

Heart Function

- ☐ Anxiety
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Trouble falling and/or staying asleep

TOTAL BOXES CHECKED: _____

Health History Questionnaire

Pancreas/Spleen Function

- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Worry
- ☐ Gurgling noise in stomach
- ☐ Fatigue after eating
- ☐ Bruise easily
- ☐ Prolapsed organs: _____
- ☐ Overthinking

TOTAL BOXES CHECKED: _____

Small/Large Intestine Function

- ☐ Loose stools
- ☐ Constipated
- ☐ Incomplete stools
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stools

TOTAL BOXES CHECKED: _____

Lung Function

- ☐ Nasal discharge (color: _____)
- ☐ Cough
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Allergies (type: _____)
- ☐ Alternation of chills/fever
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Dry nose
- ☐ Dry skin
- ☐ Sneezing
- ☐ Headache (location: _____)
- ☐ Overall achy feeling in body
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (# per day: _____)
- ☐ Sadness
- ☐ Melancholy

TOTAL BOXES CHECKED: _____

Stomach Function

- ☐ Burning sensation after eating
- ☐ Large appetite
- ☐ Bad Breath
- ☐ Canker sores (mouth)
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer
- ☐ Belching
- ☐ Hiccups
- ☐ Stomach pain
- ☐ Vomiting

TOTAL BOXES CHECKED: _____

Health History Questionnaire

Dampness Trapped in the Body

- ☐ Bodily sensation of heaviness
- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

TOTAL BOXES CHECKED: _____

Liver Function (Eyes)

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near sighted
- ☐ Far sighted

TOTAL BOXES CHECKED: _____

Liver, Gall Bladder Function

- ☐ Alternating diarrhea & constipation
- ☐ Chest pain
- ☐ Tight sensation in chest
- ☐ Bitter taste in mouth
- ☐ Anger easily
- ☐ Depression
- ☐ Frustration
- ☐ Irritability
- ☐ Skin rashes
- ☐ Headache at the top of the head
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Muscle spasms
- ☐ Seizures
- ☐ Convulsions
- ☐ Lump in the throat
- ☐ Neck tension
- ☐ Shoulder tension
- ☐ Limited range of motion in neck
- ☐ Limited range of motion in shoulder
- ☐ Alcohol consumption (per day: _____)
- ☐ Recreational drug use (which: _____)
- ☐ High-pitched ringing in ears
- ☐ Gallstones
- ☐ STD's (which: _____)
- ☐ Unable to adapt to stress

TOTAL BOXES CHECKED: _____

Health History Questionnaire

Kidney Function (Overall Temperature)

- ☐ Cold hands
- ☐ Cold fingers
- ☐ Cold feet
- ☐ Cold toes
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Hot body temp. sensation
- ☐ Cold body temp. sensation
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in the hands, feet & chest
- ☐ Hot flashes any time of the day
- ☐ Thirsty
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Do you take water to bed

TOTAL BOXES CHECKED: _____

Kidney (Urinary Bladder Function)

- ☐ Frequent cavities, teeth problems
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in knees
- ☐ Low back pain
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Low-pitched ringing in ears
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Lack of bladder control
- ☐ Wake during the night to urinate
- ☐ Fear
- ☐ Easily Startled

TOTAL BOXES CHECKED: _____

Urination (Bladder Function)

- ☐ Color: Pale ___ Dark Yellow ___ Clear ___
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning sensation
- ☐ Painful
- ☐ Discharge
- ☐ Difficult
- ☐ Urgent
- ☐ Frequent

TOTAL BOXES CHECKED: _____

Libido (Sex Drive)
Is your libido normal? Yes: _____ No: _____

If no, please check one of the following:

- ☐ Low
- ☐ High

WOMEN ONLY

Do you have a regular menstrual cycle?	☐ **Yes**	☐ **No**
Are you pregnant?	☐ **Yes**	☐ **No**
Do you have bleeding between periods?	☐ **Yes**	☐ **No**
Do you have a vaginal discharge?	☐ **Yes**	☐ **No**

Number of pregnancies_____
Number of children_____
Number of Miscarriages_____
Number of Abortions_____

Menstrual Cycle Symptoms

- ☐ **Nausea**
- ☐ **Vomiting**
- ☐ **Food cravings**
- ☐ **Water retention**
- ☐ **Breast swelling**
- ☐ **Breast tenderness**
- ☐ **Headaches**
- ☐ **Migraines**
- ☐ **Dull pain**
- ☐ **Sharp pain**
- ☐ **Depression**
- ☐ **Irritability**
- ☐ **Anxiety**
- ☐ **Other:_____**

Are you on Birth Control or Hormone Replacement: _____
TOTAL BOXES CHECKED: _____

MEN ONLY

- ☐ **Swollen testes**
- ☐ **Testicular pain**
- ☐ **Impotence**
- ☐ **Premature ejaculation**
- ☐ **Coldness or numbness external genitalia**
- ☐ **Other: _____**

TOTAL BOXES CHECKED: _____