SKY HILL WELLNESS

4105 Medical Pkwy, Ste 204, Austin, TX, 78756 512 751 2486

Patient Intake Form

Thank you for coming. Please take the time to fill out this questionnaire carefully in order to receive a complete evaluation. All your information will be confidential. If you have questions, please ask. Thank you.

Preferred title/pronouns: ☐Mr. ☐Mrs. ☐Ms./Miss ☐Dr. ☐He/His ☐She/Her ☐They/Them		Today's Date:
First Name:	Middle Initial:	Last Name:
Sex/Gender:		
Date of Birth:	Age:	Occupation:
Main phone #:	Alt. phone #:	
Email:	Allow Email contact by Sky Hill Wellness? ☐Yes ☐No	
Street Address:		
City:	State:	Zip:
Relationship Status (circle): S M D W	# of Children:	Primary Care Provider:
Do you have health insurance? ☐Yes ☐No	If yes, name of insurance provider:	
Does your insurance cover acupuncture: ☐ Yes ☐ No ☐ Don't know		Employer name:
Emergency contact name:		Phone #:
How did you find out about our clinic?	☐Friend/Relative (name)	
☐Direct mail ☐Location/Walk by	☐Website	☐Referred by:
☐Public event/Health fair ☐Social Media	☐Other (please specify)	

Main Problem(s): ______

What diagnosis, if any, have you received for this problem? ______

When did this problem begin? ______ What are the causes of this problem? ______

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? ______

What kind of treatment have you tried? ______

What makes this problem worse? ______

What makes this problem better? ______

Is there anybody in your family with the same/similar problems? ______

Remarks and additional information: ______

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries: ______ Hospitalization: ______

Significant trauma (auto accidents, sports injuries, etc): ______

Allergies (drugs, chemicals, foods, environmental): ______

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

____

Occupation ________________________________ Do you usually work ☐indoors ☐outdoors?

Occupational stress (chemical, physical, psychological, etc.): ________________________________

Personal Height __________ Weight now __________ Weight one year ago __________

Weight maximum ________ @Year __________

Habits Do you smoke? ☐Yes ☐No What? __________ How many per day? ______ Since when? __________

Please describe any use of drugs for non-medical purposes: ________________________________

Do you exercise regularly? ☐Yes ☐No Please describe your exercise program: ________________________

How many hours do you sleep in general? __________ What time do you usually go to bed? __________

Diet How much coffee do you drink (cups/day)? ______ Soda (number/day)? ______ Tea (cups/day)? ______

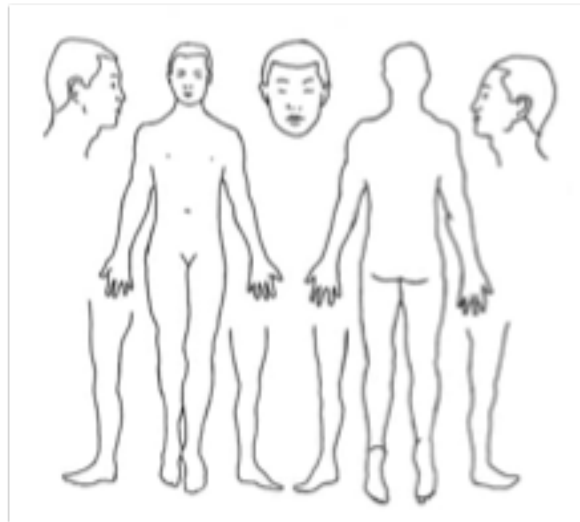
Average number of alcoholic beverages/week? __________

How much water do you drink per day? ________

Are you a vegetarian? ☐Yes ☐No ☐Yes, but not so strict Do you eat a lot of spicy food? ☐Yes ☐No

Remarks and additional information (e.g. diet) ________________________________

Indicate pain level and/or painful or distressed areas:



Wong-Baker FACES® Pain Rating Scale

0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

SKY HILL WELLNESS

4105 Medical Pkwy, Ste 204, Austin, TX, 78756 512 751 2486

Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type)			Breathing problems		
Diabetes			Heart Disease		
Hepatitis			Digestive disorders		
Thyroid disease			Venereal disease		
Seizures			Alcoholism		
Arthritis			Depression or anxiety		
Tuberculosis			High Cholesterol		
High blood pressure			Neurological disorder		
Anemia			Emotional disorder		
Other (Please explain)					

Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General
- ☐ Poor appetite ☐ Poor sleep ☐ Fatigue ☐ Fevers ☐ Chills
- ☐ Night sweats ☐ Sweat easily ☐ Tremors ☐ Cravings ☐ Change in appetite
- ☐ Poor balance ☐ Bleed or bruise easily ☐ Localized weakness ☐ Weight loss ☐ Weight gain
- ☐ Peculiar tastes ☐ Desire hot food ☐ Desire cold food ☐ Strong thirst (cold or hot drinks)
- ☐ Sudden energy drop (What time of day?) ______ Favorite time of year? ______ Worst time of year? ______

Skin & Hair
- ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema
- ☐ Pimples ☐ Acne ☐ Dandruff ☐ Dry skin ☐ Recent moles ☐ Loss of hair
- ☐ Purpura ☐ Change in hair or skin texture ☐ Other? ______

Musculoskeletal
- ☐ Joint disorders ☐ Muscle weakness ☐ Pain/soreness in the muscles ☐ Tremors
- ☐ Cold hands/feet ☐ Difficulty walking ☐ Hand/feet swelling ☐ Spinal curvature ☐ Back pain ☐ Hernia
- ☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck tightness ☐ Neck pain ☐ Shoulder pain
- ☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Joint sprain ☐ Other? ______

Head, eyes, ears, nose, & throat
- ☐ Dizziness ☐ Concussions ☐ Sores on lips/tongue
- ☐ Eye strain ☐ Eye pain ☐ Color blindness ☐ Night blindness ☐ Difficulty swallowing
- ☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Spots in front of eyes
- ☐ Migraines ☐ Glasses/lens ☐ Poor vision ☐ Cataracts ☐ Facial pain
- ☐ Sinus problems ☐ Nose bleeding ☐ Sore throat ☐ Grinding teeth ☐ Tooth problems
- ☐ Jaw clicks ☐ Other? ______

Cardiovascular
- ☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting
- ☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose veins ☐ Other? ______

Respiratory
- ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty breathing
- ☐ Bronchitis ☐ Pneumonia ☐ Chest pain ☐ Production of phlegm-What color? ______

4105 Medical Pkwy, Ste 204, Austin, TX, 78756 512 751 2486

Gastrointestinal ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Chronic laxative use

☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Abdominal pain/cramps

☐ Hemorrhoids ☐ Bad breath ☐ Rectal pain ☐ Gas ☐ Gallbladder problems

☐ Parasites ☐ Constipation

Bowel movements: Frequency ________ Color ________ Odor ________ Texture/Form ________

Neuro-psychological ☐ Loss of balance ☐ Concussion ☐ Lack of coordination

☐ Depression ☐ Anxiety ☐ Stress ☐ Bad temper ☐ Bi-polar

Genito-urinary ☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Unable to hold urine

☐ Kidney stones ☐ Urgency to urinate ☐ Dribbling ☐ Pause of flow ☐ Frequent urinary tract infection

☐ Genital pain ☐ Genital itching ☐ Genital rashes ☐ STD ☐ Other? ________

Reproductive

Sex assigned at birth: ☐ Female ☐ Male Gender reassignment operation(s) ________

☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Vaginal/genital discharge

☐ Fibroids ☐Ovarian cysts ☐ Irregular periods ☐ Clots ☐ Pain/cramps prior/during periods

☐ Breast tenderness ☐ Breast lumps ☐ Fertility problems ☐ Hot flashes ☐ Moodiness related to periods

Number of pregnancies ________ Number of births ________ Miscarriages ________ Abortions ________

Premature births ________ C-sections ________ Difficult deliveries ________

Date of last menstrual period ________ Are you currently, or could you possibly be, pregnant? ☐ Yes ☐ No

Age of first menstrual period ________ Duration of periods (days) ________ Duration of cycle (days) ________

Do you practice birth control? ☐ Yes ☐ No If yes, what type and for how long? ________

If taking oral contraceptives, what are you taking and for how long? ________

☐ Prostate problems ☐ Discharge ☐ Erectile dysfunction ☐ Ejaculation problems

☐ Frequent seminal emission ☐ Fertility problems ☐ Painful/swollen testicles

☐ Other ________

I have completed this form to the best of my knowledge.

Signature: ☐ Adult Patient ☐ Parent / Guardian ☐ Spouse

Are there any other health issues you want to discuss with us?