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New Patient Intake Form

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

IDENTIFICATION:

Name _____ Sex M ___ F ___ Date _____ Email _____

Address _____ City _____ State _____ Zip _____

Telephone: Home () _____ Work () _____ Cell () _____

Date of Birth _____ Place of birth _____ Age _____ Height _____ Weight _____

Single _____ Married _____ Separated/Divorced _____ Widowed _____ Co-Habiting _____

Education _____ Occupation _____

INITIAL VISIT:

Who referred you to me? _____

What is the reason for your visit today? _____

How long have you had this condition? _____ Have you ever experienced this before? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your Sleep ___ Work ___ Other (what?) _____

Are there any other problems you are having? _____

FAMILY HISTORY – Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	self	mother	father	sibling	spouse	children
cancer or tumors						
diabetes						
blood or bleeding disorders/anemia						
seizures						
high blood pressure/heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
age of death						
hepatitis						
kidney disorders						
thyroid disorders						
musculo-skeletal disorder						
blood transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS: For each item, please indicate how much, how many, or how often.

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

Marijuana _____

Other recreational drugs _____

Food cravings _____

Dietary restrictions _____

Exercise _____ How often? _____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.) _____

DIET: What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

MEDICAL: If you have ever been hospitalized for a serious medical illness or operation, please write the most recent ones below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Date of last physical examination: _____

Name of physician: _____

Address of physician: _____

Phone number of physician: _____

Have you ever been treated with acupuncture and/or Chinese herbal medicine before? Yes/No

MEDICINES:

What prescription drugs are you currently taking:

For what condition?

What over-the-counter medications, herbs, or supplements are you currently taking:

For what condition?

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

General

- Insomnia
- Dreams/ nightmares
- Irritability
- Depression
- Mood swings
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

Ears

- Ringing
- Hearing loss
- Infections
- Earache
- Hearing aids
- Vertigo

Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

Nose, Throat & Mouth

- Sinus infection
- hay fever/ allergies
- Frequent sore throat
- difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems
- Dry mouth

Skin

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching

Respiratory

- Difficulty breathing
- Difficulty breathing when reclining
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids
- Gall Bladder disorder

Musculoskeletal

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Other (describe)

Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

Infection Screening

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral/ genital

Other

GYNECOLOGY:

Age of first menses: _____ Date of last menstrual period: _____ Duration of flow _____

Blood clots: yes/no/when: _____ Length of cycle _____

Color of menstrual blood: pale _____ bright red _____ dark red _____ brown _____ other _____

Texture of menstrual blood: thick _____ thin _____ watery _____ normal _____

Pain: yes/no/when: _____

Irregular periods (describe): _____

PMS (please describe): _____

Current method of contraception: _____ Past method of contraception: _____

Are you currently pregnant? yes/no

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____

Number of abortions: _____

Any premature births: _____

Breast (lumps, cysts, tenderness, etc.): _____

Urinary tract infections: _____ How frequent? _____

Vaginal infections/ discharges (describe color): _____

Pain/itching of genitalia: _____

Pap smear: normal/abnormal Date of last Pap smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

Any bleeding since? _____

Are you currently on Hormone Replacement Therapy (HRT)? Yes/no Dose: _____

How long have you been on HRT? _____ Any side effects? _____

Other: _____
