Mobile ND

Kim D. Kelly, ND, MPH

Encinitas Acupuncture & Massage
121 West E Street
Encinitas, CA 92024

Phone: (760) 533-2883 **Fax: (866) 353-3603**

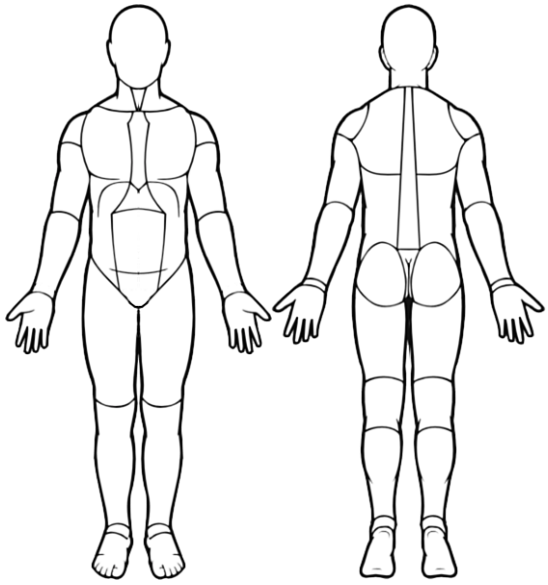
Patient Intake Form Date: _____

Last Name: _____ First Name: _____ M. I. _____

Nickname(s): _____ Birth date: _____ Sex: _____

A note to our patients: Please complete this form as thoroughly as possible to aid in your diagnosis and treatment. This is a confidential record and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Indicate painful or distressed areas:
1.		
2.		
3.		
4.		
5.		

What goals do you have for your visit at the clinic today? _____

_____

_____

_____

Do you have any questions about our clinic or care? _____

_____

_____

_____

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Please list prescription medications that you are currently taking with dosages: _____

_____

_____

_____

Please list over-the-counter medications that you are currently taking with dosages: _____

_____

_____

_____

Please list all supplements (vitamins, minerals, herbs, homeopathic remedies) that you are currently taking with dosages: _____

_____

_____

_____

_____

Please list any drug allergies, and severe or life-threatening allergies: _____

_____

_____

Personal habits:
Please circle any of the following substances that you use regularly:

Tobacco Alcohol Coffee/black tea/cola Recreational Drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

Do you exercise regularly? Yes No What type? _____

How long? _____ How often? _____

What are the top stresses in your life currently? _____

_____

Past history:

Hospitalizations: _____

Serious Illnesses and Injuries: _____

Date of last physical/annual exam: _____ Date of last blood tests: _____

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Personal and Family History:
Please check the 'yes' box next to each condition that applies to you or one of your family members. Please note whether the condition is in the past or currently by denoting a 'P' for past, or 'C" for current. Indicate who had the condition in the 'Relation' column.

	YES	RELATION	DATE RESOLVED Past (P)/Current(C)		YES	RELATION	DATE RESOLVED Past (P)/Current(C)
Alcoholism/ Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Social History:
Please circle those that apply: Single Married Significant other

Do you have any children? Yes No Please list their names and age(s): _____

_____

_____

Additional information which you would like to be noted:

_____

_____