

Elissa V. Blesch, L.Ac
BioSET Practitioner
2001 South Shields Street, Building D Suite #204
Fort Collins, CO 80526
970-484-8602

New Patient Intake Form

Name: _____

If a minor, Name of Parents / Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone (with area code): _____

Work Telephone (with area code): _____

Cell Phone (with area code): _____

Date of Birth (month/date/year): _____ Age: _____ Sex: _____

Occupation: _____

Who referred you to Elissa V. Blesch? _____

What is the main reason you are seeking care?

Surgeries / Major Illnesses: _____

Other Practitioners You See:

M.D. _____
 Acupuncturist: _____ Chiropractor: _____
 Massage Therapist: _____ Naturopath: _____
 Other: _____

Medications You Are Currently Taking

Name	Reason for Taking	Frequency of use

Supplements/ Vitamins / Homeopathics / Herbs You Are Currently Taking

Name	Reason for taking	Frequency of use

Health Habits

Do you use...	How Often?
Caffeine:	
Alcohol:	
Tobacco:	

Hours of Sleep _____ Do you feel rested upon waking? _____
 Do you exercise? _____
 What kind and Frequency? _____

Please indicate the symptoms you are **CURRENTLY** having or have
REGULARLY throughout the year

- | | |
|--|--|
| <input type="checkbox"/> Absent Minded | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Abdominal Bloating | <input type="checkbox"/> Fungus |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Gums Swollen / Red |
| <input type="checkbox"/> Addiction to Alcohol | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Addiction to Drugs | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Addiction to Tobacco | <input type="checkbox"/> High Alt. Problems |
| <input type="checkbox"/> Appetite - Excessive / Low | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Humidity Discomfort |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Burping | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Body Odor | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Blood Pressure - High / Low | <input type="checkbox"/> Irritable Bowel |
| <input type="checkbox"/> Breast Pain / Swelling / Lumps | <input type="checkbox"/> Joint Pain / Swelling |
| <input type="checkbox"/> Canker Sores / Cold Sores | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Colds - Frequently get | <input type="checkbox"/> Loss of Taste/ Smell |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Lump in Throat |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Menses - Difficulty |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Mental Confusion |
| <input type="checkbox"/> Crave Salt / Sour / Sweet | <input type="checkbox"/> Metallic Taste |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Moody |
| <input type="checkbox"/> Digestive Troubles | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Dreams - Disturbing | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Muscle Spasms |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Nasal Polyps |
| <input type="checkbox"/> Ears Ache / Infection / Congested | <input type="checkbox"/> Nasal Congestion |
| <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Nasal Drip |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Edema (swelling) | <input type="checkbox"/> Nervous Stomach |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Eyes - Watery | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Eyes - Red / Puffy / Itchy | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Eye - Vision Problems | <input type="checkbox"/> Restless Leg |

- Seizures
- Shortness of Breath
- Sinusitis
- Skin Rash
- Skin Itch
- Skin Burning
- Sleeping Problems
- Sneezing
- Sore Throat
- Stomach Discomfort
- Swollen Glands
- Teeth Pain
- Tongue Swelling
- Throat Constriction
- Tightness in Chest
- Tires Easily
- Urinary Tract Disorders
- Urination Painful / Burning
- Vomiting
- Weight Loss / Gain
- Yeast Infections

Any other symptoms: _____

Is there anything else you would like Elissa to know about your health?

