New Patient Intake Form

TODAY'S DATE:_____

Name: _____Birth date: _____/_____/_____

Address: _____City: _____Zip: _____ Email: _____

Marital Status: _____ Age: _____ ☐Male ☐Female Ht _____ Wt_____

Best Contact Phone #: 1.(_____)_____ 2.(_____)_____

Emergency Contact (Name & Phone)_____Occupation/Employer:_____

Referred by _____ Have you had Acupuncture before? ☐Yes ☐No

Reason for today's visit_____

How long have you had this condition?_____

Does it bother your: ☐Sleep ☐Work ☐Other_____

What seemed to make it better or worse? _____

Are you currently under the care of physician? ☐ Yes ☐ No If yes, for what?_____

Who is your physician? (Name & Phone): _____

Current Medications : _____

Other concurrent therapies: _____

FAMILY MEDICAL HISTORY

☐ Allergies	☐ Arteriosclerosis	☐ Cancer	☐ High Blood Pressure	☐ Pregnant
_____	☐ Asthma	_____	☐ Seizures	☐ Heart Disease
_____	☐ Alcoholism	_____	☐ Stroke	☐ Diabetes

Please check ✓ if YES to any of following Medical condition:

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are significant part of your medical history.)

☐ AIDs/HIV	☐ Epilepsy	☐ Pacemaker	☐ Thyroid Disorders	☐ Pregnant
☐ Alcoholism	☐ Heart Disease	☐ Seizure	☐ Tuberculosis	☐ Whooping Cough
☐ Allergies	☐ Hepatitis	☐ Stroke	☐ Trauma:_____	☐ Other (Specify):
☐ Asthma	☐ Herpes	☐ Surgery (List):	_____	_____
☐ Cancer	☐ High Blood Pressure	_____	_____	_____
☐ Diabetes	☐ Multiple Sclerosis	_____	_____	_____

GENERAL SYMPTOMS

☐ Poor appetite	☐ Poor sleep	☐ Bodily heaviness	☐ Chills	☐ Bleed or bruise easily
☐ Heavy appetite	☐ Heavy sleep	☐ Cold hands or feet	☐ Night sweats	☐ Peculiar taste (describe)
☐ Prefer cold drinks	☐ Dream disturbed sleep	☐ Poor circulation	☐ Sweat easily	_____
☐ Prefer hot drinks	☐ Fatigue	☐ Shortness of breath	☐ Muscle cramps	_____
☐ Weight gain or loss	☐ Lack of strength	☐ Fever	☐ Vertigo or dizziness	_____

YOUR LIFESTYLE

☐ Alcohol	☐ Marijuana	☐ Stress	☐ Regular Exercise	
☐ Tobacco	☐ Drugs	☐ Occupational Hazards	Type:_____	Frequency:_____

HEAD/ EYES/ EARS/NOSE/THROAT

- ☐ Glasses
- ☐ Eyestrain
- ☐ Eye pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in eyes
- ☐ Poor vision
- ☐ Blurry vision
- ☐ Night blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth problems
- ☐ TMJ
- ☐ Facial pain
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Gum problems
- ☐ Sores on lips or tongue
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Grinding teeth
- ☐ Sore throat
- ☐ Lumps in throat
- ☐ Enlarged thyroid
- ☐ Earaches
- ☐ Ringing in ears:
  - ☐ high pitch
  - ☐ low pitch
- ☐ Headaches
- ☐ Concussions

Other head or neck problems:

_____

_____

- ☐ Poor hearing

RESPIRATORY

- ☐ Tightness in chest
- ☐ Bronchitis
- ☐ Cough

  Productive?_____

  Wet or dry?_____
- ☐ Pneumonia
- ☐ Excessive phlegm

  Color of phlegm:

  _____
- ☐ Asthma/wheezing
- ☐ Shortness of breath

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Chest pain
- ☐ Difficult breathing
- ☐ Tachycardia
- ☐ Irregular heartbeat
- ☐ Palpitations

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Acid regurgitation
- ☐ Gas
- ☐ Rectal pain
- ☐ Bad breath
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative use
- ☐ Bloating
- ☐ Mucous in stools
- ☐ Intestinal pain/cramp
- ☐ Itchy anus
- ☐ Burning anus
- ☐ Bloody stools
- ☐ Anal fissures

Bowel movements: ____ /day

Color_____ Odor_____

- ☐ Hiccup
- ☐ Hemorrhoid
- ☐ Black stools

MUSCULOSKELETAL

- ☐ Neck/shoulder pain
- ☐ Muscle pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Joint pain
- ☐ Rib pain
- ☐ Limited range of motion
- ☐ Limited use

Other (describe):

_____

SKIN/HAIR

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Hair loss
- ☐ Change in hair
- ☐ Fungal infection
- ☐ Change in skin texture

Other hair or skin problems:

_____

_____

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Numbness
- ☐ Tics
- ☐ Poor memory
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily stressed
- ☐ Abuse survivor
- ☐ Considered suicide
- ☐ Attempted suicide
- ☐ Seeing therapist

Other (specify):

_____

_____

GENITO-URINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Incomplete urination
- ☐ Venereal disease
- ☐ Bedwetting
- ☐ Wake to urinate
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Kidney stone
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission

GYNECOLOGY (WOMEN only)

- ☐ Age menses began

  _____
- ☐ Length of cycle

  _____
- ☐ Duration of flow

  _____
- ☐ Irregular periods
- ☐ Painful periods
- ☐ PMS
- ☐ Vaginal discharge (color)_____
- ☐ Vaginal sores
- ☐ Vaginal odor
- ☐ Clots
- ☐ Breast lumps

#Pregnancies_____

Births_____

Premature births_____

Age at Menopause_____

Date of last PAP:

_____

Date last period began:

_____