NEW PATIENT INTAKE FORM

Name: _____ Date: _____

Age: _____ Gender: _____ Date of birth: _____ Height: _____ Weight: _____

Address: _____ Home phone: _____

City, State, Zip: _____ Cell phone: _____

Email address: _____ Work phone: _____

Occupation: _____ Preferred phone #: Work Cell Home

Emergency contact: _____

Phone: _____ Relationship: _____

How did you hear about us? Friend Ad Website Doctor Other _____

Have you ever had acupuncture before? Yes No

What are your primary reasons for coming in for treatment?

1. _____
2. _____
3. _____

Primary Health Concerns:

When condition began: _____ Have you had this in the past? Yes No

Is your condition: Getting worse Staying constant Coming and going

What makes it worse? _____

What makes it better? _____

Have you been treated by a doctor for this condition?

What diagnosis have you been given? _____

Name of current doctor: _____

Address: _____

Phone number: _____ Date of last physical exam: _____

List any lab tests that have been done in the last 2 years.(Attach results that you would like us to consider)

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Please indicate if you have or are taking any of the following:

- ❑ Pacemaker
- ❑ Sleeping aids
- ❑ Cortisone or other steroids
- ❑ Blood thinner (Coumadin, etc)
- ❑ Contagious disease
- ❑ Thyroid medication
- ❑ Tranquilizers
- ❑ Clotting disorder
- ❑ Pain relivers (Tylenol, Advil, aspirin, etc)
- ❑ Antacids (Tums, etc)

Please list any hospitalizations and/or surgeries/injuries/accidents:

Hospitalization/Surgery	Date	Reason / Relation to health concerns

Please list all prescriptions and over-the-counter medications you are currently taking:

Name	Dosage	Reason for taking	Date began taking

Please list all vitamins, supplements, herbs, and performance-enhancing aids you are currently taking:

Name	Dosage	Reason for taking	Date began taking

Have you been diagnosed with any of the following:

- ❑ Hypertension
- ❑ AIDS/HIV
- ❑ Cancer
- ❑ Heart disease
- ❑ Diabetes
- ❑ Arthritis
- ❑ Epilepsy
- ❑ Stroke
- ❑ Emotional disorder
- ❑ Autoimmune disease
- ❑ Osteopenia/Osteoporosis
- ❑ Asthma
- ❑ Bleeding disorder
- ❑ Thyroid disorder
- ❑ Depression/Anxiety
- ❑ Migraine headaches
- ❑ Fibromyalgia
- ❑ Chronic fatigue
- ❑ High cholesterol
- ❑ Infertility

Please carefully read the symptoms below and circle any that you have currently.

Eye, Ear, Nose and Throat

Eye pain	Eye twitching	See floating black spots	Eye dryness/itching	Ear infections (frequent)
Dry mouth	Ringing in ear	Teeth/Gum problems	TMJ/Jaw problems	Sore throat (frequent)
Sinus problems	Nose bleeding	Sensitivity to light	Hay fever/allergies	Eye infections (frequent)
Night blindness	Swollen glands			

Cardiovascular and Circulatory

Heart disease	Hand swelling	Low blood pressure	Palpitations	Chest pain	Irregular heartbeat
Blood clots	Ankle swelling	High blood pressure	Facial swelling	Pacemaker	Numbness/Tingling

Respiratory

Persistent cough	Asthma	Cough with phlegm	Difficulty breathing when lying down
Bronchitis	Pneumonia	Difficulty breathing	

Digestive

Loss of appetite	Bad breath	Gallbladder disease	Heartburn	
Nausea/vomiting	Anal fissures	Increased appetite	Other_____	
Epigastric pain	Gas/bloating	Fatigue after eating	Bowel movement frequency	x per day

Stool

Colon problems	Diverticulitis	Change in bowel habits	Diarrhea/Constipation	
Pain/Cramping	Burning anus	Bloody or tarry stools	Undigested food in stool	

Urinary Tract

Cloudy urine	Strong smell	Frequent urination	Kidney disease	Urinary infection (frequent)
Blood in Urine	Incontinence	Nighttime urination	Painful urination	Decrease in force of urination

Muscle and Joint Pain

Neck pain	Knee	Back pain - recurrent	Muscle cramp	Arthritis/Rheumatism
Hand/wrists	Sciatica	Cold, numb feet	Hip	Bone fracture/joint injury
Foot/ankle				

Emotional

Mood swings	Mental tension	Depression	Attempted suicide - how long ago?	_____
Poor memory	Easily stressed	Anxiety	Did you see a therapist? Yes	No
Intrusive thoughts	Anger easily	Mental fogginess	Stress - 1(low) - 10 (high) _____	/10
Past traumas_____				

Energy/Immunity

Catch colds easily	Use energy drinks	Chronic fatigue syndrome	Energy level - 1(low) - 10 (high)	
Fatigue	Slow wound healing	Chronic infections	Best time of day _____	Worst time _____

General Symptoms

Weight loss	Headache (frequent)	Thyroid disease	Hot flashes	Stroke	Alternate chills and fever
Herpes	Vertigo/dizziness	Night sweats	Jaundice	Anemia	Chills/Aversion to cold
Hepatitis	Cold hands/feet	Hernia	Insomnia	Cancer	Perspire without exertion
STD	Warm palms/soles	Paralysis	Bruise easily	Diabetes	Tremor/Hands shaking
Seizures					

Skin

Rashes	Hives	Psoriasis	Boils	Moles
Oily skin	Itching	Eczema	Dry skin	Warts

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Habits

Alcohol_____drinks/week Smoking_____cig./day Recreational drugs _____

Soft drinks_____cans/day Coffee/tea_____cups/day

Sleep

# of hours of sleep_____ Fall asleep_____ Wake up_____

Difficulty falling asleep? Yes No Why? _____

Difficulty staying asleep? Yes No Waking when? _____

Dreams: Yes No Sleep quality: Good Poor Wake feeling rested: Yes No

Female - History

# of pregnancies: _____ # of live births: _____ # of miscarriages: _____ # of abortions: _____

Birth control method: _____ Birth control pill name: _____

Menstruation

Irregular	Heavy flow	Scanty flow	Dark color	Abdominal bloating
Painful/tender breasts	Clotting	Backache	Light color	Spotting between periods
Constipation	Diarrhea	Emotional changes		Other _____

Are you pregnant or is there any possibility you could be pregnant? Yes No # of weeks

Age of first period: _____ Age of menopause: _____

Date last period began: _____ # of days of flow _____ # of days in cycle: _____

Average # of tampons/pads used per day: 1st___ 2nd___ 3rd___ 4th___ 5th___ 6th___ 7th___

Other issues/concerns: _____

Male

Premature ejaculation Prostate problems Impotence/erectile dysfunction

Other _____

External genitalia having sensations of: cold numbness pain swelling

Is there anything else you'd like us to know about? _____

Thank you for taking the time to answer these questions.

I certify that the information I have provided above is correct and accurate to the best of my knowledge.

_____ _____ _____

Patient's (or patient representative's) signature *Patient's name* *Date*

_____ _____

Patient representative's name *Representative's relationship to patient*