

NEW PATIENT INTAKE FORM

Today's Date _____ / _____ / _____

Name _____ SS# _____ Birthdate _____ / _____ / _____
Marital Status _____ Age _____
Address _____ M F Ht _____ Wt _____

Email _____ Employer: _____
City, State, Zip _____ Occupation _____
Home Phone _____ Work _____ Cell _____
Emergency Contact's Name & Phone _____
Referred by _____
Reason for visit today _____ Have you had acupuncture before? Yes No Chinese herbal medicine? Yes No

How long have you had this condition? _____
Is it getting worse? _____ Does it bother your Sleep Work Other (specify) _____

What seemed to be the initial cause? _____
What seems to make it better? _____
What seems to make it worse? _____
Are you under the care of a physician now? Yes No If yes, for what? _____
Physician's name _____ Physician's phone _____

Other concurrent therapies _____

Health Insurance Info:
Insurance Co. Name _____ Policy # _____
Address _____ Phone _____
City, State, Zip _____

Medicare Info:
Insurance Co. Name _____ Policy # _____
Address _____ Phone _____
City, State, Zip _____

Family Medical History
 Allergies (list) _____ Arteriosclerosis _____ Cancer (type) _____ Diabetes (Type: _____) Seizures _____
 Asthma _____ Depression _____ Heart disease _____ Stroke _____
 Alcoholism _____ High blood pressure _____

Your Past Medical History
(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 a significant part of your medical history.)
 AIDS/HIV Diabetes (Type: _____) Multiple Sclerosis Surgery (list) _____ Tuberculosis _____
 Alcoholism Emphysema Mumps _____ Typhoid fever _____
 Allergies Epilepsy Pacemaker (Date: _____) Ulcers _____
 Appendicitis Goiter Pleurisy _____ Venereal disease _____
 Arteriosclerosis Gout Pneumonia Thyroid disorders _____ Whooping cough _____
 Asthma Heart disease Polio Major trauma _____ Other (Specify) _____
 Birth trauma (your own birth) Hepatitis (Type: _____) Rheumatic fever _____
 Cancer Herpes (Type: _____) Scarlet fever _____
 Chicken pox High blood pressure Seizures _____
 Measles Stroke _____

Your Diet
Appetite Low High Coffee/Tea Soft Drinks/Fruit Juices Protein Intake Low High Artificial Sweeteners Sugar Salty foods Thirst for water: # glasses per day: _____

Average Daily Menu
Morning _____ Snack _____ Noon _____ Snack _____ Evening _____ Snack _____

Pharmaceuticals taken in the last 2 months: _____
Vitamins/supplements taken in the last 2 months: _____

Practitioner Use Only

Your Lifestyle

- | | | | | |
|----------------------------------|------------------------------------|---|------------------|-----------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stress | Regular Exercise | Frequency _____ |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs | <input type="checkbox"/> Occupational hazards | Type _____ | Frequency _____ |
| | | | Type _____ | Frequency _____ |

General Symptoms

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Chills | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Peculiar taste (Describe) |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Sweat easily | _____ |
| <input type="checkbox"/> Strongly like hot drinks | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps | _____ |
| <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Fever | <input type="checkbox"/> Vertigo or dizziness | _____ |

Head, Eyes, Ears, Nose, Throat

- | | | | | |
|--|---|--|---|--------------------------------------|
| <input type="checkbox"/> Glasses (What age: _____) | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Myopia or Presbyopia | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Enlarged thyroid | Other head or neck problems |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nosebleeds | _____ |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Ringing in ears (High or Low?) | _____ |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> TMJ | Color: _____ | <input type="checkbox"/> Poor hearing | _____ |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Facial pain | | <input type="checkbox"/> Earaches | _____ |

Respiratory

- | | | | | |
|---|--|--------------------------------|-----------------------|--|
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Cough | Color of phlegm _____ | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma/wheezing | Wet or Dry? _____ | | <input type="checkbox"/> Pneumonia |
| | <input type="checkbox"/> Difficult inhalation? exhalation? | Thick or thin? _____ | | |

Cardiovascular

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat |

Gastrointestinal

- | | | | | |
|---|---|--|------------------|--------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain or cramping | Bowel movements: | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Burning anus | Frequency _____ | Texture/form _____ |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Black stools | <input type="checkbox"/> Rectal pain | Color _____ | Odor _____ |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Anal fissures | | |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Laxative use | | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Hemorrhoid | What kind? | | |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Itchy anus | How often? | | |

Musculoskeletal

- | | | | | |
|---|--|-------------------------------------|--|------------------|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion | Other (Describe) |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Limited use | _____ |

Skin and Hair

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|--------------------------------------|------------------------------------|------------------------------------|--|-----------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Change in hair/skin texture | Other hair or skin problems |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching | <input type="checkbox"/> Fungal infections | _____ |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne | <input type="checkbox"/> Hair loss | | _____ |

Neuropsychological

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|-----------------------------------|--------------------------------------|--|---|-----------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered/attempted suicide | Other (Specify) |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Seeing a therapist | _____ |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abuse survivor | | _____ |

Genitourinary

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Nocturnal emission |

Gynecology

- | | | | | |
|---|--|--|---------------------------------------|------------------------|
| <input type="checkbox"/> Age menses began | <input type="checkbox"/> Duration of flow | <input type="checkbox"/> Vaginal discharge (color) | <input type="checkbox"/> Breast lumps | Date of last PAP |
| Length of cycle (day 1 to day 1) | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal sores | # Pregnancies _____ | _____ |
| _____ | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal odor | # Live births _____ | Date last period began |
| _____ | <input type="checkbox"/> PMS | <input type="checkbox"/> Clots | # Premature births _____ | _____ |
| | | | Age at menopause _____ | _____ |

Other *Medication, Supplements:*