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New Patient Intake Form

Today's Date_____

Name		SS#	
Birthdate		Age	
Marital Status		___ M ___F	Ht _____ Wt _____
Address		City, State, Zip	
Home Phone		Work Phone	
Occupation		Referred by:	
Emergency Contact Name		Emergency Contact Phone	

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 (what?)
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?

Who is your physician?
Physician's Phone
Other concurrent therapies

Health Insurance Info:

Insurance Co. Name	
Policy #	
Address	
City, State, Zip	
Phone	

Indicate all serious illnesses, injuries, accidents or surgeries you have had and give approximate dates: _____

_____

_ist any pharmacetuticals, herbal medications, homeopathic medicines, vitamins, etc. you are now taking: _____

_____

Choose one or two EMOTIONS that seem predominant in your life (frequently experienced, difficult to express, or in some way influential) _____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, change of residence, injury, death in family, bankruptcy, etc.):

Date	Event
_____	_____
_____	_____
_____	_____
_____	_____

Do you now undertake or have you undertaken a restricted diet? Please describe and indicate when:

Describe your current program of physical fitness:

What are the top priorities in your life at present?

Do you have a religious or spiritual practice? If so, what?

What are your goals for your health?

Please provide any additional information about yourself or your condition that might not have been covered by the above questions. You may continue on the back if you need additional space.

Family Medical History

☐ Allergies _____

☐ Cancer _____

☐ Arteriosclerosis	☐ Asthma	☐ Alcoholism	☐ Diabetes
☐ Heart Disease	☐ High Blood Pressure	☐ Seizures	☐ Stroke

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	☐ Multiple Sclerosis	☐ Thyroid Disorders
☐ Alcoholism	☐ Emphysema	☐ Mumps	☐ Tuberculosis
☐ Allergies	☐ Epilepsy	☐ Pacemaker	☐ Typhoid Fever
☐ Appendicitis	☐ Goiter	☐ Pleurisy	☐ Ulcers
☐ Arteriosclerosis	☐ Gout	☐ Pneumonia	☐ Venereal Disease
☐ Asthma	☐ Heart Disease	☐ Polio	☐ Whooping Cough
☐ Birth Trauma	☐ Hepatitis	☐ Rheumatic Fever	☐ Other (Specify)
(your own birth)	☐ Herpes	☐ Scarlet Fever	_____
☐ Cancer	☐ High Blood Pressure	☐ Seizures	_____
☐ Chicken Pox	☐ Measles	☐ Stroke	_____

☐ Surgery (list) _____

☐ Major Trauma (Car, fall, etc. - list) _____

Your Diet

Appetite	☐ Low	☐ Coffee	☐ Artificial Sweetener	☐ Sugar	Thirst for water:
	☐ High	☐ Soft Drinks	☐ Salty Food		# glasses per day: _____

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in last 2 months:

Vitamins/supplements taken in last 2 months:

Your Lifestyle

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

General Symptoms

- ☐ Allergies
- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Excessive thirst
- ☐ Strongly like cold drinks
- ☐ Strongly like hot drinks
- ☐ Peculiar taste (describe)

_____

- ☐ Poor sleep
- ☐ Heavy sleep
- ☐ Dream-disturbed sleep
- ☐ Fatigue
- ☐ Lack of strength
- ☐ Bodily heaviness
- ☐ Recent weight loss/gain

- ☐ Chills
- ☐ Cold hands or feet
- ☐ Aversion to heat
- ☐ Aversion to cold
- ☐ Poor circulation
- ☐ Muscle cramps
- ☐ Bleed or bruise easily

- ☐ Night sweats
- ☐ Sweat easily
- ☐ Lack of sweating
- ☐ Fever
- ☐ Shortness of-breath
- ☐ Vertigo or dizziness
- ☐ Nervousness

Head, Eyes, Ears, Nose, Throat

- ☐ Glasses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in eyes
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Night blindness
- ☐ Glaucoma
- ☐ Cataracts

- ☐ Teeth problems
- ☐ Grinding teeth
- ☐ TMJ
- ☐ Taste change
- ☐ Facial pain
- ☐ Gum problems
- ☐ Sores on lips or tongue
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Sinus problems
- ☐ Nasal obstruction
- ☐ Nasal discharge

- ☐ Loss of sense of smell
- ☐ Phlegm in nose
- ☐ Phlegm in throat
- ☐ Color of phlegm

_____

- ☐ Recurrent sore throat
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Enlarged thyroid
- ☐ Nose bleeds

- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Earaches
- ☐ Headaches
- ☐ Heaviness in the head
- ☐ Migraines
- ☐ Concussions

Other head or neck problems:

_____
_____
_____

Respiratory

- ☐ Asthma/wheezing
- ☐ Difficulty inhaling
- ☐ Difficulty exhaling
- ☐ Difficulty breathing when lying down

- ☐ Shortness of breath
- ☐ Hayfever
- ☐ Tight chest
- ☐ Pneumonia
- ☐ Coughing blood

- ☐ Cough

Wet or Drv?

_____

Thick or thin?

_____

Color of phlegm

_____

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain

- ☐ Tachycardia
- ☐ Irregular heartbeat
- ☐ Heart palpitations

- ☐ Phlebitis
- ☐ Blood clots

- ☐ Fainting
- ☐ Difficulty breathing

Gastrointestinal

- ☐ Poor appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Abdominal pain
- ☐ Acid regurgitation
- ☐ Indigestion
- ☐ Belching

- ☐ Hiccup
- ☐ Difficulty swallowing
- ☐ Bloating
- ☐ Bad breath
- ☐ Gas
- ☐ Intestinal pain or cramping
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative use

- ☐ Black stools
- ☐ Bloody stools
- ☐ Mucous in stools
- ☐ Itchy anus
- ☐ Burning anus
- ☐ Rectal pain
- ☐ Hemorrhoid
- ☐ Anal fissures

Bowel movements:

Frequency

_____

Color

_____

Texture/form

_____

Odor

_____

Musculoskeletal

- ☐ Neck/shoulder pain
- ☐ Muscle pain
- ☐ Rib pain
- ☐ Other (describe) _____

- ☐ Upper back pain
- ☐ Low back pain
- ☐ Joint pain

- ☐ Limited range of motion
- ☐ Limited use

- ☐ Cold limbs
- ☐ Knee problems

Skin and Hair

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Other hair or skin problems _____
- ☐ Dry skin
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Fungal infections
- ☐ Hair loss
- ☐ Premature grey hair\
- ☐ Dry, brittle hair
- ☐ Hair falling out
- ☐ Change in hair/skin texture
- ☐ Dark circles around eyes
- ☐ Bags under eyes
- ☐ Brittle nails

Neurologic & Neuropsychological

- ☐ Fainting
- ☐ Tremor
- ☐ Seizures
- ☐ Numbness
- ☐ Tics
- ☐ Poor memory
- ☐ Depression
- ☐ Other (specify) _____
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily stressed
- ☐ Insomnia
- ☐ Often feel angry
- ☐ Troubling dreams
- ☐ Cry uncontrollably
- ☐ Feel sad a lot
- ☐ Forgetful
- ☐ Mind not clear
- ☐ Anxiety
- ☐ Much fear
- ☐ Unrestrained joy
- ☐ Terrors
- ☐ Difficulty expressing emotions
- ☐ Abuse survivor
- ☐ Considered/attempted suicide
- ☐ Seeing a therapist

Genitourinary

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

Gynecology

Age menses began _____

Length of cycle (day 1 to day 1) _____

Duration of flow _____

Date of last PAP _____

Date last period began _____

- ☐ Abnormal pap smear
- ☐ Irregular periods
- ☐ Bleed between periods
- ☐ <25 day cycle
- ☐ >35 day cycle
- ☐ Painful periods
- ☐ Clots
- ☐ Vaginal discharge (color) _____
- ☐ Vaginal sores
- ☐ Vaginal odor
- ☐ Breast lumps
- ☐ PMS
- ☐ Low sexual energy
- ☐ Uterine prolapse
- ☐ Facial hair
- ☐ May be pregnant

Pregnancies _____

Live births _____

Premature births _____

Age at Menopause _____

Men Only

- ☐ Genital pain
- ☐ Impotence
- ☐ Genital sores
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Nocturnal emission
- ☐ Low sexual energy

Other

_____

_____

_____

_____

_____

_____

_____