New Patient Intake Form

Today's Date_____/_____/_____

Name | SS# | Birthdate / /

Marital Status | Age

Address | ❑ M ❑ F | Ht | Wt

Email

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
❑ Asthma
❑ Alcoholism

❑ Cancer (type) _____
❑ Depression

❑ Diabetes (Type:)
❑ 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
❑ Alcoholism
❑ Allergies
❑ Appendicitis
❑ Arteriosclerosis
❑ Asthma
❑ Birth trauma (your own birth)
❑ Cancer
❑ Chicken pox
❑ Diabetes (Type:)
❑ Emphysema
❑ Epilepsy
❑ Goiter
❑ Gout
❑ Heart disease
❑ Hepatitis (Type:)
❑ Herpes (Type:)
❑ High blood pressure
❑ Measles
❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker (Date:)
❑ Pleurisy
❑ Pneumonia
❑ Polio
❑ Rheumatic fever
❑ Scarlet fever
❑ Seizures
❑ Stroke
❑ Surgery (list) _____
❑ Thyroid disorders
❑ Major trauma (Car, fall, etc–list)
❑ Tuberculosis
❑ Typhoid fever
❑ Ulcers
❑ Venereal disease
❑ Whooping cough
❑ Other (Specify)

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