New Patient Intake Form

Today's Date

Name _____ DOB: _____ Age: _____ __M __F __Other

Address _____ Appointment Reminder Preference: __Email __Text __Phone Call

_____ Occupation _____

Email _____ Have you had acupuncture before? Y N

Phone Primary _____ Chinese herbal medicine? Y N

Phone Other _____

Emergency Contact Name & Phone _____

Referred by _____

Reason for today's visit _____

How long have you had this condition? _____

Is it getting worse? __Y __N 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? Y N If yes, for what? _____

Physician's Name _____ Physician's Phone _____

Other concurrent therapies _____

Family Medical History ("X" next to what applies)

Allergies(list)

_____ __Arteriosclerosis __Asthma __Alcoholism __Depression __Diabetes (Type?)

_____ __Cancer __High blood pressure __Heart disease __Seizures __Stroke

_____

Your Past Medical History ("X" next to what applies)

__AIDs/HIV __Alcoholism __Allergies __Appendicitis __Arteriosclerosis __Asthma __Bleed Easily __Birth trauma (your own birth) __Cancer __Chicken pox __Colitis __Diabetes (Type?) __Emphysema __Epilepsy __Goiter __Gout __Heart disease __Hepatitis (Type?) __Herpes (Type?) __High blood pressure __kidney disease __Measles __Multiple Sclerosis __Mumps __Pacemaker (Date?) __Pleurisy __Pneumonia __Polio __Rheumatic fever __Scarlet fever __Seizures __Stroke __Substance Abuse

__Surgeries & Date_____

__Thyroid disorders __Major trauma (car, fall, etc-list)_____

__Tuberculosis __Typhoid fever __Ulcers __Varicose Veins __Venereal disease __Whooping cough

__Other (specify)_____

Your Diet ("X" next to what applies)

Appetite: __Low or __High __Coffee/Tea __Soft Drinks/Fruit Juice __ Artificial Sweeteners __Sugar __Salty foods

Protein Intake: __Low or __High __Thirst for Water # of glasses per day:_____

Average Daily Menu

Morning Snack Lunch Snack Evening Snack

_____

_____

_____

_____

Medications (list all)

_____

_____

_____

_____

Your Lifestyle

__Alcohol __Marijuana __Stress __Tobacco __Drugs __Occupational Hazards

Regular Exercise: Type_____ Frequency_____

Type_____ Frequency_____

General Symptoms

__Poor Appetite __Heavy Appetite __Strongly like cold drinks __Strongly like hot drinks __Recent weight gain/loss

__Poor sleep __Heavy sleep __Dream-disturbed sleep __Fatigue __Lack of Strength __Bodily Heaviness __Cold hands or feet

__Poor circulation __Shortness of breath __Fever __Chills __Night sweats __Sweat easily __Muscle cramps

__Vertigo or dizziness __Bleed or bruise easily __Peculiar taste (Describe)_____

Head, Eyes, Ears, Nose, Throat

__Glasses __Eye strain __Eye pain __Red eyes __Itchy eyes __Spots in eyes __Poor vision __Blurred vision __Night blindness

__Myopia or Presbyopia __Glaucoma __Cataracts __Teeth problems __Grinding teeth __TMJ __Facial pain __Gum problems

__Sores on lips or tongue __Dry mouth __Excessive saliva __Sinus problems __Excessive phlegm, Color_____

__Recurrent sore throat __Swollen glands __Lumps in throat __Enlarged thyroid __Nosebleeds __Ringing in ears (high or low)

__Poor hearing __Earaches __Headaches __Migraines __Concussions __Other head or neck problems_____

Respiratory

__Difficulty breathing when lying down __Shortness of breath __Tight chest __Asthma/wheezing

__Difficult inhalation or exhalation __Cough, Wet or Dry? Thick or Thin? Color of phlegm_____

__Coughing up blood __Pneumonia

Cardiovascular

__High blood pressure __Low blood pressure __Blood clots __Fainting __Chest pain __Difficulty breathing __Tachycardia

__Heart palpitations __Phlebitis __Irregular heartbeat

Gastrointestinal

__Nausea __Vomiting __Acid reflux __Gas __Hiccup __Bloating __Bad breath __Diarrhea __Constipation

__Irritable bowel syndrome __Black stools __Bloody stools __Mucous in stools __Hemorrhoid __Itchy anus __Intestinal pain or cramping __Burning anus __Rectal pain __Anal fissures __Laxative use, what kind?_____How often?_____

Bowel movements: Frequency_____Color_____Texture/form_____Odor_____

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 and Hair

__Rashes __Hives __Ulcerations __Eczema __Psoriasis __Acne __Dandruff __Itching __Hair loss __Change in hair/skin texture

__Fungal infections __Other hair or skin problems_____

Neuropsychological

__Seizures __Numbness __Tics __Poor memory __Depression __Anxiety __Irritability __Easily stressed __Abuse survivor

__Considered/attempted suicide __Seeing a therapist __Other (Specify)_____

Genitourinary

__Pain in 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 __Other (Specify)_____

Gynecology

Age menses began_____ Length of cycle (day 1 to day 1) _____ Duration of flow_____ __Irregular periods

__Painful periods __PMS __Vaginal discharge (color)_____ __Vaginal sores __Vaginal odor __Clots __Breast lumps

#Pregnancies_____ #Live births_____ #Premature births_____ Age at menopause_____

Date of last PAP_____ Date of last period_____

Other_____

_____

_____

_____