NEW PATIENT INTAKE FORM

Today's Date ____/____/____

Name | **Marital Status** | **Birthdate** / / | **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

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

Your Lifestyle

- ❑ Alcohol
- ❑ Tobacco
- ❑ Marijuana
- ❑ Drugs
- ❑ Stress
- ❑ Occupational hazards

Regular Exercise
Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Strongly like cold drinks
- ❑ Strongly like hot drinks
- ❑ Recent weight loss/gain
- ❑ 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 (What age:)
- ❑ 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? exhalation?
- ❑ Cough
  Wet or Dry?_____
  Thick or thin?_____

Color of phlegm_____

- ❑ Coughing up blood
- ❑ Pneumonia

Cardiovascular

- ❑ High blood pressure
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Fainting
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Tachycardia
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heartbeat

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Acid regurgitation
- ❑ Gas
- ❑ Hiccup
- ❑ Bloating
- ❑ Bad breath
- ❑ Diarrhea
- ❑ Constipation
- ❑ 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_____ Texture/form_____
Color_____ 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 on 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

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 last period began _____

Other