NEW PATIENT INTAKE FORM

TODAY'S DATE_____

Name_____Birthdate_____Age_____Weight_____
Address_____ __ M __F Marital Status_____
City, State, Zip_____Occupation_____
E-Mail (**to receive our free newsletter**)_____
Home Phone_____Work_____Cell_____
Emergency Contact Name/Phone_____
Referred by_____
Reason for your visit today_____
How long have you had this condition?_____ Is it getting worse? _____
What seems to be the initial cause? _____
What seems to make it **better**? _____**worse**?_____
Are you under the care of a physician now? ___Yes ___No If yes, for what? _____
Physician's Name_____Physician's Phone_____
Have you had Acupuncture before? ___ Yes ___ No Chinese Herbal Medicine? ___ Yes ___ No
Other current therapies_____

Family Medical History

___Athlerosclerosis ___Asthma ___Alcoholism ___ Cancer (type) _____ ___ Diabetes
___Depression ___Heart Disease ___Hypertension ___ Seizures ___Stroke

Your Past & Current Medical History

___AIDS/HIV ___Alcoholism ___Appendicitis ___Arteriosclerosis ___Asthma ___Chicken Pox
___Diabetes ___Emphysema ___Goiter ___Gout ___Heart Disease ___Hepatitis
___Herpes/Shingles ___Hypertension ___Measles ___MS ___Cancer ___Mumps
___Pacemaker ___Pleurisy ___Pneumonia ___Polio ___Rheumatic fever ___Scarlet Fever
___Seizures ___Stroke ___Thyroid Disorder ___Tuberculosis ___Typhoid Fever ___Prostate Problems
___Ulcers ___Venereal disease ___Whooping Cough ___Allergies ___Epilepsy ___High Cholesterol
___Major Trauma (car, fall, etc.)_____
___Surgeries _____
Acupuncturist Notes_____

Your Diet

Appetite ___Low ___High Protein Intake ___Low ___High ___Coffee/Tea ___Sugar ___Artificial Sweeteners ___Salty Foods ___Soft Drinks ___Fruit Juices

Thirst for water: # glasses per day_____

Average Daily Menu

Breakfast	Snack	Lunch	Snack	Dinner	Snack

Medications & Supplements (please list below or provide us with your list to copy)

Lifestyle

___Alcohol ___Marijuana ___Stress Regular Exercise: Type_____
___Tobacco ___Drugs ___Occupational hazards Frequency_____

General Symptoms

___Recent weight loss ___Poor sleep ___Bodily heaviness ___Chills ___Lack of strength
___Recent weight gain ___Heavy sleep ___Cold hands or feet ___Night Sweats ___Fatigue
___Strongly like cold drinks ___Dream-disturbed sleep ___Poor circulation ___Sweat easily ___Hot flashes
___Strongly like hot drinks ___Bleed or bruise easily ___Muscle cramps ___Fever ___Vertigo/dizziness

Head, Eyes, Ears, Nose, Throat

___Glasses(age:_____) ___Night blindness ___Gum problems ___Headaches ___Recurrent sore throat
___Eye strain ___Myopia or Presbyopia ___Sores on lips/tongue ___Swollen glands ___Migraines
___Eye pain ___Glaucoma ___Dry mouth ___Lumps in throat ___Concussions
___Red eyes ___Cataracts ___Excessive saliva ___Enlarged thyroid ___Nosebleeds
___Itchy eyes ___Teeth problems ___Sinus problems ___Tinnitus (high or low?)
___Spots in eyes ___Grinding teeth ___Excessive phlegm ___Poor hearing ___Facial pain
___Poor/blurry vision ___TMJ ___Earaches ___Other_____

Respiratory

___Difficulty breathing when lying down ___Tight chest ___Asthma/wheezing ___Wet cough ___Dry cough ___Pneumonia ___Shortness of breath Color of phlegm _____

Cardiovascular

___High blood pressure ___Blood clots ___Chest pain ___Tachycardia ___Phlebitis
___Low blood pressure ___Fainting ___Difficulty breathing ___Heart Palpitations ___Irregular heartbeat

Gastrointestinal

___Nausea ___Diarrhea ___Constipation ___Burning anus ___Rectal pain
___Vomiting ___Acid reflux ___Gas ___Burning stools ___Anal fissures
___Hiccups ___Bloating ___Bad breath ___Black stools ___Hemorrhoid
___Intestinal pain ___Intestinal cramping ___Itchy anus ___Laxative use ___Irritable Bowel
Bowel movements: Frequency_____ Form_____ Color_____ Odor_____

Musculoskeletal

___Neck/shoulder pain ___Upper back pain ___Joint pain ___Limited use ___Carpal Tunnel
___Muscle pain ___Lower back pain Other (describe)_____

Skin and Hair

___Rashes or hives ___Eczema or Psoriasis ___Itching ___Hair loss ___Acne
___Fungal infections ___Ulcerations ___Change in texture Other_____

Neuropsychological

___Seizures ___Poor memory ___Irritability ___Seeing a therapist ___Easily stressed
___Numbness ___Anxiety ___Abuse survivor ___Considered/attempted suicide
___Tics ___Depression Other_____

Genitourinary

___Pain on urination ___Blood in urine ___Increased libido ___Impotence ___Kidney stone
___Frequent urination ___Urgent urination ___Decreased libido ___Wake to urinate ___Incomplete urination

Gynecology

___Irregular periods ___PMS #Pregnancies_____ Date last period began_____
___Painful periods ___Clots #Live births_____ Age at menopause_____
___Breast lumps Other_____