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## NEW PATIENT INTAKE FORM

**Name:** _____ **Date:** _____
**Date of Birth:** _____/_____/_____ **Age:**____ **Height:** _____ **Weight:** _____ **M:** ___ **F:** ___
**Address:**_____**Zip code:**_____
**Home phone:** _____ **Work phone:**_____ **Occupation:** _____
**Cell phone:**_____ **Email address:**_____
**Emergency contact name & phone:**_____
**Referred by:** _____ **Have you had acupuncture before?** __Yes __No
**Reason for visit today:**_____ **When did symptoms first appear?** _____
**Are symptoms related to an accident, birth defect or heredity? Please explain:** _____
**Severity of symptoms:** __Slight __Moderate __Severe **Does it bother your:** __Sleep __Work __Other
**Have you had these symptoms in the past?** __Yes __No **Are symptoms:** __Better __Worse __Constant __Comes & Goes? **What makes it better?** _____ **What makes it worse?** _____
**Are you under the care of a physician now?** __Yes __No **If yes, for what?**_____
**Physician's name:** _____ **Phone:** _____
**Other concurrent therapies:** _____
**Medications, drugs, herbs, supplements you are currently taking and for what conditions (Attach separate sheet if necessary):**_____

_____
**Surgeries and dates:** _____
**Date of last physical exam:** _____ **By whom:** _____

_____

**MEDICAL HISTORY: (Do you have or have you ever had any of the following conditions?)**

| | | | | |
|---|---|---|---|---|
| __AIDS/HIV | __Chronic Fatigue | __Herpes | __Pneumonia | __Tuberculosis |
| __Alcoholism | __Diabetes | __High Blood Pressure | __Polio | __Ulcers |
| __Allergies | __Emphysema | __Jaundice | __Rheumatic Fever | __Venereal Disease |
| __ADD/ADHD | __Epilepsy | __Kidney/Bladder Trouble | __Scarlet Fever | __Whooping Cough |
| __Appendicitis | __Gallstones | __Measles | __Seizures | __Other_____ |
| __Arthritis | __Goiter | __Multiple Sclerosis | __Stroke | _____ |
| __Asthma | __Gout | __Mumps | __Sudden Weight Gain | _____ |
| __Cancer | __Heart Disease | __Pacemaker | __Sudden Weight Loss | __Metal plate or |
| __Chicken Pox | __Hepatitis | __Pleurisy | __Thyroid Disorders | steel in body |

__Major Trauma (Auto, fall, etc.) _____

_____

**FAMILY MEDICAL HISTORY: Has any member of your family had any of the above?** __Yes __No
**If yes, which member and what did they have?** _____

| | | | |
|---|---|---|---|
| **ENERGY LEVEL:** | __Night sweat | **SKIN:** | __Psoriasis |
| **From 0-10:** | __Spontaneous daytime sweating | __Normal | __Changing moles |
| __High time of day | __Rarely sweat | __Dry | __Changing lumps |
| __Low time of day | __Spontaneous daytime sweat | __Itchy | __Bruise easily |
| **STRESS LEVEL:** | __Excess sweat | __Moist/clammy | __Dry scalp |
| __None | **CIRCULATION:** | __Burning | __Thinning hair |
| __Moderate | __Normal | __Boils | |
| __Caused by_____ | __Feeling of cold | __Hives | |
| **PERSPIRATION:** | **What area?**_____ | __Acne | |
| __Normal | **Bleed easily?** __Yes __No | __Eczema | |

**SCARS: List scars from accidents or surgeries** _____

**SLEEP:**
__Normal
__Trouble falling asleep
__Trouble staying asleep
__Excessive dreaming
__Hours sleep at night

**HEAD:**
__Headaches-describe location_____
__Memory loss
__Loss of balance
__Other_____

**EYES:**
__Pain
__Dryness
__Blurred vision
__Darkness under eyes
__Other_____

**EARS:**
__Hearing loss
__Earaches
__Ear discharge/infections
__Ringing/buzzing
__Other

**NOSE:**
__Frequent nose bleeds
__Sinus problems
__Nasal drip
__Other_____

**THROAT:**
__Soreness
__Hoarseness
__Difficulty swallowing
__Jaw problems
__Teeth/gum problems
__Swollen/sore tongue
__Other_____

**CHEST:**
__Difficulty breathing
__Shortness of breath
__Wheezing
__Trouble breathing at night
__Persistent cough
__Pain/pressure in chest
__Palpitations
__Cough with blood
__Cough with phlegm:
Color_____
Consistency_____
__Other

**BLOOD PRESSURE:**
__Normal
__High
__Low
__Don't know

**BOWELS:**
__Diarrhea
__Constipation
__Bloody stools
__Black stools
__Mucus in stools
__Hemorrhoids
__Lower bowel gas
__Foul smelling stools
__Colon disease
__# of bowel movements/day

**URINE:**
Color_____
Amount_____
__Frequent? __Day __Night
__Strong smell
__Difficult to urinate
__Pain/burning w/urination
__Blood in urine
__Frequent infections
__Dribbling urine
__Water retention

**MUSCULOSKELETAL PAIN:**
__Neck
__Shoulders
__Arms
__Hands
__Hip
__Knees
__Joints
__Fingers
__Big toe
__Upper back
__Mid back
__Lower back __Sciatica
__Loss of grip
__Swollen knees/elbows
__Nighttime leg cramps
__Weakness in legs
__Weak ankles
__Stiff all over
__Tingling in feet
__Muscle spasms/cramps
__Loss of feeling in hands/feet
__Other

**NEUROLOGICAL:**
__Nervousness
__Depression
__Easily angered/irritated
__Frequent crying
__Worry/anxiety
__Mood swings
__Confusion
__Poor concentration
__Tremors
__Numbness/tingling in limbs
__Poor coordination
__Muscle weakness
__Feel weak/shaky
__Seizures
__Neuralgia (nerve pain)
__Shingles
__Other_____

**FEMALES:**
__Pregnant
Date last monthly period_____
Date last PAP test_____
Age started menstrual cycle:_____
Age stopped:_____
__Irregular cycle
__Menstrual pain
__Low backache
__Clotting
__Heavy bleeding
__Light scanty bleeding
Color of menstrual blood:_____
__Mood changes
__Low or no sex drive
__Painful breasts
__Hot flashes
__Food cravings
__Other

**Discharges:**
__Yellow
__White
__Thick
__Clear
__Odor
__Itching
__Other_____
__No. of pregnancies
__No. Of miscarriages
__No. Of abortions
__No. Of Cesareans
__Other_____

**FEMALES: Continued**
__Surgeries:
__Cervix
__Uterus
__Ovaries
__Other

**MALES:**
__Low sex drive
__Impotence
__Pain with ejaculation
__Enlarged prostate
__Prostate infection
__Other

**APPETITE:**
__Excessive
__Poor
__Constantly changing
__Feel tired/weak if meal missed
__Excessive thirst
__Never thirsty
__Thirsty, no desire to drink
__Food cravings:_____
_____
_____

**DIGESTION:**
__Stomach gas
__Lower bowel gas
__Heartburn
__Belching
__Stomach pain/cramps
__Nausea
__Vomiting
__Bad breath
__Mouth sores
__Weight gain
__Weight loss
__Bitter/sour taste in mouth
__Abdominal bloating
How long after eating?_____
__Food allergies
If yes, to which foods?_____
_____

**NUTRITION:**
__Skip breakfast
__Eat a hearty breakfast
__No. Of meals per day
Biggest meal_____
__Eat when worried/rushed
How often?_____

__No. Glasses water per day
__Coffee
__Sodas
__Artificial sweetener
__Sugar
__Salty food

**LIFESTYLE:**
__Alcohol
__Tobacco
__Marijuana
__Drugs
__Stress
__Occupational hazards
__Regular exercise
Type & frequency_____
_____
_____
_____

**TEENS:**
__Sexually active
__Use protection
__Use drugs/alcohol
__Depressed
__Able to speak with parent
__Friends
__Extracurricular activities/sports

**Physician's comments:** _____

# CANCELLATION POLICY

**Appointments must be cancelled <u>by phone</u> 24 hours in advance. If an appointment is cancelled less than 24 hours in advance and we are unable to fill the appointment time, or the appointment is forgotten (patient does not show up or call), the normal fee will be charged.**

**Patient's signature:**_____ **Date:**_____