

New Patient Intake Form

Name (last, first) _____

Date of birth _____ **Age** _____

Address _____

City / State / Zip _____

Home phone _____

Email _____

Occupation _____

Work phone _____

May I call you at work? Yes No

Mother's Name _____ **Father's Name** _____

Emergency contact _____
(name & phone)

Referred by _____

Have you ever had acupuncture? Yes No

Main reason(s) for seeking treatment?

How long have you experienced symptoms?

Your condition is improved by...

Your condition is aggravated by...

Are you currently under the care of a physician? If so, who, and for what condition(s)?

Are you currently utilizing other complimentary care providers? If so, who, what modality, and for what condition(s)?

List all current medications, prescribed or otherwise, including vitamins & supplements

Health History

Significant illnesses (please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple sclerosis | <i>For the next three choices, please list details on lines below</i> |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Surgery (date and type) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Obesity | <input type="checkbox"/> Major Trauma (emotional or accidental: describe) |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression | <input type="checkbox"/> Allergies – please list |
| <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Shingles | |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chronic Fatigue | |

General symptoms

- | | | |
|---|--|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Bleed / bruise easily |
| <input type="checkbox"/> Energy Drops | <input type="checkbox"/> Fever / chills | <input type="checkbox"/> Low immunity |
| <input type="checkbox"/> Sweat without exertion | <input type="checkbox"/> Dizziness / vertigo | <input type="checkbox"/> Aversion to Heat |
| | | <input type="checkbox"/> Aversion to cold |

Digestion

- | | | |
|---|---|--|
| <input type="checkbox"/> Extreme appetite | <input type="checkbox"/> Bloating | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> No appetite | <input type="checkbox"/> Gas | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Irritability or low energy
between meals |
| <input type="checkbox"/> Dieting | <input type="checkbox"/> Heartburn | |
| <input type="checkbox"/> Tired after eating | <input type="checkbox"/> Nausea | |

How many meals per day?

How many snacks per day?

Gastrointestinal

BM: ____ per ____ days

- | | | |
|---|--|--|
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Irritable bowel
syndrome |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mucous in stool | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Anal fissures | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Anal itching / burning | <input type="checkbox"/> Intestinal pain /
cramping | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Laxative use | <input type="checkbox"/> Incomplete evacuation | |

HEENT

- | | | |
|---|--|--|
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> TMJ | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Spots / flowery vision | <input type="checkbox"/> Sores on tongue or
mouth | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Tinnitus / ringing |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Excess saliva | <input type="checkbox"/> Deafness |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Post-nasal drip | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Sore throat | Frequency: |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Swollen glands | Location of Pain: |
| <input type="checkbox"/> Bleeding gums | | Triggers: |

Cardiovascular / respiratory

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Chest tightness |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart valve abnormality | <input type="checkbox"/> Difficult inhalation |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficult exhalation |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Cold hands / feet | <input type="checkbox"/> Productive cough (color of phlegm?) |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Dry cough | |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Wheezing | |

Skin / hair

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Pimples / acne | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Rashes / hives | <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Brittle nails | |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Ridged nails | |

Musculoskeletal

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Spinal pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Vertebral disc degeneration | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Swelling | | |

Neuropsychological

- | | | |
|--|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Poor memory | psychotherapy |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Seasonal mood disorder | <input type="checkbox"/> Job stress |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Tics | <input type="checkbox"/> Recent divorce |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Tremors | <input type="checkbox"/> Death of someone close |
| <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Currently in | <input type="checkbox"/> Financial setback |

Genito-urinary

Urine: _____times per day

- Frequent urination
- Loss of urine when laughing or sneezing
- Incomplete urination / retention

- Dribbling
- Burning urination
- Blood in urine
- Wake frequently to urinate
- Kidney stones

- Bedwetting
- Decreased libido / sexual desire
- Impotency
- Infertility

Men only

- Prostate problems
- Erectile dysfunction
- Herpes

Women only

Age menses began:

Age menses ended (if applicable):

Date of last ob/gyn exam?

- Hysterectomy? partial full
- hormone replacement therapy

Headaches before menstrual cycle during cycle after cycle

- | | | |
|--|--|--|
| <input type="checkbox"/> Abortion(s) # _____ | <input type="checkbox"/> Herpes | <input type="checkbox"/> Constipation or diarrhea associated with period |
| <input type="checkbox"/> Miscarriage # _____ | <input type="checkbox"/> Human Papilloma Virus positive | <input type="checkbox"/> Emotional irritability or depression associated with period |
| <input type="checkbox"/> Live births # _____ | <input type="checkbox"/> STD history (chlamydia, PID, etc) | <input type="checkbox"/> Bleeding outside of regular menstrual cycle |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Breast cancer | <input type="checkbox"/> No period / skipped cycles |
| <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Fibrocystic breast | <input type="checkbox"/> Irregular cycle |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Pain at ovulation | |
| <input type="checkbox"/> Candida / yeast | <input type="checkbox"/> Cramps / low back pain | |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Acne associated with period | |
| <input type="checkbox"/> Vaginal odor | | |
| <input type="checkbox"/> Vaginal sores | | |

Period lasts _____ days

_____ days between periods (usually)

Menstrual flow

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> Clotting | <input type="checkbox"/> Watery, thin and bright red | <input type="checkbox"/> Flooding and trickling |
| <input type="checkbox"/> Brownish | <input type="checkbox"/> Normal red | <input type="checkbox"/> Stop and start flow |