New Patient Intake Form – Acupuncture

Today's Date_____

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you don't feel certain questions pertain to your present condition. Thank you.

Personal Information

Name_____ Age _____ Date of Birth_____

Marital Status_____ Gender _____ Height_____ Weight _____

Occupation _____ Employer _____

Address_____ Drivers License Number _____

City_____State_____ Zip_____

Home Phone_____ Work Phone _____ Mobile _____

Email _____ Fax _____

Emergency Contact: Name_____ Phone _____

Whom should we thank for referring you? _____

Have you had acupuncture before? ☐Yes ☐No Chinese Herbal Medicine? ☐Yes ☐No

With whom? _____ When? _____

For what condition(s)? _____

Please indicate if any of the following pertain to you.
Indicating "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities.

☐Hepatitis ☐HIV ☐High Blood Pressure ☐Seizures ☐Pacemaker ☐Blood Thinners ☐Pregnancy

Insurance

Insurance Company _____ Phone _____

Policy Number _____ Deductible _____ % of Coverage _____

Current Condition

Reason for todays visit _____

When did it start? _____

How did it start? _____

What makes it better? _____
(heat, cold, rest, activity, time of day, emotions, food?)

What makes it worse ? _____

Does it bother your: Sleep? Work? Activities of Daily Living? _____

Are you under the care of a physician for this or any other condition? _____

Physician's name _____ Physician's phone _____

Health Concerns

Including your reason for being here today, what other concerns do you have? Please list in order of importance.

	Severe	Moderate	Slight
1. _____	☐	☐	☐
2. _____	☐	☐	☐
3. _____	☐	☐	☐
4. _____	☐	☐	☐
5. _____	☐	☐	☐
6. _____	☐	☐	☐
7. _____	☐	☐	☐

Health History

How was your birth?

How was your childhood health?

Immunizations/ Vaccines?

Which	When	Reaction

Allergies:

Medications _____

Food _____

Chemicals _____

Seasonal _____

Environmental _____

Please check any conditions you have had or currently have:

☐ Cancer	☐ Diabetes	☐ Heart Disease	☐ Stoke/TIA	☐ Epilepsy/Seizure	☐ Sexually Transmitted Disease
☐ HIV/AIDS	☐ Herpes	☐ Shingles	☐ Syphilis	☐ Addiction	☐ Chemical Dependency
☐ Chlamydia	☐ Hepatitis	☐ Jaundice	☐ Gonorrhea	☐ Substance Abuse	☐ Hashimoto's Thyroiditis
☐ Pancreatitis	☐ Choleocystitis	☐ Goiter	☐ Gout	☐ Hyperthyroid	☐ Hypothyroid
☐ Alcoholism	☐ Low BP	☐ High BP	☐ Hypertension	☐ Obesity	☐ Metabolic Syndrome
☐ Meningitis	☐ Measles	☐ Mumps	☐ Chicken Pox	☐ Polio	☐ Mononucleosis
☐ Strep Throat	☐ Anorexia	☐ Bulimia	☐ Depression	☐ Kidney Disease	☐ Rheumatic Fever
☐ Mental Illness	☐ PTSD	☐ Bi Polar	☐ Anxiety	☐ Eating Disorder	☐ Arteriosclerosis
☐ Anemia	☐ Arthritis	☐ Asthma	☐ Allergies	☐ Suicide Attempt	☐ Atherosclerosis
☐ IBS	☐ IBD	☐ Ulcers	☐ Candida	☐ Bleeding Tendency	☐ Multiple Sclerosis/MS
☐ Emphysema	☐ COPD	☐ Pneumonia	☐ Fibromyalgia	☐ Autoimmune Disease	☐ Chronic Fatigue Syndrome
☐ Cystic Breasts	☐ Hernia	☐ Bronchitis	☐ Osteoporosis	☐ Whooping Cough	☐ Uterine Fibroids
☐ Parkinson's	☐ Alzheimer's	☐ Dementia	☐ Appendicitis	☐ Prostate Problems	☐ Organ Transplant

Surgery (please include dates and any complications)

_____
_____
_____

Motor Vehicle Accidents (please include dates and injuries)

_____
_____
_____
_____

Falls/Other Physical Trauma (please include dates and any complications)

_____
_____
_____
_____

Hospital Stays:

_____
_____
_____

Medications

Type	Dose/Duration	Reason	Side Effects

Supplements

Type	Dose/Duration	Reason

Recent Tests (dates and results)

Physical Exam _____
Blood _____
Cholesterol _____
HIV/STD _____
Ob/Gyno _____
Mammogram _____
Pap _____
Prostate _____
Colonoscopy _____

Family Health History

Family Member	Alive	Deceased	Present Health Condition
Father			
Mother			
Spouse			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandmother			
Brother(s)			
Sister (s)			

Lifestyle

Exercise: (type, duration, frequency)

_____
_____
_____
_____

Habits:

Coffee	☐never	☐rarely	☐__x/week	☐__x/day	Recreational Drugs	☐never	☐rarely	☐__x/week	☐__x/day
Tea	☐never	☐rarely	☐__x/week	☐__x/day	Alcohol	☐never	☐rarely	☐__x/week	☐__x/day
Soda	☐never	☐rarely	☐__x/week	☐__x/day	Diet Soda	☐never	☐rarely	☐__x/week	☐__x/day
Sugar	☐never	☐rarely	☐__x/week	☐__x/day	Cigarettes	☐never	☐rarely	☐__x/week	☐__x/day

Diet: (please describe your current diet, including a typical breakfast, lunch, dinner snack, cravings and goals)

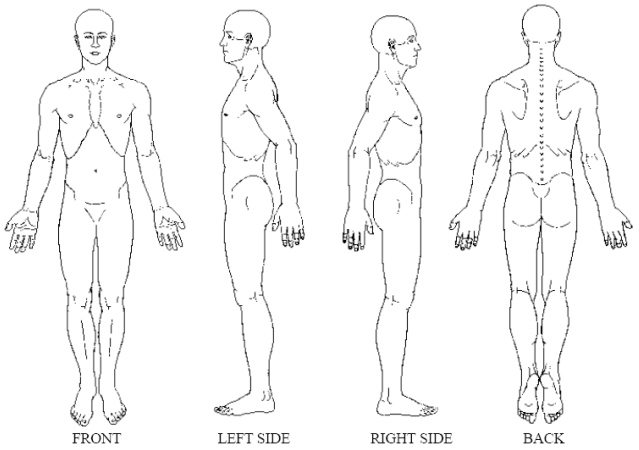
Symptom Overview by System

Please check all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY.
Please indicate (by circling) if the symptom is acute, chronic or experienced frequently.

A = Acute (under 3 months) C = Chronic (over 3 months—experience at some point most days) F = Experience frequently (on & off)

MUSCULOSKELETAL

A	C	F	Joint clicking	A	C	F	Limited range of motion	A	C	F	Stiffness
A	C	F	Spasms	A	C	F	Cramps	A	C	F	Swelling
A	C	F	Pain: Full body	A	C	F	Pain: Facial (e.g. jaw)	A	C	F	Pain: Neck
A	C	F	Pain: Upper Back	A	C	F	Pain: Mid Back	A	C	F	Pain: Low Back
A	C	F	Pain: Shoulder	A	C	F	Pain: Elbow	A	C	F	Pain: Wrist
A	C	F	Pain: Hand	A	C	F	Pain: Hip	A	C	F	Pain: Knee
A	C	F	Pain: Ankle	A	C	F	Pain: Foot	A	C	F	Weakness



Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.

Key:
→ Radiating Pain
X Spasm
Z Tenderness
V Burning
* Numbness/Tingling
o Ache/Pain

OTHER (Please list) _____

HEAD, EYES, EARS, NOSE & THROAT

A	C	F	Loss of vision	A	C	F	Eye pain	A	C	F	Eye discharge
A	C	F	Itchy eyes	A	C	F	Tearing	A	C	F	eye dryness
A	C	F	Blurry vision	A	C	F	Red eyes	A	C	F	Spots before your eyes
A	C	F	Near sighted	A	C	F	Far sighted	A	C	F	Astigmatism
A	C	F	Dry mouth	A	C	F	Bitter taste in mouth	A	C	F	Bland taste in mouth
A	C	F	Excessive salivation	A	C	F	Sour taste in mouth	A	C	F	Sore throat
A	C	F	Bad breath	A	C	F	Mouth sores				
A	C	F	Loss of hearing, deafness	A	C	F	Tinnitus	A	C	F	Problems with balance (vertigo)
A	C	F	Ear discharge	A	C	F	Ear itching	A	C	F	Ear discharge
A	C	F	Impaired sense of smell	A	C	F	Nasal congestions	A	C	F	Nose bleeds
A	C	F	Sinus pain, pressure	A	C	F	Sinusitis	A	C	F	Allergic Rhinitis

OTHER (Please list) _____

DIGESTIVE

A	C	F	Low/no appetite	A	C	F	Constipation	A	C	F	Indigestion
A	C	F	Big/excessive appetite	A	C	F	Loose stools/Diarrhea	A	C	F	Acid regurgitation/ GERD
A	C	F	Abdominal distention	A	C	F	Alternating constipation/diarrhea	A	C	F	Heartburn
A	C	F	Gurgling/rumbling in abdomen	A	C	F	Gas	A	C	F	Bloating
A	C	F	Pain/discomfort around ribs	A	C	F	Rectal bleeding	A	C	F	Nausea
A	C	F	Abdominal pain, cramps	A	C	F	Hemorrhoids	A	C	F	Vomiting
A	C	F	Abdominal mass	A	C	F	Hiccups	A	C	F	Eating disorder
A	C	F	Jaundice (yellow skin &/or eyes)	A	C	F	Belching/Burping				

OTHER (Please list) _____

RESPIRATORY

A C F Chest pain	A C F Chest tightness	A C F Bluish discoloration of skin
A C F Cough	A C F Coughing up blood (hemoptysis)	A C F Shortness of breath (dypsnea)
A C F Sputum production	A C F Voice changes	A C F Hoarseness
A C F Wheezing		

OTHER (Please list) _____

CARDIOVASCULAR

A C F Chest pain &/or pressure	A C F Changes in skin temperature	A C F Changes in skin color
A C F Edema	A C F Fainting (syncope)	A C F Sweating with little/no exertion
A C F Swelling of the ankles &/or legs	A C F Fatigue	A C F Palpitations
A C F Missed heart beat	A C F Racing heart	

OTHER (Please list) _____

UROGENITAL

A C F Painful urination (dysurea)	A C F Blood in urine	A C F Frequent urination
A C F Difficulty with urine flow	A C F Dark urine	A C F Abundant urination
A C F Dribbling after urination	A C F Urinary tract infection (UTI)	A C F Excessive urination at night
A C F Incontinence	A C F STD	A C F Scanty urine

OTHER (Please list) _____

NEUROLOGICAL

A C F Difficulty concentrating	A C F Changes in consciousness	A C F Problems coordinating movements
A C F Cloudy thinking	A C F Loss of consciousness	A C F Gait disturbance
A C F Confusion	A C F Dizziness	A C F Dysphasia (impaired speech)
A C F Loss of memory	A C F Headache	A C F Paralysis
A C F Severe forgetfulness	A C F Visual disturbance	A C F Tremor
A C F Numbness and/or tingling	A C F Post shingles pain	A C F Weakness

OTHER (Please list) _____

INTEGUMENTARY (SKIN)

A C F Rash and/or skin lesion	A C F Changes in hair	A C F Never sweat
A C F Changes in skin color	A C F Hair loss	A C F Unusual sweating
A C F Itching (pruritus)	A C F Changes in nails	
A C F Wounds that will NOT heal		

OTHER (Please list) _____

SLEEP

A C F Insomnia	A C F Dream disturbed sleep	A C F Wake up & cannot fall back asleep
A C F Difficulty falling asleep	A C F Nightmares	

OTHER (Please list) _____

EMOTIONAL/ PSYCHOLOGICAL/MENTAL

A C F Frequent crying	A C F Anger	A C F Fear
A C F Grief	A C F Mania	A C F Easily startled
A C F Melancholy	A C F Anxiety	A C F Worry
A C F Depression	A C F Restlessness	A C F Overthinking
A C F Feeling overwhelmed	A C F Stress	A C F Obsessive thinking
A C F Extreme lack of emotion	A C F Extreme mood swings	A C F Difficulty making decisions

OTHER (Please list) _____

MISCELLANEOUS

A	C	F	Extremely low energy/fatigue	A C F	Feel cold
A	C	F	Frequent colds	A C F	Feel hot
A	C	F	Chills and/or fever	A C F	Cold hands and feet

OTHER (Please list) _____

FOR WOMEN ONLY

Age of first period _____ Date of last period _____
Length of cycle_____ # days bleeding _____

	Color of flow (pale, bright, dark, brown)	Amount of flow (light, heavy, clots)	# of tampons you use/day (super, regular, liner)	pain/cramping (mild, moderate, severe)
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
+days				

Are you pregnant OR trying to become pregnant? ☐ YES ☐ NO
Number of pregnancies _____ Live births_____ Miscarriages _____ Abortions _____

A	C	F	Irregular menstruation	A	C	F	Abnormal vaginal bleeding	A	C F No menses
A	C	F	Difficult menstruation	A	C	F	Vaginal discharge	A	C F Fertility concerns
A	C	F	Pain with menses (dysmenorrhea)	A	C	F	Fibrocystic breasts	A	C F Menopausal symptoms
A	C	F	Pain during or after sex	A	C	F	Sexual dysfunction	A	C F Low libido
A	C	F	Pelvic pain	A	C	F	Changes in hair distribution	A	C F Excessive sex drive

PMS Symptoms

A	C	F	Swollen breasts	A	C	F	Increased appetite	A	C F Constipation
A	C	F	Headache	A	C	F	Decreased appetite	A	C F Diarrhea
A	C	F	Mood swings	A	C	F	Insomnia		
A	C	F	Water retention						

OTHER (Please list) _____

Have you ever been diagnosed with:

☐ Fibroids	☐ PID	☐ Ovarian cysts
☐ Endometriosis	☐ STD	☐ Polycystic ovarian syndrome

OTHER (Please list) _____

FOR MEN ONLY

A	C	F	Fertility concerns	A	C	F	Prostate problems		
A	C	F	Sexual dysfunction	A	C	F	Unusual discharge		
A	C	F	Low libido	A	C	F	Excessive sex drive		

OTHER (Please list) _____

Signature_____ Printed name _____ Date _____