New Patient Intake Form

Today's Date_____/_____/_____

Name | SS# | Birthdate / /
Marital Status | Age
Address | ❑M ❑ F | Ht | Wt

City, State, Zip | EMail:
Home Phone | Work Phone | Occupation
Emergency Contact 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 (what?)
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?
Who is your physician? | Physician's Phone
Other concurrent therapies

Health Insurance Info:
Insurance Co. Name | Policy #
Address | Phone
City, State, Zip

Medicare Info:
Insurance Co. Name | Policy #
Address | Phone
City, State, Zip

Family Medical History

❑ Allergies
❑ Arteriosclerosis
❑ Asthma
❑ Alcoholism
❑ Cancer
❑ Diabetes
❑ 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
❑ Alcholism
❑ Allergies
❑ Appendicitis
❑ Arteriosclerosis
❑ Asthma
❑ Birth Trauma (your own birth)
❑ Cancer
❑ Chicken Pox
❑ Diabetes
❑ Emphy sema
❑ Epilepsy
❑ Goiter
❑ Gout
❑ Heart Disease
❑ Hepatitus
❑ Herpes
❑ High Blood Pressure
❑ Measles
❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker
❑ 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
❑ Soft Drinks
❑ Artificial Sweetener
❑ Sugar
❑ Salty Food
Thirst for water: # glasses per day:________

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in last 2 months:
Vitamins/supplements taken in last 2 months:

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
- ❑ Eye strain
- ❑ Eye pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Spots in eyes
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Night blindness
- ❑ 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 of phlegm
____

- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Enlarged thyroid
- ❑ Nose bleeds
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Headaches
- ❑ Migraines
- ❑ Concussions

Other head or neck problems
____
____
____

Respiratory

- ❑ Difficulty breathing when lying down
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Asthma/wheezing
- ❑ Cough

Wet or Dry?________________
Thick or thin?______________

Color of phlegm
____

- ❑ Coughing 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
- ❑ Laxative use
- ❑ Black stools
- ❑ Bloody stools
- ❑ Mucous in stools
- ❑ Intestinal pain or cramping
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Rectal pain
- ❑ Hemorrhoid
- ❑ Anal fissures

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)
____
____

Genito-urinary

- ❑ 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

____
____
____
____

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Consent to Treatment

I____, hereby authorize Dr. Dong Liu, OMD, LAc to administer Oriental Medicine modalities relevant to my diagnosis and treatment, including but not limited to the following:

1. Insertion of various styles of acupuncture needles into my body at various depths and locations.

2. Administration of heat with smouldering Mugwort Leaf or a conventional heat lamp. The heat may be administered to any location as deemed necessary for effective treatment.

3. Oriental TuiNa and Acupressure techniques.

4. The application of suction cups to the skin, which may produce a red/purple discoloration of the area beneath the cup, which may last for up to 5 days.

5. Electrical stimulation of acupuncture needles may produce a vibration or electrical sensation at the points being treated.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatments, and I have been informed of the risks and possible consequences involved with this treatment, and I have been given the opportunity to ask questions relevant to my treatment.

I understand that there is always a possibility of unexpected complications arising from the treatment and I understand that no guarantee can be made concerning the results of this treatment.

Signature of Patient

____

Date

_________/_________/_________

Printed Name

____

Signature of Practitioner

____