NEW PATIENT INTAKE FORM

Please complete this form before your first visit. Your information is confidential.

PATIENT INFORMATION

Today's date ______________________________	**Name** ______________________________
Date of birth ______________________________	**Occupation** ______________________________

Address

City ______________________________	**State** ______________________________
ZIP code ______________________________	**Email** ______________________________
Mobile phone ______________________________	**Home / work phone** ______________________________

Emergency contact — name, relationship, and phone

REASON FOR VISIT

What brings you in today?

How long have you had this condition? ______________________________	**Is it getting worse?** ☐ Yes ☐ No ______________________________

What seemed to be the initial cause?

What makes it better?

What makes it worse?

Have you had acupuncture before? ☐ Yes ☐ No ______________________________	**Have you taken Chinese herbal medicine?** ☐ Yes ☐ No ______________________________

MEDICAL HISTORY

Please check all that apply

- ☐ HIV / AIDS
- ☐ Arteriosclerosis
- ☐ Chicken pox
- ☐ Goiter
- ☐ Herpes
- ☐ Mumps
- ☐ Polio
- ☐ Stroke
- ☐ Typhoid fever
- ☐ Alcohol use disorder
- ☐ Asthma
- ☐ Diabetes
- ☐ Gout
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Surgery
- ☐ Ulcers
- ☐ Allergies
- ☐ Birth trauma
- ☐ Emphysema
- ☐ Heart disease
- ☐ Measles
- ☐ Pleurisy
- ☐ Scarlet fever
- ☐ Thyroid disorder
- ☐ Venereal disease / STI
- ☐ Appendicitis
- ☐ Cancer
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Multiple sclerosis
- ☐ Pneumonia
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Whooping cough

Major trauma (car accident, fall, etc.)

Surgeries (include dates)

FAMILY MEDICAL HISTORY

- ☐ Allergies
- ☐ Alcohol use disorder
- ☐ Heart disease
- ☐ Stroke
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ High blood pressure
- ☐ Other: ________________
- ☐ Asthma
- ☐ Diabetes
- ☐ Seizures

MEDICATIONS & SUPPLEMENTS

Prescription or over-the-counter medications taken in the last 2 months

Vitamins, herbs, or supplements taken in the last 2 months

GENERAL SYMPTOMS

- ☐ Poor appetite
- ☐ Recent weight loss / gain
- ☐ Fatigue
- ☐ Poor circulation
- ☐ Night sweats
- ☐ Bleed or bruise easily
- ☐ Heavy appetite
- ☐ Poor sleep
- ☐ Lack of strength
- ☐ Shortness of breath
- ☐ Sweat easily
- ☐ Peculiar taste
- ☐ Strong preference for cold drinks
- ☐ Heavy sleep
- ☐ Bodily heaviness
- ☐ Fever
- ☐ Muscle cramps
- ☐ Strong preference for hot drinks
- ☐ Dream-disturbed sleep
- ☐ Cold hands or feet
- ☐ Chills
- ☐ Vertigo or dizziness

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

RESPIRATORY & CARDIOVASCULAR

- ☐ Difficulty breathing when lying down
- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Asthma / wheezing
- ☐ Cough
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood clots
- ☐ Fainting
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Tachycardia
- ☐ Heart palpitations
- ☐ Phlebitis
- ☐ Irregular heartbeat

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Acid regurgitation
- ☐ Gas
- ☐ Hiccups
- ☐ Bloating
- ☐ Bad breath
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative use
- ☐ Black stools
- ☐ Bloody stools
- ☐ Mucous in stools
- ☐ Intestinal pain or cramping
- ☐ Itchy anus
- ☐ Burning anus
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Anal fissures

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

SKIN & HAIR

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Hair loss
- ☐ Change in hair / skin texture
- ☐ Fungal infections

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Numbness
- ☐ Tics
- ☐ Poor memory
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily stressed
- ☐ Substance use concerns
- ☐ Considered / attempted suicide
- ☐ Seeing a therapist

GENITO-URINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Incomplete urination
- ☐ Venereal disease / STI
- ☐ Bedwetting
- ☐ Wake to urinate
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Kidney stone
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission

GYNECOLOGICAL HISTORY

Complete only if applicable

- ☐ Irregular periods
- ☐ Painful periods
- ☐ PMS
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Vaginal odor
- ☐ Clots
- ☐ Breast lumps

Number of pregnancies ______________________________	Number of live births ______________________________	Age at menopause ______________________________

Thank you. Please bring this completed form to your first appointment.