

New Patient Intake Form

Today's Date _____ / _____ / _____

Name	SS#	Birthdate
Address	Marital Status	Age
	<input type="checkbox"/> M <input type="checkbox"/> F	Ht
		Wt
City, State, Zip	Work Phone	Occupation
Home Phone	<i>Email:</i>	
Emergency Contact Name & Phone		
Referred by		
Reason for visit today	Have you had acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chinese herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
How long have you had this condition?		
Is it getting worse?	Does it bother your: <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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

<input type="checkbox"/> Allergies	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
_____	<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
_____	<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> High Blood Pressure	

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.)

<input type="checkbox"/> AIDs/HIV	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Surgery (list)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker	_____	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pleurisy	_____	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Major Trauma	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Birth Trauma (your own birth)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever	(Car, fall, etc--list)	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Scarlet Fever	_____	_____
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures	_____	_____
	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke	_____	_____

Your Diet

Appetite <input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> Coffee <input type="checkbox"/> Soft Drinks	<input type="checkbox"/> Artificial Sweetener	<input type="checkbox"/> Sugar <input type="checkbox"/> Salty Food	Thirst for water: # glasses per day: _____
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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 _____
Type _____
- Frequency _____
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 _____
- Color _____
- Texture/form _____
- 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

