Blue Valley Acupuncture LLC
NEW PATIENT INTAKE FORM

Today's Date_________________ Name____

Birthdate____________________ email (our use only)____

Phone (C)____________________________(H)___________________________ (W)____________________________

Address______________________________________city___________________________state_____zip____________

Emergency Contact (name & phone)____

How did you hear about us? ___________________________Had acupuncture before? Y N When? ________________

Reason for visit____

How long has this condition existed? ____

Physician (name & phone) ____

Other concurrent therapies ____

Medications ____

Surgeries/Trauma/Other:____

____

FAMILY MEDICAL HISTORY (CHECK THOSE THAT APPLY)

____Alcohol/Drug Abuse ____Heart problems ____Allergies/Asthma ____GI/digestive problems
____Depression/Anxiety ____Stroke ____Arthritis ____Diabetes
____Alzheimer's ____Seizures ____High Blood Pressure ____AutoImmune/RA

YOUR MEDICAL HISTORY & CURRENT STATUS (CHECK THOSE THAT APPLY)

____Alcohol/Drug Abuse ____Heart problems ____Allergies/Asthma ____GI/digestive problems
____Headaches/Migraines ____Stroke ____Arthritis ____Diabetes
____Anxiety/Depression ____High Cholesterol ____AutoImmune/RA ____Ringing in Ears
____Eye Disease ____High Blood Pressure ____Chronic Fatigue ____Bladder issues

____Seizures ____Bleeding Risk ____Pace Maker ____Pregnant/soon__________

YOUR CURRENT DIET/LIFESTYLE (CHECK THOSE THAT APPLY)

____high in sugar ____gluten sensitivity ____respiratory allergy ____Exercise daily
____high in salt ____dairy sensitivity ____ food allergy ____Exercise weekly
____high in fats ____nut sensitivity ____Daily activity
____high in caffeine ____no meat ____high stress ____Sedentary
____high in fruits & vegetables ____no carbs ____work nightshift

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