Leung Acupuncture

NEW PATIENT INTAKE FORM **Date:** _____

**Please only use black or blue ink to fill out this form.*

Name: _____
First Last 中文名字

Address: _____
Street City State Zip Code

Telephone: (Home)_____(Work)_____(Cell)_____

Age: _____ Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Email: _____

Occupation: _____ Marital Status: _____

Referred by/ How did you hear about us? _____

Emergency Contact (Name and Phone): _____

Have you had acupuncture before? ☐ yes ☐ no Chinese herbal medicine? ☐ yes ☐ no

Family Physician: _____ Insurance Carrier:_____

CHIEF COMPLAINT: _____

How long have you had this condition? _____

What seemed to be the initial cause? _____

Have you been given a diagnosis for the problem by your family physician? _____

If so, what is it? _____

What kinds of treatment or therapy have you tried? _____

_____

PAST MEDICAL HISTORY (Please include dates):

☐ AIDS/ HIV
☐ Allergies
☐ Appendicitis
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Hepatitis
☐ High blood pressure
☐ Heart Disease
☐ Pacemaker
☐ Seizures
☐ Stroke
☐ Thyroid disease
☐ Ulcers
☐ Birth Trauma (prolonged labor, forceps delivery, etc.)

Other significant illness (describe)_____

_____

Accident or significant trauma (describe)_____

_____

Surgeries (list) _____

_____

_____

Leung Acupuncture

FAMILY MEDICAL HISTORY:

☐ Allergies
☐ Diabetes
☐ Asthma
☐ Cancer
☐ Heart Disease
☐ High Blood Pressure
☐ Seizures
☐ Stroke
☐ Other

LIFESTYLE

Please check any of the following habits that apply. How much and how often do you use them?

☐ Cigarette smoking
☐ Coffee, tea, or cola
☐ Alcoholic beverages

List **current** medications (include vitamins, drugs, herbs, etc.):_____

_____

_____

_____

Check any conditions you are currently experiencing. Indicate the length of time you have had this condition.

GENERAL:

☐ Poor appetite
☐ Insomnia
☐ Disturbed sleep
☐ Localized weakness
☐ Cravings
☐ Strong thirst
☐ Weight gain
☐ Weight Loss
☐ Changes in appetite
☐ Sweating easily
☐ Tremors
☐ Bleeding or bruising easily
☐ Night sweat
☐ Fever
☐ Chills
☐ Sudden energy drop (time of day?)
☐ Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health _____

_____

SKIN AND HAIR:

☐ Rashes
☐ Ulcerations
☐ Hives
☐ Itching
☐ Eczema
☐ Pimples
☐ Dandruff
☐ Recent moles
☐ Hair loss
☐ Change in texture of hair or skin

Any other hair or skin problems_____

HEAD, EYES, EARS, NOSE AND THROAT:

☐ Dizziness
☐ Concussions
☐ Migraines
☐ Dry Eyes
☐ Spots in front of eyes
☐ Eye pain
☐ Poor vision
☐ Night blindness
☐ Color blindness
☐ Cataracts
☐ Blurry vision
☐ Earaches
☐ Ringing in ears
☐ Poor hearing
☐ Eye strain
☐ Sinus problems
☐ Recurring soar throat
☐ Nose bleeds
☐ Grinding teeth
☐ Sores on lips or tongue
☐ Facial pain
☐ Teeth problems
☐ Headaches (where? when?)
☐ Jaw clicks

Any other head or neck problems_____

Leung Acupuncture

CARDIOVASCULAR:

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Palpitations

Any other heart or blood vessel problems_____

RESPIRATORY:

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Excessive phlegm (color?)

Any other lung problems_____

GASTROINTESTINAL:

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use

Any other problems with stomach or intestines_____

GENITOURINARY:

- ☐ Pain on urination
- ☐ Urgent or frequent urination
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Impotence
- ☐ Sores on genitals

Do you wake up at night to urinate?_____If so, how often?_____

What color is your urine?_____

Any other genital or urinary problems_____

REPRODUCTIVE AND GYNECOLOGIC:

- ☐ Premenstrual changes
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Medium menstrual flow
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Irregular menses
- ☐ Other problems
- ☐ # of Premature births _____
- ☐ # of Miscarriages _____
- ☐ # of Abortions _____

Age at first menses_____Age at menopause_____Number of pregnancies_____

Time between cycles_____Duration of bleeding_____First day of menses_____

Any other gynecologic problems_____

4726 Park Rd., Ste B, Charlotte, NC 28209 Tel: 704-605-2602

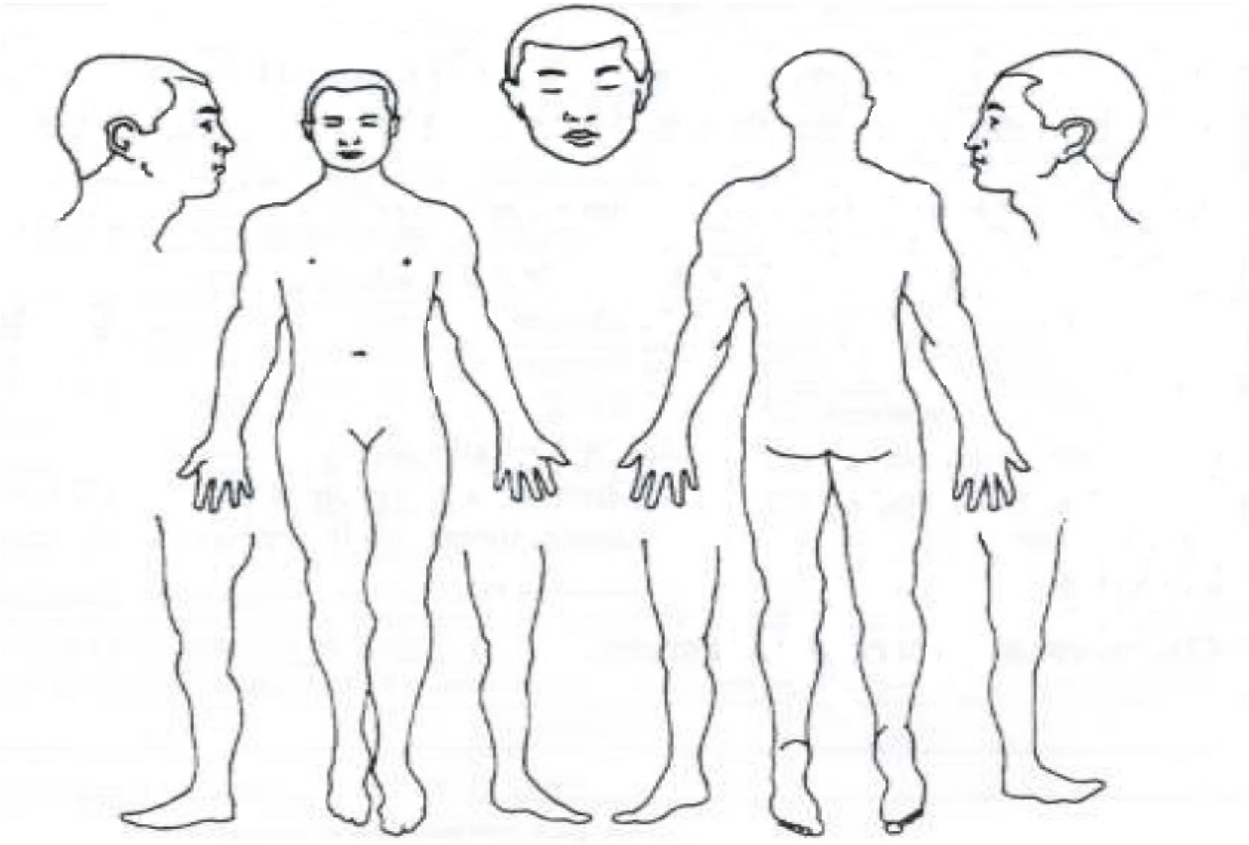
Leung Acupuncture

MUSCULOSKELETAL:

☐ Neck pain
☐ Back pain
☐ Hand/wrist pains
☐ Muscle pains
☐ Muscle weakness
☐ Shoulder pains
☐ Knee pain
☐ Foot/ankle pains
☐ Hip pains

Any other joint or bone problems_____

Please mark painful or distressed areas on the charts below:



NEUROPSYCHOLOGICAL:

☐ Seizures
☐ Poor memory
☐ Anxiety
☐ Dizziness
☐ Lack of coordination
☐ Bad temper
☐ Loss of balance
☐ Concussion
☐ Easily susceptible to stress
☐ Areas of numbness
☐ Depression

Have you ever been treated for emotional problems?_____

Have you ever considered or attempted suicide?_____

Any other neurological or psychological problems_____

COMMENTS:

Please list any other problems you would like to discuss_____

_____

_____