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) _____

_____

_____

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FAMILY MEDICAL HISTORY:

☐ Allergies ☐ Cancer ☐ Seizures
☐ Diabetes ☐ Heart Disease ☐ Stroke
☐ Asthma ☐ High Blood Pressure ☐ 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 ☐ Weight gain ☐ Night sweat
☐ Insomnia ☐ Weight Loss ☐ Fever
☐ Disturbed sleep ☐ Changes in appetite ☐ Chills
☐ Localized weakness ☐ Sweating easily ☐ Sudden energy drop (time of day?)
☐ Cravings ☐ Tremors
☐ Strong thirst ☐ Bleeding or bruising easily ☐ Poor balance

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

_____

SKIN AND HAIR:

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

Any other hair or skin problems_____

HEAD, EYES, EARS, NOSE AND THROAT:

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

Any other head or neck problems_____

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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_____

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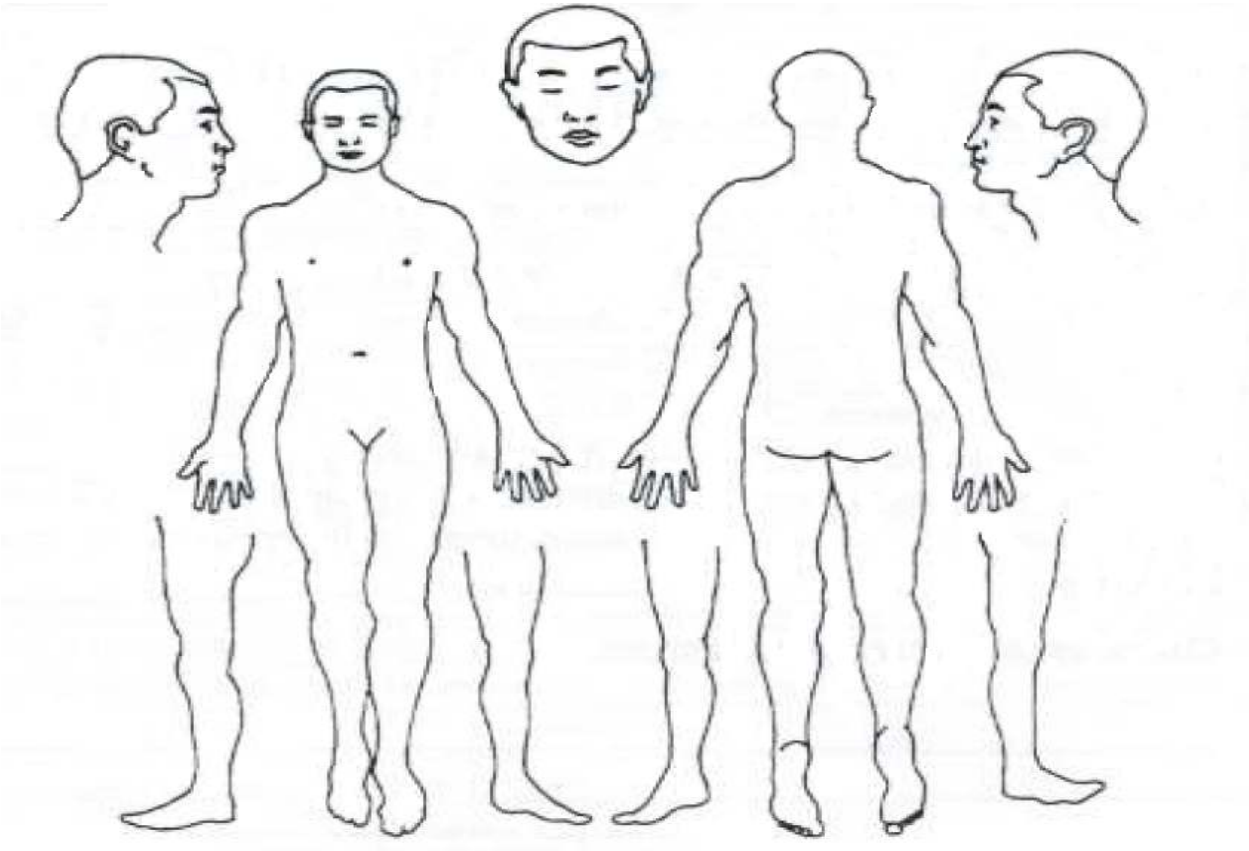
MUSCULOSKELETAL:

☐ 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_____

_____

_____