Westminster Community Acupuncture
Acupuncture · Herbal Medicine · Massage Therapy

WCA New Patient Intake

Date:_____

Name_____ Birthdate_____ Marital Status_____

Age _____ ☐ Female ☐ Male Height _____ Weight _____

Address_____

City_____ State_____ Zip_____

Home Phone _____ Work Phone _____

Mobile Phone_____ E-mail Address _____

Occupation _____

Emergency Contact (Name & relation) _____ Phone _____

How were you referred for this appointment? _____

Have you ever been treated with Traditional Chinese Medicine? ☐ No ☐ Yes

What health concern would you like addressed today? _____

What do you feel is the cause of this health concern? _____

How long have you had this condition? _____

What makes your condition better? _____

What makes it worse? _____

What is the severity of your health concern TODAY? (Circle only one number)

None 0	1	2	3	4	5	6	7	8	9	**Most** 10

Have you seen another health care provider for this? ☐ No ☐ Yes

When:_____ Provider:_____ Diagnosis_____

Past Medical History

	YES		YES		YES		YES	Explanation
AIDSs/HIV		Epilepsy		Whooping cough		Diabetes (type)		
Alcoholism		Goiter		Rheumatic fever		Hepatitis (type)		
Allergies		Gout		Scarlet fever		Herpes (type)		
Atherosclerosis		Heart disease		Seizures		Pacemaker (date)		
Appendicitis		High BP		Stroke		Surgeries (list)		
Asthma		Measles		Thyroid disorders				
Own birth trauma		Multiple sclerosis		Tuberculosis				
Cancer		Mumps		Typhoid fever		Major trauma		
Chicken pox		Pleurisy		Ulcers		(list)		
Emphysema		Pneumonia		Venereal disease		Other		

Family Medical History

	YES / Explanation		YES / Explanation		Explanation
Arteriosclerosis		Heart disease		Cancer (type)	
Asthma		Stroke		Diabetes (type)	
Alcoholism		Seizure			
Depression					

Lifestyle & General Symptoms

	At times	Often		At times	Often		At times	Often
Alcohol			Recent wt loss/gain			Shortness of breath		
Tobacco			Poor sleep			Fever		
Marijuana			Dream disturbed sleep			Chills		
Drugs			Fatigue			Night sweats		
Stress			Lack of strength			Sweats easily		
Poor appetite			Bodily heaviness			Vertigo or dizziness		
Heavy appetite			Cold hands or feet			Bleed/bruise easily		
Likes cold/hot drinks			Poor circulation			Muscle cramps		

Regular Exercise: Type_____Frequency _____

Diet

	Explanation		**Average Daily Menu**
Coffee/tea daily intake		Morning	
Sodas/juices intake		Noon	
Protein intake(high/low)	Low	Evening	
Water daily intake		Snacks	

Respiratory & Cardiovascular

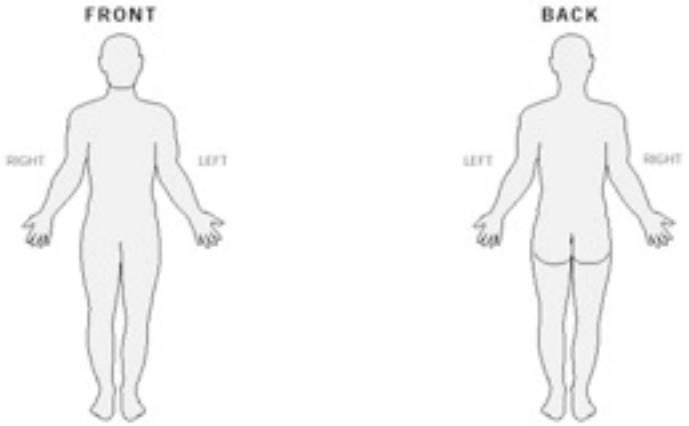
	At times	Often		At Times	Often		At times	Often
Difficulty breathing			Wet/Dry cough			Fainting		
Tight/painful chest			Cough up blood			Tachy/bradicardia		
Asthma/wheezing			Pneumonia			Heart palpitations		
Difficult inhalation			High/Low blood pressure			Irregular heartbeat		
Difficult exhalation			Blood clots			Color of phlegm		

Musculoskeletal

	At times	Often		At times	Often		At times	Often
Neck/shoulder pain			Lower back pain			Limited range of motions		
Muscle pain			Joint pain			Limited use		
Upper back pain			Rib pain			Other:		

Use diagram below, to mark the area with the symbol that best describes your pain:

Aching Pain	*******	Pins and needles	OOOOO
Burning Pain	xxxxxxxx	Stabbing pain	/ / / / / /
Numbness	======		



Head, Eyes, Ears, Nose, Throat, Skin, Hair

	At times	Often		At times	Often		At times	Often
Spots in eyes			Grinding teeth			Concussions		
Blurry vision			TMJ			Rashes		
Wear glasses			Facial pain			Hives		
Red / dry / itchy eyes			Gum problems			Ulcerations		
Eye pain/strain			Sores on lips/tongue			Eczema		
Night blindness			Excessive saliva			Psoriasis		
Sinus problems			Enlarged thyroid			Acne		
Dry mouth			Nosebleeds			Dandruff		
Dental problems			Ringing in ears			Itching		
Recurrent sore throat			Poor hearing			Hair loss		
Swollen glands			Earaches			Change in hair/skin		
Lumps in throat			Headaches/Migraines			Fungal infection		

Neuropsychological

	At times	Often		At times	Often		At times	Often
Seizures			Depression			Abused survivor		
Numbness			Anxiety			Considered/attempted suicide		
Tics			Irritability			Seeing a therapist		
Poor memory			Easily stressed			Other (write below)		

Gastrointestinal & Genitourinary

	At times	Often		At times	Often		At times	Often
Nausea			Bloody stools			Incomplete urine		
Vomiting			Mucus in stool			Bedwetting		
Acid regurgitation			Hemorrhoids			Nocturnal emission		
Gas			Itchy/burning anus			Venereal disease		
Hiccup			Rectal pain			Increased libido		
Bloating			Painful urination			Decreased libido		
Bad breath			Frequent urination			Kidney stone		
Diarrhea			Blood in urine			Impotence		
Constipation			Unable to hold urine			Premature ejaculation		

Laxative use: What kind?_____How often?_____
Bowel Movements: Frequency _____Color _____Texture/form _____Odor_____

Reproduction

Women	At times	Often	**Women**	At times	Often	**Men**	At times	Often
Irregular periods			Age menses began			Prostate problems		
Painful periods			Length of cycle			Genital itching		
PMS			Duration of flow			Genital rash		
Vaginal sores			Discharge (color)			Genital pain		
Vaginal odor			# of pregnancies			Sexual dysfunction		
Clots			# of live births			Other		
Breast lumps			Age of menopause					
			Date of last PAP					
			Date last period began					

List prescribed & over-the-counter medications, vitamins, supplements, & herbs you take
