CONFIDENTIAL

New Patient Intake Form

Last Name _____First_____

Cellular Phone (_____) _____ Alternate Phone (_____) _____

Address _____

Email _____

Sex: □ Male □ Female □ Other Date of Birth _____Age _____

Height: _____ Weight: _____ lbs Occupation: _____

Emergency Contact:_____ Phone (_____)_____

Are you under the care of a physician now? □ Yes □ No
If yes, for what? _____

Physician's Name _____Phone (_____) _____

Have you received Acupuncture before? □ Yes □ No If yes, when?_____

Condition(s) treated _____

How was your experience?_____

Is today's visit a □ Work or □ Auto related injury? If yes, Date of Incident_____

List up to two main health concerns/ related symptoms for which you are seeking acupuncture:

1) CHIEF COMPLAINT _____

Date of onset of symptoms _____Severity: 1 (mild) - 10 (severe) _____

Prior attempts to correct problems □ chiropractic adjustments □ diet □ heat □ ice □ massage □ medication □ physical therapy □ stretching □ surgery □ other _____

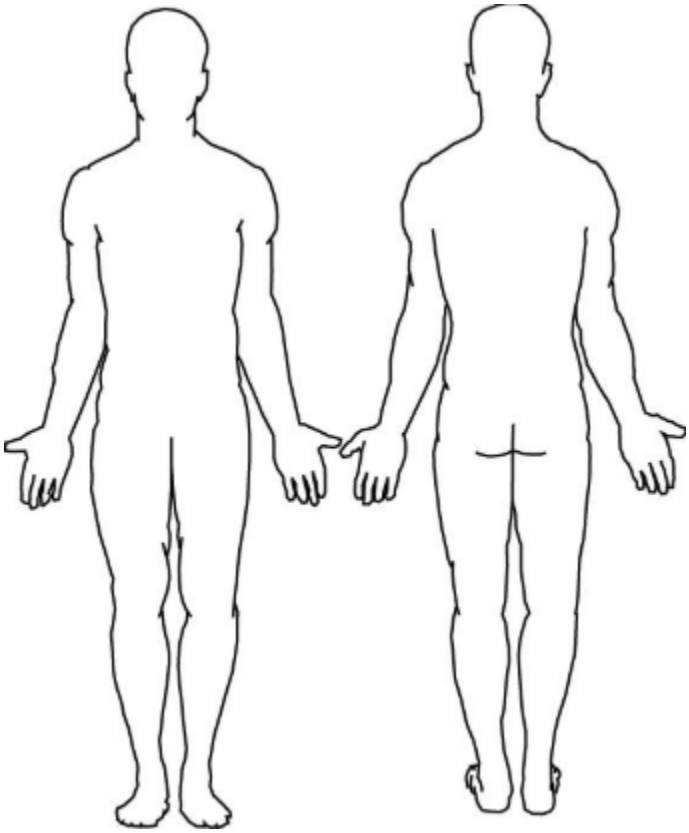
2) SECONDARY condition_____

Date of onset of symptoms _____Severity of Symptoms 1-10 _____ _____

Prior attempts to correct problems □ chiropractic adjustments □ diet □ heat □ ice □ massage □ medication □ physical therapy □ stretching □ surgery □ other _____

What are your goals of treatment?_____

Please indicate the affected areas:



Check the Box if any of the following statements are true:

□ I have known Allergies □ I am taking Coumadin/Warfarin □ History of Seizures

□ I have a Pacemaker □ I am taking Lithium □ History of Head Trauma

□ I have the following chronic bloodborne disease _____

Prescription drugs you are currently taking:

Drug Name: _____ Condition _____

Drug Name: _____ Condition _____

Drug Name: _____ Condition _____

Drug Name: _____ Condition _____

Drug Name: _____ Condition _____

Vitamins, Supplements, Over-the-Counter Medication you are currently taking:

Name: _____ Condition_____

Name: _____ Condition_____

Name: _____ Condition_____

Name: _____ Condition_____

Name: _____ Condition_____

MEDICAL HISTORY

Please list diagnosed medical conditions and indicate S (self) or F (family)

_____

_____

List all past Hospitalizations, Surgeries, and Accidents including dates

_____

_____

Allergies, Food Sensitivities:

_____

WOMEN ONLY: Date of last menstrual period _____

Number of days in flow _____ Number of days of cycle _____ Heavy? Light? Clots?

PERSONAL LIFESTYLE

Relationship Status □ Married □ Single □ Divorced □ Widowed □ Partnered # Children_____
Bedtime From _____ until _____ Average # of times you wake _____
Cigarettes (packs/ day) _____ Coffee/Tea/ Soda (cups/ day) _____ Alcohol (drinks/ wk)_____
Recreational Drugs_____
Food cravings_____

PRACTITIONER NOTES: