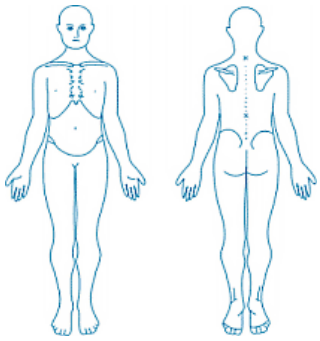
New Patient Intake Form

Name: _____ **Date:**_____ **Social Security #:**_____
Date of Birth:_____ **Age:**_____ **Email:** _____
Address:_____ **City, State, Zip** _____
Home Phone #: _____ **Work:** _____ **Cell:** _____
Occupation: _____ ☐ **Please check here if we can email you updates and a newsletter.**
Marital Status: ☐ **M** ☐ **S** ☐ **W** ☐ **D** **Height:** _____ **Weight:** _____ **Allergies:** _____
Emergency Contact Name:_____ **Phone:**_____ **Relationship:**_____
Physician: (Name) _____ **(Phone)** _____

General Questions:

PLEASE MARK YOUR AREA OF PAIN



Have you had acupuncture before? ☐ Yes ☐ No
Chief Complaint: _____
How long have you had this condition?_____
Is it getting worse? ☐ Yes ☐ No **Does it bother your:** ☐ Sleep ☐ Work ☐ Other _____
What seemed to be the initial cause? _____
What seems to make it better? _____
What seems to make it worse? _____
Are you experiencing pain right now? ☐ Yes ☐ No
Describe your pain: ☐ Dull ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Other_____
What makes your pain better? ☐ Heat ☐ Pressure ☐ Movement ☐ Cold ☐ Massage ☐ Rest

Family Medical History:

☐ Arteriosclerosis ☐ Cancer ☐ Diabetes ☐ Seizures ☐ Asthma ☐ Heart Disease ☐ Stroke
☐ Alcoholism ☐ High Blood Pressure ☐ Other: _____

Are you currently on any medications? ☐ No ☐ Yes If Yes, Please List: _____
Do you take any vitamins/supplements? ☐ No ☐ Yes If Yes, Please List: _____

Lifestyle:

☐ Alcohol # per day_____ ☐ Stress ☐ Marijuana ☐ Regular Exercise:
Type _____ Frequency_____
Type _____ Frequency_____

☐ Tobacco # per day_____ ☐ Drugs ☐ Occupational Hazards

Your Past Medical History: (Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history)

☐ AIDs/HIV	☐ Diabetes	☐ Measles	☐ Thyroid Disorders	☐ Major Trauma:
☐ Alcoholism	☐ Emphysema	☐ Mumps	☐ Tuberculosis	_____
☐ Allergies	☐ Epilepsy	☐ Pacemaker	☐ Thyroid Fever	_____
☐ Appendicitis	☐ Goiter	☐ Pneumonia	☐ Ulcers	_____
☐ Arteriosclerosis	☐ Gout	☐ Polio	☐ Venereal Disease	_____
☐ Asthma	☐ Heart Disease	☐ Rheumatic Fever	☐ Whooping Cough	☐ Other:
☐ Birth Trauma (your own birth)	☐ High Blood Pressure	☐ Scarlet Fever	☐ Surgery (Please List All)	_____
☐ Cancer	☐ Herpes	☐ Seizures	_____	_____
☐ Chicken Pox	☐ Hepatitis	☐ Stroke	_____	_____

General Symptoms: (Please check all that apply)

☐ Poor appetite	☐ Heavy appetite	☐ Craves cold drinks	☐ Craves hot drinks	☐ Bleed or bruise easily
☐ Chills	☐ Cold hands or feet	☐ Poor circulation	☐ Night sweats	☐ Sweat easily(describe): _____ _____
☐ Dream-Disturbed Sleep	☐ Insomnia	☐ Heavy Sleep	☐ Anxiety ☐ Depression	☐ Facial pain
☐ Fatigue	☐ Vertigo or dizziness	☐ Blurred vision	☐ Recent weight loss/gain	☐ Poor Memory
☐ Fever	☐ Glaucoma	☐ Sinus problems	☐ Eczema ☐ Hives	☐ Easily Stressed ☐ Hair Loss
☐ Asthma/wheezing	☐ Nose bleeds	☐ Headaches	☐ Migraines	☐ Change in hair/skin texture
☐ Difficulty breathing when lying down	☐ Shortness of breath	☐ Tight Chest	☐ Numbness	☐ Chest Pain
☐ Cough: If yes, is it ☐ Wet OR ☐ Dry ☐ Thick OR ☐ Thin	☐ Coughing Blood ☐ Tachycardia ☐ Fainting	☐ Pneumonia ☐ Blood clots ☐ Seizures	☐ High blood pressure ☐ Irregular Heartbeat	☐ Low blood pressure ☐ Heart Palpitations ☐ Difficulty Breathing
☐ Diarrhea	☐ Constipation	☐ Intestinal Pain	☐ Bloody Stools	☐ Bowel Movements: Frequency per day _____
☐ Nausea	☐ Acid regurgitation	☐ Vomiting		
☐ Pain on urination	☐ Blood in urine ☐ Lymph Nodes Removed	☐ Frequent urination ☐ Infectious Diseases: _____ _____	☐ Impotence	

Musculoskeletal: (Please check all that apply)

☐ Neck/shoulder pain	☐ Upper Back Pain	☐ Joint Pain	☐ Limited Range of Motion	☐ Other: _____
☐ Muscle pain	☐ Low Back Pain	☐ Rib Pain	☐ Muscle Spasm	_____

Woman Only: Gynecology

Are you pregnant? ☐ Yes ☐ No	Duration of flow _____	☐ Irregular Periods	☐ Painful Periods	☐ PMS
Vaginal Discharge (Color) _____	☐ Vaginal Sores	☐ Vaginal Odor	☐ Clots	Date Last Period began _____
Length of cycle (Day 1 to Day 1) _____	# Pregnancies _____	# Live Births _____	Premature Births _____	Age at Menopause _____

Please List Any Other Pertinent Information:

_____

_____

_____

_____

I agree that the information I provided on this intake is true. It is my responsibility to inform the Acupuncturist at any point of my course of treatments if any information has changed.

Signature of Patient_____ **Date**_____