

NEW PATIENT INTAKE FORM

Today's Date _____ / _____ / _____

Name		Marital Status		Birthdate / /	
Address		<input type="checkbox"/> M <input type="checkbox"/> F		Age	
Email		Occupation		Ht Wt	
City, State, Zip		Work		Cell	
Home Phone		Emergency Contact's Name & Phone		Referred by	
Reason for visit today		Have you had acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No		Chinese herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How long have you had this condition?					
Is it getting worse? Does it bother your <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Other (specify)					
What seemed to be the initial cause?					
What seems to make it better?					
What seems to make it worse?					
Are you under the care of a physician now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what?					
Physician's name					
Other concurrent therapies					

Health Insurance Info:

Insurance Co. Name	Policy #
Address	Phone
City, State, Zip	

Insurance Co. Name	Policy #
Address	Phone
City, State, Zip	

Family Medical History

<input type="checkbox"/> Allergies (list)	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Cancer (type)	<input type="checkbox"/> Diabetes (Type:)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Alcoholism			<input type="checkbox"/> High blood pressure	

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.)

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Diabetes (Type:)	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Surgery (list)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mumps		<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker (Date:)		<input type="checkbox"/> Ulcers
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pleurisy		<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid disorders	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Major trauma	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Birth trauma (your own birth)	<input type="checkbox"/> Hepatitis (Type:)	<input type="checkbox"/> Rheumatic fever	(Car, fall, etc--list)	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes (Type:)	<input type="checkbox"/> Scarlet fever		
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizures		
	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke		

Your Diet

Appetite <input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> Coffee/Tea <input type="checkbox"/> Soft Drinks/Fruit Juices	Protein Intake <input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> Artificial Sweeteners	<input type="checkbox"/> Sugar <input type="checkbox"/> Salty foods	Thirst for water: # glasses per day: _____
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Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmaceuticals taken in the last 2 months: _____
 Vitamins/supplements taken in the last 2 months: _____

Your Lifestyle

- | | | | | |
|----------------------------------|------------------------------------|---|-------------------------|-----------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stress | Regular Exercise | Frequency _____ |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs | <input type="checkbox"/> Occupational hazards | Type _____ | Type _____ |

General Symptoms

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|--|--|--|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Chills | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Peculiar taste (Describe) |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Sweat easily | _____ |
| <input type="checkbox"/> Strongly like hot drinks | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps | _____ |
| <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Fever | <input type="checkbox"/> Vertigo or dizziness | _____ |

Head, Eyes, Ears, Nose, Throat

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Glasses (What age: _____) | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Myopia or Presbyopia | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Other head or neck problems |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nosebleeds | _____ |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Ringing in ears (High or Low?) | _____ |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> TMJ | Color: _____ | <input type="checkbox"/> Poor hearing | _____ |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Facial pain | | <input type="checkbox"/> Earaches | _____ |

Respiratory

- | | | | | |
|---|--|--------------------------------|-----------------------|--|
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Cough | Color of phlegm _____ | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma/wheezing | Wet or Dry? _____ | | <input type="checkbox"/> Pneumonia |
| | <input type="checkbox"/> Difficult inhalation? exhalation? | Thick or thin? _____ | | |

Cardiovascular

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat |

Gastrointestinal

- | | | | | |
|---|---|--|------------------|--------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain or cramping | Bowel movements: | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Burning anus | Frequency _____ | Texture/form _____ |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Black stools | <input type="checkbox"/> Rectal pain | Color _____ | Odor _____ |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Anal fissures | | |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Laxative use | | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Hemorrhoid | What kind? | | |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Itchy anus | How often? | | |

Musculoskeletal

- | | | | | |
|---|--|-------------------------------------|--|------------------------|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion | Other (Describe) _____ |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Limited use | _____ |

Skin and Hair

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|--------------------------------------|------------------------------------|------------------------------------|--|-----------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Change in hair/skin texture | Other hair or skin problems |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching | <input type="checkbox"/> Fungal infections | _____ |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne | <input type="checkbox"/> Hair loss | | _____ |

Neuropsychological

- | | | | | |
|-----------------------------------|--------------------------------------|--|---|-----------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered/attempted suicide | Other (Specify) _____ |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Seeing a therapist | _____ |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abuse survivor | | _____ |

Genitourinary

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Nocturnal emission |

Gynecology

- | | | | | |
|---|--|--|---|------------------------------|
| <input type="checkbox"/> Age menses began _____ | <input type="checkbox"/> Duration of flow _____ | <input type="checkbox"/> Vaginal discharge (color) _____ | <input type="checkbox"/> Breast lumps _____ | Date of last PAP _____ |
| Length of cycle (day 1 to day 1) _____ | <input type="checkbox"/> Irregular periods _____ | <input type="checkbox"/> Vaginal sores _____ | # Pregnancies _____ | |
| | <input type="checkbox"/> Painful periods _____ | <input type="checkbox"/> Vaginal odor _____ | # Live births _____ | Date last period began _____ |
| | <input type="checkbox"/> PMS _____ | <input type="checkbox"/> Clois _____ | # Premature births _____ | |
| | | | Age at menopause _____ | |

Other
