

New Patient Intake Form

Today's Date _____ / _____ / _____

Name _____ Date of Birth _____

Address _____

Phone _____ Work Phone _____

Occupation _____

Emergency Contact-Name & Phone _____

Physician Name & Phone _____

Have you had acupuncture before? Yes No Referred by _____

Reason for visit _____

How long have you had this condition? _____

What makes it better? _____ What makes it worse? _____

Family Medical History (Mother, Father, Siblings, Children)

Allergies : Diabetes Seizures

Asthma Heart Disease Stroke

Cancer (type): High Blood Pressure

Your Medical History

(Check any of the following conditions that you currently have, or have had in the past.)

AIDS/HIV Heart Disease Stroke Tuberculosis

Alcoholism Hepatitis Surgery (please list) Ulcers

Allergies High Blood Pressure Whooping Cough

Appendicitis Measles Other (specify): _____

Asthma Multiple Sclerosis

Cancer Pacemaker Thyroid Problems

Diabetes Pneumonia Trauma/Accidents (list) _____

Emphysema Polio

Epilepsy Rheumatic Fever

Gout Seizures

Your Diet

Appetite: Low High Thirst: Low High

Cravings/Preferences: Salty Sweets Spicy Sour Other: _____

Beverages: Coffee (cups per day): _____ Soft Drinks (# per day): _____ Water (cups per day): _____ Other: _____

Allergies to Foods or Medications:

Medications / Supplements

(List medications and supplements you are currently taking, or any you have taken in the past 2 months)

Lifestyle

- Alcohol Marijuana Stress Regular Exercise (type & frequency):
 Tobacco Drugs Occupational Hazards

General Symptoms

- Recent weight loss Poor sleep Cold hands or feet Fever Sweat easily
 Recent weight gain Heavy sleep Poor circulation Chills Dizziness/Vertigo
 Fatigue Dream-disturbed sleep Shortness of breath Night sweats Peculiar taste (describe):
 Lack of strength

Head, Ears, Eyes, Nose, Throat

- Headaches Red eyes Sinus problems TMJ Ringing in ears
 Migraines Itchy eyes Dry mouth Sores on lips or tongue Poor hearing
 Concussions Dry eyes Excess saliva Sore throat Ear pain
 Facial Pain Glaucoma Excessive phlegm Swollen glands Other:
 Blurred vision Cataracts Teeth problems Lump in throat
 Eye pain Nosebleeds Gum problems Enlarged thyroid

Respiratory

- Difficulty breathing when lying down Tight chest Dry cough Cough with phlegm Coughing blood

Cardiovascular

- Chest pains Blood clots Low blood pressure Palpitations Irregular heartbeat Other:

Gastrointestinal

- Nausea Gas Bad breath Laxative use Mucous in stools Other:
 Vomiting Hiccups Diarrhea Black stools Intestinal pain/cramps
 Acid reflux Bloating Constipation Bloody stools Hemorrhoids

Musculoskeletal

- Neck/Shoulder pain Muscle pain (where?) Joint pain (where?) Other (specify):
 Upper back pain
 Lower back pain

Skin and Hair

- Acne Eczema Fungal infections Dandruff Change in hair/skin texture
 Hives Psoriasis Itching Hair loss Other (specify):

Neuropsychological

- Numbness Anxiety Poor memory Easily stressed Other (specify):
 Tic/twitching Depression Irritability Abuse survivor

Genito-urinary

- Pain on urination Incomplete urination Bedwetting Increased libido Other (specify):
 Frequent urination Blood in urine Wake to urinate Decreased libido
 Urgent urination Unable to hold urine Kidney stones Impotence

Gynecology

- Irregular periods PMS # Pregnancies: Age menses began: Date of last PAP:
 Painful periods Vaginal discharge # Live births: Age at menopause:
 Clots Breast lumps Date last period began:

Other (Please list any other problems or conditions not covered above.)
