

# New Patient Intake Form

Today's Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name	Marital Status	Birthdate / /
E-mail Address		<input type="checkbox"/> M <input type="checkbox"/> F Age
Address	Work Phone	Ht Wt
	Cell Phone	
City, State, Zip		Occupation
Home Phone		
Emergency Contact Name & Phone	Have you had acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chinese herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
Referred by		
Reason for visit today		
How long have you had this condition?		
Is it getting worse?	Does it bother you: <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Other (what?)	
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?	
Who is your physician?	Physician's Phone	
Other concurrent therapies		

## Family Medical History

<input type="checkbox"/> Allergies	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
_____	<input type="checkbox"/> Arteriosclerosis	_____	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke
_____	<input type="checkbox"/> Asthma	_____	<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	<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	_____	<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	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever	(Car, fall, etc.—list)	_____
(your own birth)	<input type="checkbox"/> Herpes	<input type="checkbox"/> Scarlet Fever	_____	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures	_____	_____
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke	_____	_____

## Your Diet

Appetite <input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> Coffee <input type="checkbox"/> Soft Drinks	<input type="checkbox"/> Artificial Sweetener	<input type="checkbox"/> Sugar <input type="checkbox"/> Salty Food	Thirst for water: # glasses per day: _____
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## Average Daily Menu

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

Pharmaceuticals taken in last 2 months:

Vitamins/supplements taken in last 2 months:

## Your Lifestyle

- |                                  |                                    |   |                  |                |
|----------------------------------|------------------------------------|---|------------------|----------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stress               | Regular Exercise |                |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs     | <input type="checkbox"/> Occupational Hazards | Type_____        | Frequency_____ |
|                                  |                                    |   | Type_____        | Frequency_____ |

## General Symptoms

- |  |  |  |   |  |
|--|--|--|---|--|
| <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        | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sores on lips    | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Headaches                   |
| <input type="checkbox"/> Eye strain     | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> or tongue        | <input type="checkbox"/> Swollen glands        | <input type="checkbox"/> Migraines                   |
| <input type="checkbox"/> Eye pain       | <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Dry mouth        | <input type="checkbox"/> Lumps in throat       | <input type="checkbox"/> Concussions                 |
| <input type="checkbox"/> Red eyes       | <input type="checkbox"/> Teeth problems  | <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"/> Grinding teeth  | <input type="checkbox"/> Sinus problems   | <input type="checkbox"/> Nose bleeds           | _____  |
| <input type="checkbox"/> Spots in eyes  | <input type="checkbox"/> TMJ             | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Ringing in ears       | _____  |
| <input type="checkbox"/> Poor vision    | <input type="checkbox"/> Facial pain     | Color of phlegm _____                     | <input type="checkbox"/> Poor hearing          | _____  |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Gum problems    |   | <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 blood |
| <input type="checkbox"/> Shortness of breath                  | <input type="checkbox"/> Asthma/whooping | Wet or Dry? _____              |                       | <input type="checkbox"/> Pneumonia      |
|   |  | 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"/> Itchy anus                  | Frequency _____  | Texture/form _____ |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Laxative use     | <input type="checkbox"/> Burning anus                | Color _____      | Odor _____         |
| <input type="checkbox"/> Gas                | <input type="checkbox"/> Black stools     | <input type="checkbox"/> Rectal pain                 |                  |                    |
| <input type="checkbox"/> Hiccup             | <input type="checkbox"/> Bloody stools    | <input type="checkbox"/> Hemorrhoid                  |                  |                    |
| <input type="checkbox"/> Bloating           | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Anal fissures               |                  |                    |
| <input type="checkbox"/> Bad breath         |   |  |                  |                    |

## 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

- |                                      |                                    |                                    |  |                             |
|--------------------------------------|------------------------------------|------------------------------------|--|-----------------------------|
| <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  |   | _____           |

## Genito-urinary

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> Pain on urination  | <input type="checkbox"/> Blood in urine       | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increase 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 _____                    |                              |
|   | <input type="checkbox"/> PMS               | <input type="checkbox"/> Clots                           | Premature births _____                | Date last period began _____ |
|   |  |  | Age at Menopause _____                | _____                        |

## Other

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