New Patient Intake Form

Today's Date______/_______/_________

Name

Marital Status
❑ M ❑ F

Birthdate / /

Age

Address

Email

Cell Phone

Ht Wt

City, State, Zip

Occupation

Home Phone

Emergency Contact Name & Phone

Have you had acupuncture before? ❑ Yes ❑ No

Chinese herbal medicine? ❑ Yes ❑ No

Reason for visit today

How long have you had this condition?

Is it getting worse? Does it bother you: ❑ Sleep ❑ Work ❑ 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? ❑ Yes ❑ No If yes, for what?

Who is your physician? Physician's Phone

Other concurrent therapies

Family Medical History

❑ Allergies
____
____

❑ Alcoholism
❑ Arteriosclerosis
❑ Asthma

❑ Cancer
____
____

❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure

❑ Seizures
❑ Stroke

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
❑ Alcoholism
❑ Allergies
❑ Appendicitis
❑ Arteriosclerosis
❑ Asthma
❑ Birth Trauma (your own birth)
❑ Cancer
❑ Chicken Pox

❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Goiter
❑ Gout
❑ Heart Disease
❑ Hepatitus
❑ Herpes
❑ High Blood Pressure
❑ Measles

❑ Multiple Sclerosis
❑ Mumps
❑ Pacemaker
❑ Pleurisy
❑ Pneumonia
❑ Polio
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Seizures
❑ Stroke

❑ Surgery (list)
____
____
____
❑ Thyroid Disorders
❑ Major Trauma
(Car, fall, etc.—list)
____
____
____

❑ Tuberculosis
❑ Typhoid Fever
❑ Ulcers
❑ Venereal Disease
❑ Whooping Cough
❑ Other (Specify)
____
____
____
____

Your Diet

Appetite ❑ Low ❑ High

❑ Coffee
❑ Soft Drinks

❑ Artificial Sweetener

❑ Sugar
❑ Salty Food

Thirst for water:
glasses per day:____________________

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in last 2 months:

Vitamins/supplements taken in last 2 months:

Your Lifestyle

- ❑ Alcohol
- ❑ Tobacco
- ❑ Marijuana
- ❑ Drugs
- ❑ Stress
- ❑ Occupational Hazards

Regular Exercise
Type__________________ Frequency_________________
Type__________________ Frequency_________________

General Symptoms

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Strongly like cold drinks
- ❑ Strongly like hot drinks
- ❑ Recent weight loss/gain
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream-disturbed sleep
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Bodily heaviness
- ❑ Cold hands or feet
- ❑ Poor circulation
- ❑ Shortness of breath
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Muscle cramps
- ❑ Vertigo or dizziness
- ❑ Bleed or bruise easily
- ❑ Peculiar taste (describe)

____
____
____

Head, Eyes, Ears, Nose, Throat

- ❑ Glasses
- ❑ Eye strain
- ❑ Eye pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Spots in eyes
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Night blindness
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ TMJ
- ❑ Facial pain
- ❑ Gum problems
- ❑ Sores on lips
- ❑ or tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Sinus problems
- ❑ Excessive phlegm

Color of phlegm
____

- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Enlarged thyroid
- ❑ Nose bleeds
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Headaches
- ❑ Migraines
- ❑ Concussions
- ❑ Other head or neck problems

____
____
____

Respiratory

- ❑ Difficulty breathing when lying down
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Asthma/wheezing
- ❑ Cough

Wet or Dry?____________
Thick or thin?__________

Color of phlegm
____

- ❑ Coughing blood
- ❑ Pneumonia

Cardiovascular

- ❑ High blood pressure
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Fainting
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Tachycardia
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heartbeat

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Acid regurgitation
- ❑ Gas
- ❑ Hiccup
- ❑ Bloating
- ❑ Bad breath
- ❑ Diarrhea
- ❑ Constipation
- ❑ Laxative use
- ❑ Black stools
- ❑ Bloody stools
- ❑ Mucous in stools
- ❑ Intestinal pain or cramping
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Rectal pain
- ❑ Hemorrhoid
- ❑ Anal fissures

Bowel movements:

Frequency _____________ Texture/form _______________

Color_________________ Odor______________________

Musculoskeletal

- ❑ Neck/shoulder pain
- ❑ Muscle pain
- ❑ Upper back pain
- ❑ Low back pain
- ❑ Joint pain
- ❑ Rib pain
- ❑ Limited range of motion
- ❑ Limited use

Other (describe)
____
____

Skin and hair

- ❑ Rashes
- ❑ Hives
- ❑ Ulcerations
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Dandruff
- ❑ Itching
- ❑ Hair loss
- ❑ Change in hair/skin texture
- ❑ Fungal infections

Other hair or skin problems
____
____

Neuropsychological

- ❑ Seizures
- ❑ Numbness
- ❑ Tics
- ❑ Poor memory
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily stressed
- ❑ Abuse survivor
- ❑ Considered/attempted suicide
- ❑ Seeing a therapist

Other (specify)
____
____

Genito-urinary

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Veneral disease
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increase libido
- ❑ Decreased libido
- ❑ Kidney stone
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission

Gynecology

- ❑ Age menses began

____

Length of cycle (day 1 to day 1)
____

- ❑ Duration of flow

____

- ❑ Irregular periods
- ❑ Painful periods
- ❑ PMS
- ❑ Vaginal discharge (color)__________________
- ❑ Vaginal sores
- ❑ Vaginal odor
- ❑ Clots
- ❑ Breast lumps

#Pregnancies ______________
#Live births ______________
Premature births __________
Age at Menopause__________

Date of last PAP
____

Date last period began
____

Other

____
____
____