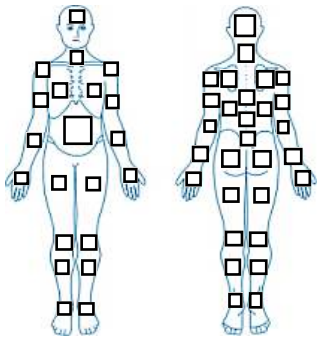
New Patient Intake Form

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	☐ Frequent urination	☐ Impotence	
	☐ Lymph Nodes Removed	☐ Infectious Diseases: _____ _____		

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**_____