

New Patient Intake Form

Today's Date _____

Name _____ - _____ - _____

Birthdate ____/____/____

Address _____ M F

Ht _____ Wt _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Occupation _____

Referred By _____

Reason For Visit Today _____ Have you ever had acupuncture before?

Yes No

Chinese Herbal Medicine Yes No

How long have had this condition?

Is it getting worse Yes No

Does it bother your Sleep Work Other(what?) _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

What hour of the day is it worse? _____ Better? _____

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 _____

Medicines taken in the last 2 months _____

Vitamins: _____

Herbs: _____

Family Medical History

- Allergies _____
- Arteriosclerosis _____
- Cancer _____
- Diabetes _____
- Seizures _____
- Asthma _____
- Heart Disease _____
- Stroke _____
- Alcoholism _____
- High Blood Pressure _____

Your Past Medical History

(Check any of the following conditions your 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"/> Whooping Cough |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever (Car, fall, etc-list) | | <input type="checkbox"/> Major Trauma |
| (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 Low High Coffee Soft Drinks Artificial Sweetener Sugar Salty Food
- Thirst for water: # of glasses per day: _____

Average Daily Menu

- | | | | | | |
|---------|-------|-------|-------|---------|-------|
| Morning | Snack | Noon | Snack | Evening | Snack |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

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

Head, Eyes, Ears, Nose, Throat .

- | | | | | |
|---|--|---|--|---------------------------------------|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sores on lip or tongue | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Migraine |
| <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"/> Earaches |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Other head or neck problems | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> TMJ | <input type="checkbox"/> Excessive Phlegm | <input type="checkbox"/> Nose bleeds | |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Color of Phlegm | <input type="checkbox"/> Ringing in ears | |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Gum problems | | | |

Respiratory

- | | | | |
|---|--|---|-----------------|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Cough | Color of phlegm |
| <input type="checkbox"/> when lying down | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Wet or Dry? _____ | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> 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 | <input type="checkbox"/> Blood Pressure numbers _____ | | | |
-

Gastrointestinal.

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

Musculoskeletal

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

Skin and Hair

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

Neuropsychological

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

Genito-urinary

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

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

Other

Clots

Breast Lumps

Pregnancies _____

Live births _____

Premature births _____

Age at menopause _____

Date of last PAP _____

Date last period began _____

Birth Control used

Are you pregnant now? Yes No