

**NEW PATIENT INTAKE FORM**

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

(please feel free to attach any additional information)

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Marital Status \_\_\_\_\_ Age \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work / Cell Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

M  F Ht \_\_\_\_\_ Wt \_\_\_\_\_ Occupation \_\_\_\_\_ Retired Y / N

Permission to add you to our valued subscriber's list: Y / N

Email address \_\_\_\_\_

Referred by \_\_\_\_\_

Have you had acupuncture before?  Yes  No

Have you had Chinese Herbs before?  Yes  No

Reason for Visit Today

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How long have you had this condition? \_\_\_\_\_

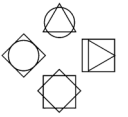
What seemed to be the initial cause? \_\_\_\_\_

What seems to make it better / worse? \_\_\_\_\_

Any additional health concerns \_\_\_\_\_

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Are you under the care of a physician now? Yes No

If yes, for what diagnosis? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

Physician's Phone# \_\_\_\_\_ (we will not contact without your permission)

Other current therapies \_\_\_\_\_

Other therapies tried in the past \_\_\_\_\_

Any Pets? Y / N    Type of Pets & general health -  
\_\_\_\_\_

**Family Medical History** (indicate which: Grandparents, Parents, Siblings, or your Children):

- |   |                                      |  |  |
|---|--------------------------------------|--|--|
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Gall Bladder issues | <input type="checkbox"/> Kidney stones       |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Cancer      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Obesity             |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Alcoholism          |
| <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Stroke      | <input type="checkbox"/> Depression          | <input type="checkbox"/> Inherited Disorders |

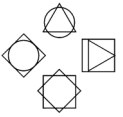
**Your Past Medical History** (includes you, only):

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> AIDs/HIV  | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Alcoholism  | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Gall Stones   | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Typhoid Fever       |
| <input type="checkbox"/> Appendicitis  | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Pacemaker     | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Arteriosclerosis  | <input type="checkbox"/> Goiter           | <input type="checkbox"/> Pleurisy      | <input type="checkbox"/> Whooping Cough      |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Gout          | <input type="checkbox"/> Pneumonia           |
| <input type="checkbox"/> Thyroid Disorders   | <input type="checkbox"/> Polio            | <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Measles       | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Rheumatic Fever   | <input type="checkbox"/> Birth Trauma     | <input type="checkbox"/> Depression    | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Major Trauma Other (Specify) (Car accident, fall, abuse, war, etc.) |   |  |  |

\_\_\_\_\_  
 Surgery (list/date)  
\_\_\_\_\_

**Your Diet:**

- Appetite:     Low                       Moderate                       High  
Cravings:     Sugar                       Carbohydrates                       Salty food                       Spicy food  
Thirsty alot?     Yes                       No    Average # of glasses of water per day \_\_\_\_\_



Typical Daily Menu:

Breakfast (approx time \_\_\_\_\_) Lunch (approx time \_\_\_\_\_) Dinner (approx time \_\_\_\_\_)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How often do you eat wheat products? \_\_\_\_\_

How often do you eat dairy? \_\_\_\_\_

How often do you sugar? \_\_\_\_\_

Snacks: \_\_\_\_\_

\_\_\_\_\_

**Prescription Medications** currently taking (indicate dosage, how many times per day):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Vitamins/Supplements** currently taking (indicate dosage, how many times per day):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Lifestyle:**

Alcohol                       Tobacco     Marijuana     Drugs             Stress

Occupational Hazards

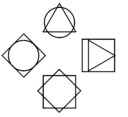
Hobbies \_\_\_\_\_

How is your energy? \_\_\_\_\_

When is at its highest? \_\_\_\_\_ Lowest? \_\_\_\_\_

Regular Exercise    Type \_\_\_\_\_ Frequency \_\_\_\_\_

   Type \_\_\_\_\_ Frequency \_\_\_\_\_



**General Symptoms:**

- Poor appetite       Poor Sleep       Bodily Heaviness       Dream disturbed
- Chills       Bleed or Bruising       Heavy appetite       Heavy Sleep
- Cold hands or feet       Night Sweats       Vertigo/dizzy       Like cold drinks
- Poor circulation       Sweat easily       Like hot drinks       Fatigue
- Shortness of breath       Muscle cramps       Fever       Lack of strength
- Recent wt loss/gain       Peculiar taste (describe) \_\_\_\_\_

**Head, Eyes, Ears, Nose, Throat**

- Glasses       Night blindness       Eye strain       Glaucoma
- Headache       Swollen glands       Migraines       Eye pain
- Cataracts       Dry mouth       Lumps in throat       Concussion
- Red eyes       Teeth problems       Excessive saliva       Sores on lips or tongue
- Itchy eyes       Enlarged thyroid       Grinding teeth       Sinus problems
- Nose bleeds       Neck problem       Spots in eyes       Blurred vision
- Poor vision       Facial pain       Ringing in ears       Poor hearing
- TMJ       Gum problems       Earaches       Recurrent sore throat
- Excessive phlegm; **Color of phlegm** \_\_\_\_\_
- Concussion       other head or neck problems \_\_\_\_\_

**Respiratory:**

- Difficulty breathing when lying down       Tight chest       Cough       wet or       dry?
- Coughing blood       Asthma       Pneumonia
- Shortness of breath      Color of phlegm \_\_\_\_\_       thick or       thin?

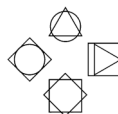
**Cardiovascular:**

- High blood pressure       Low blood pressure       Chest pain       Tachycardia
- Blood clots       Palpitations       Difficulty breathing
- Irregular heart beat       Phlebitis       Breathlessness

**Gastrointestinal:**

- Nausea       Vomiting       Gas       Hiccups
- Hiccups       Strange Tastes       Acid Regurgitation / Heartburn
- Diarrhea       Constipation       Laxative use
- Intestinal pain/cramping       Parasites (current / past)

**Bowel Movement Frequency:** \_\_\_\_\_/\_\_\_\_\_ day or week\_ (circle one)



**Musculoskeletal:**

- Neck/shoulder pain       Upper back pain     Joint pain     Limited range of motion
- Muscle pain               Lower back pain     Rib pain     Limited use
- Swollen Joints             Arthritis               Tendonitis     Muscle Cramping
- Fracture \_\_\_\_\_       Sprain \_\_\_\_\_       Broken Bone \_\_\_\_\_

**Type of Pain:**

- Sharp       Numb       Burning       Dull               Superficial
- Tingling     Itching     Deep             Shooting
- Better or worse with heat       Better or worse with cold
- Better or worse with pressure
- Better or worse in the AM       Better or worse in the PM

Other (describe) \_\_\_\_\_

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**Skin and Hair:**

- Rashes       Eczema       Dandruff               Change in hair/skin texture
- Hives       Psoriasis     Ulcerations           Itching Fungal infections
- Acne       Hair loss     Dry Skin               Other skin conditions \_\_\_\_\_

**Neuropsychological:**

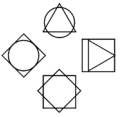
- Seizures     Poor memory       Irritability               Panic Attacks
- Numbness     Depression       Easily stressed       Difficult Concentration
- Tics             Anxiety             Abuse survivor       Considered Suicide
- Seeing therapist              Other (specify) \_\_\_\_\_

**Genito-urinary:**

How often do you urinate? \_\_\_\_\_ times per day;

Color:  Pale yellow  Dark yellow/orange

- Painful urination               Blood in urine       Venereal disease
- Increased libido               Impotence             Frequent urination
- Unable to hold urine       Bedwetting             Decreased libido
- Premature Ejaculation       Urgent urination     Incomplete voiding
- Wake to urinate               Kidney stone         Nocturnal emission



Are you, or could you be pregnant?\_\_\_\_\_ If so, how far along?\_\_\_\_\_

Number of pregnancies\_\_\_\_\_ Births\_\_\_\_\_ Abortions\_\_\_\_\_ Miscarriages\_\_\_\_\_

What form of birth control do you use?\_\_\_\_\_

Do you have regular PAP smears?\_\_\_\_\_ How Often? \_\_\_\_\_

Age of first menses\_\_\_\_\_ Age of menopause, if applicable\_\_\_\_\_

Do you bleed between periods?\_\_\_\_\_ Do you bleed after intercourse?\_\_\_\_\_

Have you ever had any gynecological surgeries or any abnormal findings on any tests?  
\_\_\_\_\_  
\_\_\_\_\_

Are your periods uncomfortable or painful, either emotionally or physically?\_\_\_\_\_

**Are your periods:**

Short (Less than 28 days)\_\_\_\_\_ Long (28+ days)\_\_\_\_\_ Varied\_\_\_\_\_ Regular\_\_\_\_\_

Painful? If so, Before\_\_\_\_\_ During\_\_\_\_\_ After\_\_\_\_\_

Do you bleed heavily\_\_\_\_\_? Lightly\_\_\_\_\_? Very little?\_\_\_\_\_

Do you have clots ?\_\_\_\_\_ Early in the cycle\_\_\_\_\_ or throughout?\_\_\_\_\_

Relative to the blood that comes from a wound, is your menstrual blood:

The same color\_\_\_\_\_ More pale\_\_\_\_\_ Purple\_\_\_\_\_

More Red\_\_\_\_\_ More Brown\_\_\_\_\_

How many days do you bleed?\_\_\_\_\_

Do you have any of the following Pre-Menstrual Symptoms?

Irritability\_\_\_ Depression\_\_\_\_\_ Crying\_\_\_\_\_ Rage\_\_\_\_\_ Nausea\_\_\_\_\_

Cravings, and if so for what?\_\_\_\_\_ Breast Tenderness\_\_\_\_\_

Any other symptoms around the time of your period?\_\_\_\_\_

Are you experiencing any low or high sexual desires?\_\_\_\_\_

Do you have any other gynecological concerns or complaints?\_\_\_\_\_

\_\_\_\_\_

I have provided correct and complete information to the best of my knowledge.

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Patient's or Guardian's signature

Date