Emma Browning Acupuncture
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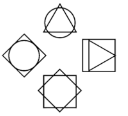

NEW PATIENT INTAKE FORM Today's Date: ______/______/______
(please feel free to attach any additional information)

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

____

____

____

____

____

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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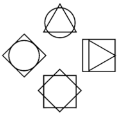


Are you under the care of a physician now? Yes No
If yes, for what diagnosis? ___________________________________
Who is your primary care physician?____
Physician's Phone#___________________ (we will not contact without your permission)

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):

☐ Allergies	☐ Alzheimer's	☐ Gall Bladder issues	☐ Kidney stones
☐ Arteriosclerosis	☐ Cancer	☐ High Blood Pressure	☐ Obesity
☐ Asthma	☐ Diabetes	☐ Seizures	☐ Alcoholism
☐ Heart Disease	☐ Stroke	☐ Depression	☐ Inherited Disorders

Your Past Medical History (includes you, only):

☐ AIDs/HIV	☐ Diabetes	☐ Kidney Stones	☐ Multiple Sclerosis
☐ Alcoholism	☐ Tuberculosis	☐ Gall Stones	☐ Stroke
☐ Allergies	☐ Emphysema	☐ Mumps	☐ Typhoid Fever
☐ Appendicitis	☐ Epilepsy	☐ Pacemaker	☐ Ulcers
☐ Arteriosclerosis	☐ Goiter	☐ Pleurisy	☐ Whooping Cough
☐ Asthma	☐ Venereal Disease	☐ Gout	☐ Pneumonia
☐ Thyroid Disorders	☐ Polio	☐ Hepatitis	☐ Cancer
☐ Heart Disease	☐ Chicken Pox	☐ Measles	☐ Seizures
☐ Rheumatic Fever	☐ Birth Trauma	☐ Depression	☐ High Blood Pressure

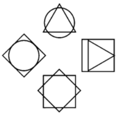
☐ Major Trauma Other (Specify) (Car accident, fall, abuse, war, etc.)
____

☐ 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________________________

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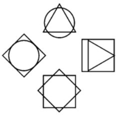


General Symptoms:

☐ 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?

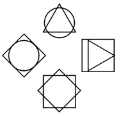
Cardiovascular:

☐ 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)____
____

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

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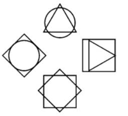

Do you experience any of the following:

Reduced Libido________ Excessive Libido_________ Impotence_____________

Urinary Frequency_______ Premature Ejaculation__________ Discharge________

Genital/ Testicular pain___________

Any other concerns?____

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

_____________________________________ ______________________

Patient's or Guardian's signature Date