New Patient Intake Form

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician (Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Phone)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*General Questions*

Have you had Acupuncture before?\_\_\_ Yes\_\_No

Chief Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Is it getting worse?\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it bother your:\_\_\_ Sleep\_\_\_\_ Work\_\_ Other

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

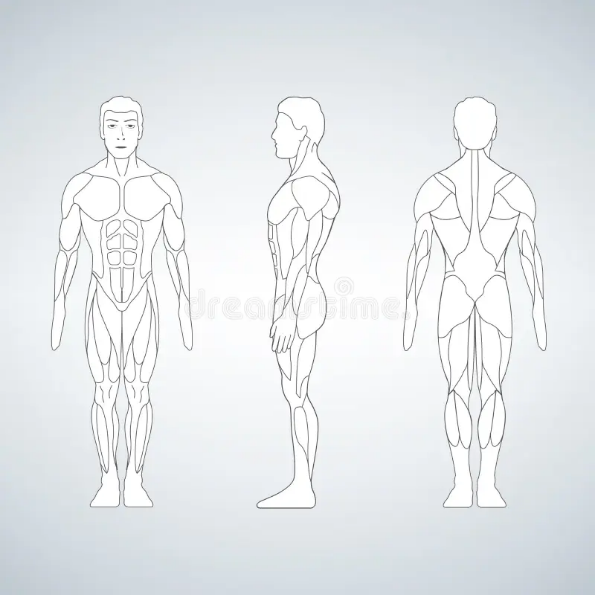
What seems to make it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you experiencing pain right now? \_\_\_\_\_\_\_\_\_\_\_\_

Describe the pain: \_\_\_\_\_Dull \_\_\_\_\_Sharp \_\_\_\_\_\_\_Stabbing \_\_\_\_\_\_\_Shooting \_\_\_\_\_\_\_Burning \_\_\_\_\_\_Other

Which of the following helps: \_\_\_\_Heat \_\_\_\_ Pressure \_\_\_\_Movement \_\_\_\_Cold \_\_\_\_\_Massage



PLEASE MARK YOUR AREA OF PAIN

*Family Medical History*

* \_\_\_\_Arteriosclerosis
* \_\_\_\_Alcoholism
* \_\_\_\_Cancer
* \_\_\_\_Diabetes
* \_\_\_\_High Blood Pressure
* \_\_\_\_Seizures
* \_\_\_\_Asthma
* \_\_\_\_Stroke
* \_\_\_\_Heart Disease
* \_\_\_\_Other

Are you currently on any medications? \_\_ No\_\_ Yes If Yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any vitamins or supplements? \_\_\_No \_\_\_Yes If Yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_

*Lifestyle*

Alcohol use: \_\_\_Yes \_\_\_No If Yes, how often\_\_\_\_\_\_\_\_\_\_\_\_

Tabacco use: \_\_\_Yes \_\_\_ No If Yes, how often\_\_\_\_\_\_\_\_\_\_\_\_\_

Stress: \_\_\_Yes \_\_\_ No If Yes, where on a scale of 1 – 10\_\_\_\_\_\_\_\_

Marijuana:\_\_\_\_\_\_\_\_\_\_\_

Drugs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupational Hazards:\_\_\_\_\_\_\_\_\_\_\_\_

Regular Exercise: \_\_\_\_\_\_\_\_\_\_ How often:\_\_\_\_\_\_ Type of Exercise:\_\_\_\_\_\_\_\_\_\_\_\_

Acupuncture confidential health history

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The items below may relate to your current conditions. In the space in front of each item, place a H if you previously HAD the problem. Place P if you PRESENTLY have the problem. Leave space blank if you NEVER had the problem.

General

o \_\_\_\_Fever/Chills

o \_\_\_\_Night Sweats

o \_\_\_\_ Spontaneous Sweat

o \_\_\_\_Loss of Sleep

o \_\_\_\_Fatigue

o \_\_\_\_Nervousness

o \_\_\_\_Weight Loss/Gain

o \_\_\_\_Allergies

o \_\_\_\_Bleeding

o \_\_\_\_Diabetes

o \_\_\_\_Thyroid disease

o \_\_\_\_Cancer

o \_\_\_\_HIV risk factors

o \_\_\_\_Cold or Warm extremities

HEENT

Ear

o \_\_\_\_Ringing

o \_\_\_\_Hearing loss

o \_\_\_\_Itching/Pain

o \_\_\_\_Other

Eye

o \_\_\_\_Dryness

o \_\_\_\_\_Redness

o \_\_\_\_Itching/Pain

o \_\_\_\_Burning

o \_\_\_\_Blurred Vision

o \_\_\_\_Tearing

o \_\_\_\_Other

Nose

o \_\_\_\_Bleeding

o \_\_\_\_Congestion

o \_\_\_\_Clear Running Nose

o \_\_\_\_Ulcerations

o \_\_\_\_Sinus Infection

o \_\_\_\_Loss of Smell

o \_\_\_\_Other

Mouth

o \_\_\_\_Dryness

o \_\_\_\_Abnormal Taste

o \_\_\_\_Sore/Pain

o \_\_\_\_Ulcerations

o \_\_\_\_Bleeding Gums

o \_\_\_\_Bad Taste in Mouth

o \_\_\_\_Dental Problems

o \_\_\_\_Other

Throat

o \_\_\_\_Dryness

o \_\_\_\_Itching/Soreness/Pain

o \_\_\_\_Swelling

o \_\_\_\_Difficulty Swallowing

o \_\_\_\_Hoarseness

o \_\_\_\_Tonsillectomy

Chest

o \_\_\_\_Congestion

o \_\_\_\_Pain

o \_\_\_\_Warm/Heat sensation

o \_\_\_\_Other

Breast

o \_\_\_\_Pulling sensation

o \_\_\_\_Pain

o \_\_\_\_Distention in part

o \_\_\_\_Nodule

o \_\_\_\_Discharge

Epigastric Area

o \_\_\_\_Pain

o \_\_\_\_Pulling sensation

o \_\_\_\_Warm/Heat

o \_\_\_\_Cold

LUNG/ RESPIRATORY

o \_\_\_\_Difficulty Breathing

o \_\_\_\_Shortness of Breath

o \_\_\_\_Cough

o \_\_\_\_Chronic Cough

o \_\_\_\_Spitting Phlegm

o \_\_\_\_Wheezing Asthma

o \_\_\_\_Pneumonia

o \_\_\_\_Bronchitis

o \_\_\_\_Tuberculosis

o \_\_\_\_Lack of Perspiration

o \_\_\_\_Excessive Perspiration

o \_\_\_\_Other

HEART/ CARDIOVASCULAR

o \_\_\_\_Irregular Heartbeat

o \_\_\_\_High Blood Pressure

o \_\_\_\_Low Blood Pressure

o \_\_\_\_Pain Over Heart

o \_\_\_\_Palpitations

o \_\_\_\_Poor Circulation

o \_\_\_\_Dizziness

o \_\_\_\_Fainting

o \_\_\_\_Heart Disease History

o \_\_\_\_Swelling Ankles

o \_\_\_\_Varicose Veins

o \_\_\_\_Rheumatic Fever

o \_\_\_\_Stroke

o \_\_\_\_Other

SP/ST/LV GASTROINTESTINAL

Abdomen

o \_\_\_\_Swollen

o \_\_\_\_Distention or Gas

o \_\_\_\_Pain

o \_\_\_\_Belching

o \_\_\_\_Stinging

o \_\_\_\_Coldness

o \_\_\_\_Constriction

o \_\_\_\_Cramping

o \_\_\_\_Pulling Down Sensation

o \_\_\_\_Poor Appetite

o \_\_\_\_Excessive Appetite

o \_\_\_\_Poor Digestion

o \_\_\_\_Nausea

o \_\_\_\_Vomiting

o \_\_\_\_Vomiting Blood

o \_\_\_\_Acid Regurgitation

o \_\_\_\_Black/ Bloody Stool

o \_\_\_\_Ulcer

o \_\_\_\_Hernia

o Frequency of bowel movements

Everyday\_\_\_\_\_Day(s)\_\_\_\_Time(s)

o \_\_\_\_Diarrhea

o \_\_\_\_Loose Stools

o \_\_\_\_Constipation

o \_\_\_\_Hemorrhoids

o \_\_\_\_Appendicitis

Liver

o \_\_\_\_Liver disease

o \_\_\_\_Jaundice

o \_\_\_\_Hypochondriac pain

o \_\_\_\_Other

List Dates and Reasons for Hospitalizations / Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications (including name, dose, frequency, and reason): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Last Seen: \_\_\_\_\_\_\_\_\_\_\_

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 treatment if any information has changes.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_