

# NEW PATIENT INTAKE FORM

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

Name	SS#	Marital Status	Birthdate / /	Age
Address		<input type="checkbox"/> M <input type="checkbox"/> F	Ht	Wt
Email				
City, State, Zip			Occupation	
Home Phone	Work		Cell	
Emergency Contact's Name & Phone				
Referred by				
Reason for visit today	Have you had acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chinese herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No		
How long have you had this condition?				
Is it getting worse?	Does it bother your <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Other (specify)			
What seemed to be the initial cause?				
What seems to make it better?				
What seems to make it worse?				
Are you under the care of a physician now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what?				
Physician's name			Physician's phone	
Other concurrent therapies				

**Health Insurance Info:**

Insurance Co. Name	Policy #
Address	Phone
City, State, Zip	

**Medicare Info:**

Insurance Co. Name	Policy #
Address	Phone
City, State, Zip	

**Family Medical History**

<input type="checkbox"/> Allergies (list)	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Cancer (type)	<input type="checkbox"/> Diabetes (Type: )	<input type="checkbox"/> Seizures
_____	<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stroke
_____	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	

**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.)

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Diabetes (Type: )	<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 (Date: )	_____	<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"/> Thyroid disorders	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Major trauma	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Birth trauma (your own birth)	<input type="checkbox"/> Hepatitis (Type: )	<input type="checkbox"/> Rheumatic fever	(Car, fall, etc--list)	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes (Type: )	<input type="checkbox"/> Scarlet fever	_____	_____
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizures	_____	_____
	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke	_____	_____

**Your Diet**

Appetite <input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> Coffee/Tea <input type="checkbox"/> Soft Drinks/Fruit Juices	Protein Intake <input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> Artificial Sweeteners	<input type="checkbox"/> Sugar <input type="checkbox"/> Salty foods	Thirst for water: # glasses per day: _____
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**Average Daily Menu**

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmaceuticals taken in the last 2 months:  
 Vitamins/supplements taken in the last 2 months:

**Practitioner Use Only**

## Your Lifestyle

- |                                  |                                    |   |                  |                 |
|----------------------------------|------------------------------------|---|------------------|-----------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stress               | Regular Exercise | Frequency _____ |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs     | <input type="checkbox"/> Occupational hazards | Type _____       | Frequency _____ |
|                                  |                                    |   | Type _____       |                 |

## General Symptoms

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

## Head, Eyes, Ears, Nose, Throat

- |  |   |  |   |                                      |
|--|---|--|---|--------------------------------------|
| <input type="checkbox"/> Glasses (What age: _____) | <input type="checkbox"/> Night blindness      | <input type="checkbox"/> Gum problems            | <input type="checkbox"/> Recurrent sore throat          | <input type="checkbox"/> Headaches   |
| <input type="checkbox"/> Eye strain                | <input type="checkbox"/> Myopia or Presbyopia | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Swollen glands                 | <input type="checkbox"/> Migraines   |
| <input type="checkbox"/> Eye pain                  | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Dry mouth               | <input type="checkbox"/> Lumps in throat                | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Red eyes                  | <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Excessive saliva        | <input type="checkbox"/> Enlarged thyroid               | Other head or neck problems          |
| <input type="checkbox"/> Itchy eyes                | <input type="checkbox"/> Teeth problems       | <input type="checkbox"/> Sinus problems          | <input type="checkbox"/> Nosebleeds                     | _____                                |
| <input type="checkbox"/> Spots in eyes             | <input type="checkbox"/> Grinding teeth       | <input type="checkbox"/> Excessive phlegm        | <input type="checkbox"/> Ringing in ears (High or Low?) | _____                                |
| <input type="checkbox"/> Poor vision               | <input type="checkbox"/> TMJ                  | Color: _____                                     | <input type="checkbox"/> Poor hearing                   | _____                                |
| <input type="checkbox"/> Blurred vision            | <input type="checkbox"/> Facial pain          |  | <input type="checkbox"/> Earaches                       | _____                                |

## Respiratory

- |   |  |                                |                       |  |
|---|--|--------------------------------|-----------------------|--|
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Tight chest                       | <input type="checkbox"/> Cough | Color of phlegm _____ | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Shortness of breath                  | <input type="checkbox"/> Asthma/whoezing                   | Wet or Dry? _____              |                       | <input type="checkbox"/> Pneumonia         |
|   | <input type="checkbox"/> Difficult inhalation? exhalation? | 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 |

## Gastrointestinal

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

## Musculoskeletal

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

## Skin and Hair

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

## Neuropsychological

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

## Genitourinary

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

## Gynecology

- |   |  |  |                                       |                              |
|---|--|--|---------------------------------------|------------------------------|
| <input type="checkbox"/> Age menses began | <input type="checkbox"/> Duration of flow  | <input type="checkbox"/> Vaginal discharge (color) | <input type="checkbox"/> Breast lumps | Date of last PAP _____       |
| Length of cycle (day 1 to day 1)          | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal sores             | # Pregnancies _____                   |                              |
| _____                                     | <input type="checkbox"/> Painful periods   | <input type="checkbox"/> Vaginal odor              | # Live births _____                   |                              |
|   | <input type="checkbox"/> PMS               | <input type="checkbox"/> Clots                     | # Premature births _____              | Date last period began _____ |
|   |  |  | Age at menopause _____                |                              |

## Other

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_