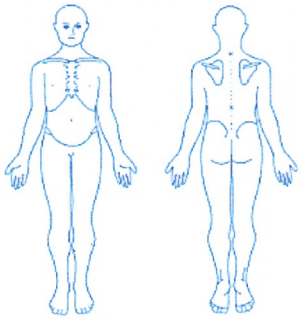
New Patient Intake Form

Name: _____ **Date:**_____ **Social Security #:**_____
Date of Birth:_____ **Age:**_____ **Email:** _____
Address:_____ **City, State, Zip** _____
Home Phone #: _____ **Work:** _____ **Cell:** _____
Occupation: _____ **Please check here if we can email you updates and a newsletter.** _____
Marital Status: ☐ **M** ☐ **S** ☐ **W** ☐ **D** **Height:** _____ **Weight:** _____ **Allergies:** _____
Emergency Contact Name:_____ **Phone:**_____ **Relationship:**_____
Physician: (Name) _____ **(Phone)** _____

General Questions:

PLEASE MARK YOUR AREA OF PAIN



Have you had acupuncture before? ☐Yes ☐ No
Chief Complaint: _____
How long have you had this condition?_____
Is it getting worse? ☐Yes ☐No **Does it bother your:** ☐Sleep ☐Work ☐Other _____
What seemed to be the initial cause? _____
What seems to make it better? _____
What seems to make it worse? _____
Are you experiencing pain right now? ☐Yes ☐ No
Describe your pain: ☐Dull ☐Sharp ☐Stabbing ☐Shooting ☐Burning ☐Other_____
What makes your pain better? ☐Heat ☐Pressure ☐Movement ☐Cold ☐Massage ☐ Rest

Family Medical History:

☐Arteriosclerosis ☐Cancer ☐Diabetes ☐Seizures ☐Asthma ☐Heart Disease ☐Stroke
☐Alcoholism ☐High Blood Pressure ☐Other: _____

Are you currently on any medications? ☐No ☐Yes If Yes, Please List: _____
Do you take any vitamins/supplements? ☐No ☐Yes If Yes, Please List: _____

Lifestyle:

☐Alcohol # per day_____ ☐Stress ☐Marijuana ☐Regular Exercise:
Type _____ Frequency_____
Type _____ Frequency_____

☐Tobacco # per day_____ ☐Drugs ☐Occupational Hazards

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)

☐ AIDs/HIV
☐ Alcoholism
☐ Allergies
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Birth Trauma (your own birth)
☐ Cancer
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart Disease
☐ High Blood Pressure
☐ Herpes
☐ Hepatitis
☐ Measles
☐ Mumps
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Stroke
☐ Thyroid Disorders
☐ Tuberculosis
☐ Thyroid Fever
☐ Ulcers
☐ Venereal Disease
☐ Whooping Cough
☐ Surgery (Please List All)
_____
_____
☐ Major Trauma:
_____
_____
_____
_____
☐ Other:
_____
_____
_____
_____

General Symptoms: (Please check all that apply)

☐Poor appetite	☐Heavy appetite	☐Craves cold drinks	☐Craves hot drinks	☐Bleed or bruise easily
☐Chills	☐Cold hands or feet	☐Poor circulation	☐Night sweats	☐Sweat easily(describe): _____ _____
☐Dream-Disturbed Sleep	☐Insomnia	☐Heavy Sleep	☐Anxiety ☐Depression	☐ Facial pain
☐Fatigue	☐Vertigo or dizziness	☐Blurred vision	☐Recent weight loss/gain	☐Poor Memory
☐Fever	☐Glaucoma	☐Sinus problems	☐Eczema ☐Hives	☐Easily Stressed ☐Hair Loss
☐Asthma/wheezing	☐Nose bleeds	☐Headaches	☐Migraines	☐Change in hair/skin texture
☐Difficulty breathing when lying down	☐Shortness of breath	☐Tight Chest	☐Numbness	☐Chest Pain
☐Cough: If yes, is it ☐Wet OR ☐Dry ☐Thick OR ☐Thin	☐Coughing Blood ☐Tachycardia ☐Fainting	☐Pneumonia ☐Blood clots ☐Seizures	☐High blood pressure ☐Irregular Heartbeat	☐Low blood pressure ☐Heart Palpitations ☐Difficulty Breathing
☐Diarrhea	☐Constipation	☐Intestinal Pain	☐Bloody Stools	☐Bowel Movements: Frequency per day _____
☐Nausea	☐Acid regurgitation	☐Vomiting		
☐Pain on urination	☐Blood in urine	☐Frequent urination	☐Impotence	
☐Considered/attempted Suicide	☐Lymph Nodes Removed	☐Infectious Diseases: _____ _____		

Musculoskeletal: (Please check all that apply)

☐Neck/shoulder pain	☐Upper Back Pain	☐Joint Pain	☐Limited Range of Motion	☐Other: _____
☐Muscle pain	☐Low Back Pain	☐Rib Pain	☐Muscle Spasm	_____

Woman Only: Gynecology

Are you pregnant? ☐Yes ☐No	Duration of flow _____	☐Irregular Periods	☐Painful Periods	☐PMS
Vaginal Discharge (Color) _____	☐Vaginal Sores	☐Vaginal Odor	☐Clots	Date Last Period began _____
Length of cycle (Day 1 to Day 1) _____	# Pregnancies _____	# Live Births _____	Premature Births _____	Age at Menopause _____

Please List Any Other Pertinent Information:

_____

_____

_____

_____

Signature of Patient_____ **Date**_____