New Patient Intake Form

SALENA HANRAHAN
acupuncture
& herbal medicine

Welcome! Please fill out the following confidential questionnaire to help me determine the best treatment plan for you.

Name: Date:
Home Address:
City State: Zip:
Preferred Phone:
E-mail:
Occupation
How did you hear about this office?
Sex: Male ☐ Female ☐ Height: Birth Date: Age:
Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnership ☐ Number of Children:
Emergency Contact: Phone:
Have you received acupuncture therapy before? Yes ☐ No ☐
If yes, when? With Whom?
For what condition?

What are the main issues for which you are seeking treatment today?
1)
2)

Please list any medications you are currently taking.

Medication:	Reason:	How long?

Please list any supplements you are currently taking.

Supplement:	Reason:	How Long?

Please indicate the use and frequency of the following:

	Yes	No	How much? How often?
Coffee/Tea	☐	☐	
Recreational drug	☐	☐	
Tobacco	☐	☐	
Alcohol	☐	☐	
Water	☐	☐	
Soda	☐	☐	

List any allergies, food sensitivities or cravings that you have:

List any accidents, surgeries, or hospitalizations (include year):

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How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad
Significant other					
Family					
Diet					
Sex					
Self					
Work					
Exercise					
Spirituality					

Have you experienced any of the following signs / symptoms?

No mark = never experience | Check mark = sometimes experience | Plus sign = frequently experience

excessive appetite	lack of appetite	loose stool/diarrhea	headaches
digestive problems	vomiting/nauseated	belching/burping	claustrophobia
heartburn/reflux	bloating	nasal problems	skin problems
low back pain	knee problems/pain	hearing impairment	easily bruised
insomnia	palpitations	cold hands/feet	nightmares
laughing w/o reason	chest pains	poor memory	vivid dreams
sadness/depression	eye problems	jaundice	mental restlessness
diff. digesting greasy foods	cough	shortness of breath	dental problems
fatigue	edema	asthma	decreased sense of smell
ear ringing	kidney stones	decreased sex drive	hair loss
gallstones	soft/brittle nails	easily angered	urinary problems
bitter taste in mouth	difficult making decisions	high cholesterol	easily/frequently gets sick
colitis/diverticulitis	constipation	depression	blood in stool/hemorrhoids
usually feel warm	usually feel cold	anxiety	light or clay colored stool
dizziness	obsession in work, relationships,etc.		

Females:

Age of menarche (1st period):	Age of last period (menopause):
Number of days in cycle:	Number of days of flow:
Color of flow:	Clots? yes no

Have you been diagnosed with any of the following conditions?

Fibroids	Fibrocystic Breasts	Endometriosis
Ovarian cysts	Pelvic Inflammatory Disease (PID)	HPV

Are any of the following associated with your menstrual cycle?

Cramping	Headaches	Discharge	Increased appetite
Stabbing pain	Mood changes	Nausea	Hot flashes

Date of last gynecologic exam:	Pap smear:
Mammogram:	Results:
Are you pregnant? Yes No	# of pregnancies: # of abortions:
Do you wake at night to urinate?	if so, how many times?

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Males:

Date of last prostate exam: PSA results:

Other lab results

Explain:

Do you wake up at night to urinate? Yes No if so, how many times

Is there anything else you would like to explain regarding your condition?

How did you hear about our services?

Cancellation Policy:

Appointments must be cancelled or changed within 24 hours of your appointment time. Without notice, the full cost of the visit will be incurred.

I understand the above cancellation policy (please sign) X