ACUPUNCTURE
CENTER
for HEALTH

NEW PATIENT INTAKE FORM

Patient Name:			Date:
Birthdate:	Age:	Height:	Weight:
Home Address:			
City:		State:	Zip:
Preferred Phone:		E-mail:	
How did you hear about this office?		Occupation:	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnership			Number of Children:
Emergency Contact:		Phone:	
Primary Care Physician:		Phone:	
Have you received acupuncture therapy before? ☐ Yes ☐ No If yes, when? _____			
If yes, Whom?			
For what condition?			
What are the main issues for which you are seeking treatment today?			
Is this injury work-related? ☐ Yes ☐ NO			
Is this injury due to an auto accident? ☐ Yes ☐ NO			
Have you had the same or similar symptoms in the past? ☐ Yes ☐ NO			
If yes, please state when and indicate prior treatment information (i.e. provider, type of treatment, etc.)			

Please list any medications you are currently taking.		
MEDICATION/SUPPLEMENTS	REASON	HOW LONG?

Please list any accidents, surgeries or hospitalizations.	
EVENT	YEAR

Please indicate the use and frequency of the following:					
	YES	NO	HOW MUCH?	HOW OFTEN?	MOST EVER USED?
Coffee/Tea					
Recreational drug					
Tobacco					
Alcohol					
Water					
Soda					
Refined Sugar					

Please indicate the use and frequency of the following:		
	TYPE (S)	FREQUENCY
Exercise		
Hobbies		

Describe your dietary/nutritional habits (what do you eat?)

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

Please check the appropriate box if you experience sensitivity to any of the following items		
Perfume		**Please Describe**:
Insecticides		
Fabrics		
Other Chemicals		
Do you currently work with or around chemicals? Yes ☐ No ☐		
If yes, please describe:		

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					

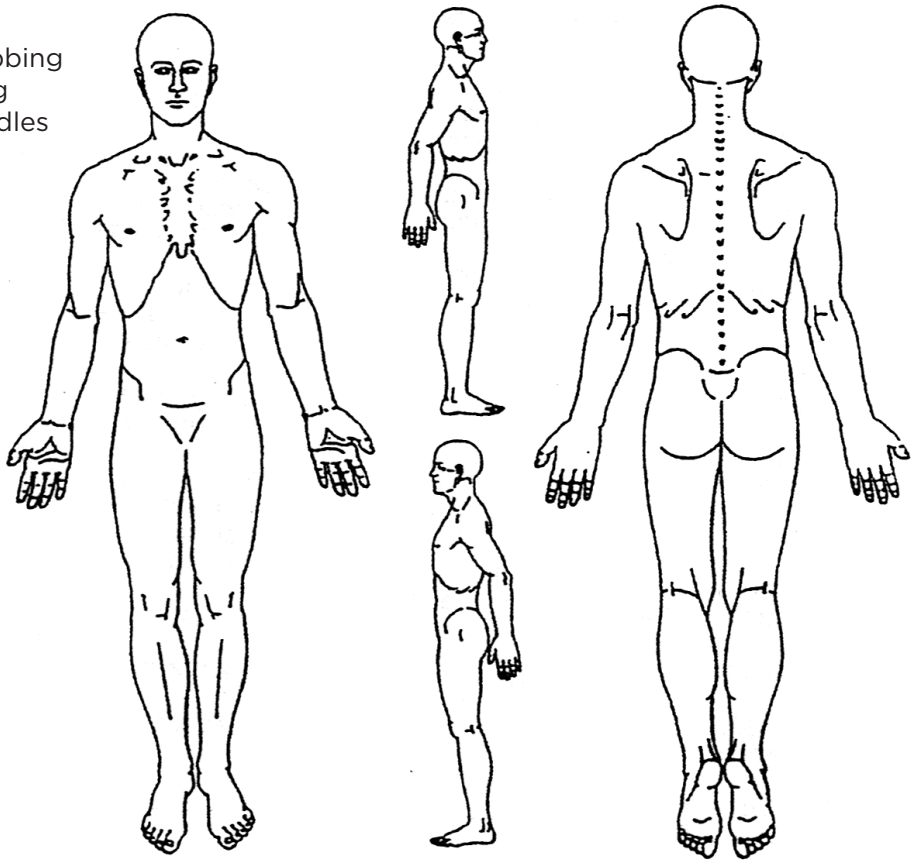
Please rate how your primary complaint affects the following aspects of your health.						
	NO PROBLEM	OCCASIONAL PROBLEM	MILD PROBLEM	MODERATE PROBLEM	SEVERE PROBLEM	NOT APPLICABLE
Energy Level	1	2	3	4	5	NA
Appetite	1	2	3	4	5	NA
Sleep Patterns	1	2	3	4	5	NA
Pain	1	2	3	4	5	NA
Digestion	1	2	3	4	5	NA
Elimination	1	2	3	4	5	NA
Emotions	1	2	3	4	5	NA
Using the scale above, how would you rate the intensity of your primary complaint						

When was your last physical exam? (month/year)	
Please list your doctor's name	
When did you last have lab (blood) work done?	
Were there any significant findings	
Can we request these records from your doctor	

Are you experiencing discomfort in any area of your body? Yes ☐ No ☐

If yes, using the models below, please indicate the appropriate location of the discomfort by using the symbol that best describes the feeling:

+++ Sharp/Stabbing
vvv Dull/Aching
ooo Pins & Needles
/// Numbness



THE PAIN INDICATED ABOVE IS

Mild ☐ Moderate ☐ Severe ☐

Please check the appropriate square to describe your present limitations in function due to the pain indicated above

ACTIVITY	NORMAL	MILDLY LIMITED	MODERATELY LIMITED	SEVERELY LIMITED
Lifting	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Sitting	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Running	☐	☐	☐	☐
Resting in bed	☐	☐	☐	☐
Intercourse	☐	☐	☐	☐
Data entry/typing	☐	☐	☐	☐

Does your condition interfere with your normal work, household or recreational activities? Yes ☐ No ☐
If yes, please explain:

Please check the symptoms/illness you have experienced within the past six months

EARTH ELEMENT	METAL ELEMENT	WATER ELEMENT	WOOD ELEMENT	FIRE ELEMENT	MISCELLANEOUS
☐ Clammy hands	☐ Bronchitis	☐ Swollen ankles	☐ Anemia	☐ Angina pains	☐ Dry skin
☐ Lack of appetite	☐ Cough	☐ Burning with urination	☐ Bitter taste in mouth	☐ Anxiety	☐ Water retention or swelling
☐ Low blood sugar	☐ Chest congestion	☐ Frequent urination	☐ Difficulty digesting oily or fatty foods	☐ Frequent crying	☐ High energy
☐ Sweet cravings	☐ Shortness of breath	☐ Frequent urination at night	☐ Difficulty making plans or decisions	☐ Heat intolerance	☐ Fatigue or tendency to faint
☐ Loose Stool or undigested food	☐ Decreased sense of smell	☐ Urine retention	☐ Easily angered or agitated	☐ Nervousness	☐ Tendency to be hot
☐ Afternoon Slump	☐ Feeling of claustrophobia	☐ Painful urination	☐ Eye problems (tearing, itching, blurred vision)	☐ Nightmares	☐ Tendency to be cold
☐ Nausea	☐ Fever	☐ Kidney stones	☐ Gall stones	☐ Poor memory	☐ Weight loss: _____ (#lbs/time frame)
☐ Drowsiness	☐ Frequent sore throats	☐ Cold intolerance	☐ Hemorrhoids	☐ Irregular heart-rate	☐ Weight Gain: _____ (#lbs/time frame)
☐ Tendency to be “obsessive”	☐ Asthma	☐ Decreased sex drive	☐ Hepatitis	☐ Pressure in chest	
☐ Fatigue after a meal	☐ Nasal problems	☐ Hair loss	☐ High cholesterol	☐ Easily excitable	
☐ Food Sensitivity	☐ Recent use of antibiotics	☐ Knee problems	☐ Impatience	☐ Mental confusion	
☐ Easily bruised	☐ Frequent colds	☐ Night sweats	☐ Depression	☐ Insomnia	
☐ Indigestion	☐ Chills	☐ Fearful	☐ Light colored stool		
☐ Vomiting	☐ Constipation	☐ Ringing in ears	☐ Pain under ribs		
☐ Tendency to worry	☐ Blood in stool	☐ Burning hands or feet	☐ Soft/brittle nails		
☐ Bloating	☐ Skin problems type_____	☐ Blood in urine	☐ Spasm or twitching muscles		
	☐ Inhalation of toxic chemicals	☐ Low blood pressure	☐ Stiff neck/ shoulders		
	☐ Swollen lymph glands	☐ Salt craving	☐ Tightness in ribs		
	☐ Allergies	☐ Stress	☐ Varicose veins		
	☐ Infections	☐ Sleeplessness	☐ Anger		
	☐ Chronic Illness	☐ Dizziness	☐ High blood pressure		
	☐ Sweating without exercise	☐ Dark circles under eyes	☐ Fever Blisters		
	☐ Intolerant to weather changes	☐ Low back pain			
		☐ Hearing impairment			
		☐ Afternoon fever			

For Females Only

Age began Menstruating			
If post-menopausal, age of menopause onset and completion			
Are your periods regular?	☐ Yes	☐ NO	☐ N/A
Number of days between cycles			
Number of days of flow			
Type of flow	☐ Light	☐ Medium	☐ Heavy ☐ Clots
Color of Blood Red	☐ Red ☐ Dark ☐ Purplish	☐ Bright Red ☐ Brown	
Last period began on (date)			
Have you ever had an abnormal PAP result?	☐ Yes	☐ NO	☐ N/A
If Yes, when & class, if known			
Have you had a mammogram(s)?	☐ Yes	☐ NO	
If yes, when (date)?			
Any abnormalities?	☐ Yes	Date: ___	☐ N/A
Do you do breast self-exams?	☐ Yes	☐ NO	
If yes, how often?			
If yes, any abnormalities?			

Check the corresponding box if you have ever had any of the following:

- ☐ Yeast infection
- ☐ Non-yeast vaginal infection
- ☐ Ovarian cysts
- ☐ Breast lumps
- ☐ Genital herpes
- ☐ Hysterectomy
- ☐ Chlamydia infection
- ☐ Irregular periods
- ☐ Genital burning
- ☐ Scanty bleeding/spotting
- ☐ Vaginal warts
- ☐ Urinary tract infection
- ☐ Menstrual cramping
- ☐ Clotting during period
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibroids
- ☐ Hot flashed
- ☐ Decreased sex drive
- ☐ Pelvic inflammatory disease
- ☐ Anal fissures
- ☐ Sexually transmitted disease(s)
  - __Genital herpes
  - __Gonorrhea
  - __Chlamydia
  - __Syphilis
  - __HIV/ARC
- ☐ Premenstrual Syndrome (PMS)
  - __Breast tenderness/swelling
  - __Sugar cravings
  - __Irritability/frustration
  - __Salt cravings
  - __Headaches
  - __Fat/oil cravings
  - __Abdominal bloating
  - __Insomnia

Obstetrical History			Are you currently pregnant?	☐ Yes	☐ NO
Pregnancies	#	AGE		#	AGE
Live births			Miscarriages		
Vaginal deliveries			Still births		
Caesarian deliveries			Abortions		

For Males Only

Check the corresponding box and sub-categories if you have ever had any of the following:

- ☐ Testicular swelling/pain
- ☐ Premature ejaculation
- ☐ Nocturnal emissions
- ☐ Weak or slow urine stream
- ☐ Dribbling urination
- ☐ Burning urination
- ☐ Discharge from penis
- ☐ Rectal/anal pressure
- ☐ Sexually transmitted diseases
  - __HIV/ARC
  - __Genital herpes
  - __Chlamydia
  - __Gonorrhea
  - __Syphilis
- ☐ Impotence
- ☐ Decreased sex drive
- ☐ Increased sex drive
- ☐ Low sperm count

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

How did you hear about our services?

CANCELLATION POLICY

Appointments must be canceled 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. _____

Signature

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