New Patient Intake Form

Today's Date

Name | Birthdate

Address | Age
City, State, Zip

Email | Occupation

Phone
Emergency Contact (Name & Number)
Referred by
Reason for visit today | Have you had acupuncture before? | Chinese herbal medicine?

Yes No Yes No

How long have you had this condition ?
Is it getting worse? | Does it bother your: | Sleep? | Work? | 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? Yes No If yes, for what?

Physician's name and number
Other concurrent therapies

Family Medical History

___ Allergies (list)
___ Arteriosclerosis
___ Alcoholism
___ Depression
___ Heart Disease
___ Seizures
___ Asthma
___ Cancer (type)
___ Diabetes (type)
___ High blood pressure
___ Stroke

Your Past Medical History

Select any of the following conditions you have, or have had in the past.
Please also select 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)
___ Cancer
___ Chicken pox
___ Diabetes (type)
___ Emphysema
___ Epilepsy
___ Goiter
___ Gout
___ Heart disease
___ Hepatitis (type)
___ Herpes
___ High blood pressure
___ Measles
___ Multiple Sclerosis
___ Mumps
___ Pacemaker Date:
___ Pleurisy
___ Pneumonia
___ Polio
___ Rheumatic fever
___ Scarlet fever
___ Seizures
___ Stroke
___ Surgery (list)
___ Thyroid disorders
___ Major trauma (Car, fall, etc - list)
___ Tuberculosis
___ Typhoid Fever
___ Ulcers
___ Venereal disease
___ Whooping cough)
Other (specify)

Your Diet

Appetite
Low High

___ Coffee/Tea
___ SoftDrinks or Fruit Juices

Protein Intake
Low High

___ Artificial Sweeteners
___ Sugar
Salty foods

Thirst for water: # glasses per day:

Average Daily Menu

Morning | Snack | Noon | Snack | Evening | Snack

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

Your Lifestyle

___ Alcohol	___ Marijuana	___ Stress	___ Regular Exercise	Type	Frequency
___ Tobacco	___ Drugs	___ Occupational hazards			

General Symptoms

___ Poor appetite	___ Recent weight loss/gain	___ Fatigue	___ Poor circulation	___ Night sweats	___ Bleed or bruise easily
___ Heavy appetite	___ Poor sleep	___ Lack of strength	___ Shortness of breath	___ Sweat easily	___ Peculiar taste (describe)
___ Strongly like cold drinks	___ Heavy sleep	___ Bodily heaviness	___ Fever	___ Muscle cramps	
___ Strongly like hot drinks	___ Dream-disturbed sleep	___ Cold hands or feet	___ Chills	___ Vertigo or dizziness	

Heads, Eyes, Ears, Nose, Throat

___ Glasses, age ___	___ Poor vision	___ Teeth problems	___ Dry mouth	___ Swollen glands	___ Earaches
___ Eye strain	___ Blurred vision	___ Grinding teeth	___ Excessive saliva	___ Lumps in throat	___ Headaches
___ Eye pain	___ Night blindness	___ TMJ	___ Sinus problems	___ Enlarged thyroid	___ Migraines
___ Red eyes	___ Myopia or Presbyopia	___ Facial Pain	___ Excessive phlegm - Color	___ Nosebleeds	___ Concussions
___ Itchy eyes	___ Glaucoma	___ Gum problems		___ Ringing in ears (high/low)	___ Other head or neck problems
___ Spots in eyes	___ Cataracts	___ Sores on lips/tongue	___ Recurrent sore throat	___ Poor hearing	

Respiratory

___ Difficulty breathing when lying down	___ Tight chest	___ Difficult Inhalation? Exhalation?	___ Cough ___ Wet or dry ___	Color of phlegm	___ Coughing up blood
___ Shortness of breath	___ Asthma or wheezing		___ Think or thin ___		___ Pneumonia

Cardiovascular

___ High blood pressure	___ Low blood pressure	___ Chest pain	___ Tachycardia	___ Phlebitis
___ Blood clots	___ Fainting	___ Difficulty breathing	___ Heart palpitations	___ Irregular heartbeat

Gastrointestinal

___ Nausea	___ Bad breath	___ Mucous in stools	___ Rectal pain	___ Bowel movements:	
___ Vomiting	___ Diarrhea	___ Hemorrhoid	___ Anal fissures	Frequency	Texture/form
___ Acid regurgitation	___ Constipation	___ Itchy anus	___ Laxative use What Kind		
___ Gas	___ Black stool	___ Intestinal pain or cramping		Color	Odor
___ Hiccup	___ Bloody stools	___ Burning anus	How often?		
___ Bloating					

Musculoskeletal

___ Neck/shoulder pain	___ Upper back pain	___ Joint pain	___ Limited range of motion	Other (describe)
___ Muscle pain	___ Low back pain	___ Rib pain	___ Limited use	

Skin and Hair

___ Rashes	___ Ulcerations	___ Psoriasis	___ Dandruff	___ Hair loss	___ Fungal infection
___ Hives	___ Eczema	___ Acne	___ Itching	___ Change in hair/skin texture	___ Other hair/skin problems

Neuropsychological

___ Seizures	___ Tics	___ Depression	___ Irritability	___ Abuse survivor	___ Seeing a therapist
___ Numbness	___ Poor memory	___ Anxiety	___ Easily stressed	___ Considered or attempted suicide	Other(specify)

Genitourinary

___ Pain on urination	___ Blood in urine	___ Venerreal disease	___ Increased libido	___ Premature ejaculation	___ Nocturnal emission
___ Frequent urination	___ Unable to hold urine	___ Bedwetting	___ Decreased libido	___ Impotence	
___ Urgent urination	urination	Wake to urinate	Kidney stone		

Gynecology

Age menses began	Duration of flow	___ Clots	___ Vaginal sores	___ # Pregnancies	Date of last PAP
		___ PMS	___ Vaginal odor	___ # Live births	
Length of cycle	___ Irregular periods	___ Vaginal discharge	___ Breast lumps	___ # Premature births	
	___ Painful periods	Color		Age at menopause	Date last period began

Other