*Complete the Intake Form prior to your first visit. Click in the box to fill in the information and/or hit tab tab to get to the next question. Click the line before/after medical history questions for a check mark.*

# 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 phelgm - 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

**Email to Elizabeth Liddell when complete at elizabethliddell@verizon.net**