

New Patient Intake Form

Date _____

Name _____ Home Phone _____ *Email _____

Address _____ **Cell Phone _____

City _____ State _____ Zip _____ Work Phone _____

Occupation _____ Birth date ____/____/____ Birth Time _____ Age _____ Gender _____

Height _____ Weight _____ Referred by _____

In case of emergency notify _____ relationship _____

Their Home Phone _____ Work Phone _____ Cell phone _____

Family Physician _____ Physician's Phone _____

Have you had acupuncture before? _____ Chinese herbal medicine before? _____

Reason for today's visit _____

How long have you had this condition? _____ Have you had it in the past? _____

If yes, (in the past) describe when _____

What makes it better? _____

What makes it worse? _____

Is your condition... getting worse _____ getting better _____ constant _____ comes and goes _____

If applicable, circle a number to indicate your level of pain. Minimal = 1 2 3 4 5 6 7 8 9 10 = extreme

If you have been given a diagnosis, what is it? _____

Diagnosing physician _____ Are any other doctors treating this condition? Y / N

Are you under the care of another physician for any other problems? (list problem and physician) _____

What kinds of treatments have you tried? _____

Please list all medications, hormones, laxatives, herbs, homeopathics and supplements you are taking and for what reason

Medical History

Date of your last physical exam _____ By whom? _____

List surgeries and dates _____

Significant accidents and traumas with dates _____

Do you have or have ever had: (Circle)

AIDS, ARC or HIV
Dyslexia
Sexually transmitted disease
Epilepsy
Gallstones
Sudden weight loss

Arthritis
Heart trouble
Kidney or bladder trouble
Thyroid problems
Hemophilia
Rheumatic fever
Tuberculosis
Cancer
Hepatitis
Scarlet fever
Ulcers

Have you ever taken adrenal corticosteroids (cortisone, prednisone, etc)? How long _____

Have you had more than 2 courses of antibiotics in your lifetime? Y / N How many? _____

Do you have silver amalgam fillings? _____

Unusual birth history (prolonged labor, forceps delivery, C-section, etc)? _____

Please list scars from accident/surgery: _____

What inoculations have you had? _____ Tetanus (lockjaw) _____ Smallpox _____ Diphtheria _____ Poliomyelitis
_____ Pertussis (whooping cough) _____ Rubella (German measles) _____ Measles _____ Flu _____ Other _____

What inoculations have you had in the last year? _____

Where have you traveled outside this country? _____

PLEASE CIRCLE ALL THAT APPLY

Head, Ears, Nose, Mouth and Throat

Frequent colds	Dizziness or loss of balance	Deafness	Sores on tongue
Sinus congestion or pain	Concussion	Nasal congestion	Sores in mouth (canker)
Facial pain (fever blister)	Seizures	Runny nose	Sores on lips
Jaw tension or clicking (TMJ) swallowing	Headache	Nose bleeds	Difficulty
Grinding teeth	Migraine headache	Sneezing	Lump or pit in throat
Frequent dental cavities	Congestion in ears	Allergies	Sore throat
Gum problems	Earache	Decreased sense of smell	Strep throat
Bleeding gums	Ringling in ears	Dry mouth	Swollen lymph nodes
Dentures	Difficulty hearing	Excessive saliva or drooling	Tonsillitis

Respiratory

Chronic cough	Thin, watery phlegm	Pneumonia	Asthma: more difficult exhale
Dry cough inhale	Clear or white phlegm	Pain with deep breath	Asthma: more difficult
Tight, rattling cough	Yellowish phlegm	Shortness of breath	Asthma: worse on exhale
Loose cough	Blood in phlegm	Emphysema	
Thick, sticky phlegm	Bronchitis	Wheezing	

General

Head or chest cold	Night sweats	Anemia	Recent weight loss
Flu	Perspire easily w/o exertion	Always fatigued	Recent weight gain
Recurrent fever	Rarely perspire	Fatigued easily	Often thirsty
Chills	Jaundice	Sudden drop in energy	Seldom thirsty

Sleep

Difficulty falling asleep and wired	Nightmares	Needs to take naps
Shallow sleep	Snoring	Sleep too much
Dream disturbed sleep	Difficulty waking in a.m.	Sleep too little
Wake at night –thinking	Wake up unrefreshed	Sleep on a waterbed
Wake at night-mind empty, eyes open	Sleepy in afternoon	Sleep with an electric blanket

How many hours do you sleep in a 24 hour period? _____

Cardiovascular

High blood pressure	Angina or chest pain	Varicose veins	Cold hands
Low blood pressure	Coronary heart disease	Bruise easily	Cold feet
Blackouts or fainting	High cholesterol	Anemia	Hot hands or palms
Irregular heartbeat	Stroke	Edema	Hot feet or soles
Heart valve problem/murmur	Blood clot	Swelling of hands	Generally too hot
Rapid heartbeat/palpitations	Phlebitis	Swelling of feet	Generally too
cold			

Gastrointestinal

Constipation	Blood in stool	Hiatal hernia	Nausea
Hard stools	Black stool	Lower abdominal pain/ cramping	Vomiting
Bowel movements feel incomplete	Hemorrhoids	Upper abdominal pain/cramping	Belching
Frequent laxative use	Colitis	Stomach acidity	Ulcer
Diarrhea	Diverticulitis	Indigestion	
Loose stools	Parasites	Gurgling noise in stomach	
Erratic bowel movements	Abdominal bloating	Bad breath	
Foul smelling stools	Gas (flatulence)	Excessive appetite	
Undigested food in stool	Mucous in stool	Poor appetite	

How often do you have a bowel movement? _____

Skin and Hair

Rashes	Herpes Zoster (shingles)	Recent change in mole	Fungus on skin
Hives	Boils	Warts	Fungus under nails
Itching	Pimples or acne	Dry Skin	Weak or brittle nails
Eczema	Ulcerations or sores	Moist feet	Loss of hair
Psoriasis	Recent moles	Moist palms	Dandruff

Any numb areas? _____ Where? _____

Eyes

Nearsighted (myopia)	Night blindness	Eye pain	Conjunctivitis
Farsighted (hyperopia)	Sensitivity to light	Dry eyes	Use eyeglasses or contacts
Astigmatism	Blurred vision	Watery eyes	Blindness
Glaucoma	Floating Spots	Itchy eyes	
Cataracts	Pressure behind eyes	Red eyes	

Pregnancy and Gynecology

Number of pregnancies	Clots	Vaginal discharge:strong odor
Number of births	Dark purple	Vaginal discharge brownish
Premature births	Dark brown	Vaginal discharge:white/curd-like
Miscarriages	Red	Vaginal discharge:frothy & profuse
Abortions	Light colored/pale blood	Vaginal discharge:itchy
Difficult deliveries	Painful periods	Vaginal discharge:burning
Caesarean sections	Endometriosis	Abnormal pap
Age of children	Cramping before period starts	Uterine fibroids
Age at first menses	Cramping after period starts	Ovarian cysts
Starting date of last menses	Low backache with period	Breast cysts or lumps

Duration of flow	Spotting between periods	Pelvic inflammatory disease
Length of cycle	Missed periods	Currently have an IUD
Age at start of menopause	Premenstrual irritability	Previously had an IUD
Age menses stopped	Premenstrual emotional sensitivity	Current use of birth control pills
Hysterectomy	Premenstrual breast tenderness	Previous use of birth control pill
Reason for	Premenstrual bloating	Other birth control_____
Oophorectomy	Premenstrual fluid retention	Cannot maintain pregnancy
Reason for	Premenstrual headache	Trying to become pregnant
Have not yet begun menstruating	Premenstrual constipation	Infertility
Irregular cycle	Premenstrual diarrhea	Pregnant
Heavy flow	Hot flashes	Nursing
Light flow	Vaginal discharge: no odor	Nausea or morning sickness

Any other pregnancy or gynecological problems?_____

Date of last pap test_____

Musculoskeletal

Neck pain/stiffness	Mid back pain/stiffness	Leg or calf cramping
Shoulderblade pain	Low back pain/stiffness	Ankle pain/stiffness
Shoulder joint pain/stiffness	Sacroiliac pain/stiffness	Weak ankles
Upper arm pain/stiffness	Hip joint pain/stiffness	Foot or toe pain/stiffness
Elbow pain/stiffness	Pain into thigh or upper leg	Numbness or tingling in feet
Wrist pain/stiffness	Pain into calf or lower leg	Muscle spasms
Hand or finger pain/stiffness	Weak legs	Muscle weakness
Numbness or tingling in hands	Knee pain/stiffness	Paralysis
Upper back pain/stiffness	Weak knees	Stiff all over

Is the problem helped by: _____ pressure _____ heat _____ cold _____ other_____

Is the problem aggravated by: _____ pressure _____ heat _____ cold _____ other_____

Urinary and Genital

Scanty or small amount of urine	Decreased flow of urine	Sores on genitals
Dark urine	Flow does not stop quickly	Pain during intercourse
Strong smelling urine	Dribbling	Low sexual energy
Cloudy urine	Bed wetting	Excessive sexual energy
Profuse or large amount of urine	Pain or burning when urinating	Inability to achieve orgasm
Clear urine	Pain in bladder area	Prostate problems
Unable to hold urine	Blood in urine	Low sperm count
Urgency to urinate	Bladder infection	Ejaculation during sleep
Frequent urination	Kidney infection	Premature ejaculation
Difficulty urinating	Kidney stones	Inability to maintain erection

How often do you urinate in 24 hours?_____ How often do you wake to urinate at night?_____

Any other problems with your urinary system?_____

Emotional

Depression	Mood swings	Frequent crying
Suicidal feelings	Manic episodes	Anxiety or fear
Frequent anger or irritation	Obsessiveness or compulsiveness	Indecisiveness
Tendency to repress emotions	Sadness or grief	Difficulty handling stress

Have you ever been emotionally, physically or sexually abused?_____

Have you ever been treated for emotional problems?_____

Have you recently had any unusually stressful experiences (divorce, death of a loved one, bankruptcy, loss of a job, illness, injury, etc.)?____

Is there a constant stress in your life, at work, with your family, etc.?_____

Any other emotional problems? _____

Family Medical History

Alcoholism	Asthma	Diabetes	High blood pressure	Lung disease
Allergies	Cancer	Epilepsy	Kidney disease	Psych. problems
Arthritis	Coronary artery disease	Heart disease	Liver disease	Stroke