NEW PATIENT INTAKE FORM
(ACUPUNCTURE)

PATIENT INFORMATION					
Last Name	First Name				Middle Name/Initial
Occupation	Gender	Age	Height	Weight	Marital Status (*circle one*) ● S W D

GENERAL INFORMATION		
Have you had acupuncture before? (*circle one*)		Y / N
Chief Complaint:		
How long have you had this complaint?	Is it getting worse?	Y / N
Does it have an impact on your: (*circle all that apply*)	Sleep Work	Other (*explain*):
What seemed to be the initial cause?		
What seems to make it better?		
What seems to make it worse?		
Are you experiencing pain right now?		Y / N

Describe your pain (*circle all that apply*):

Dull | Sharp/Stabbing | Shooting | Burning | Aching/Dull | Pins & Needles | Electrical

Other (*explain*):

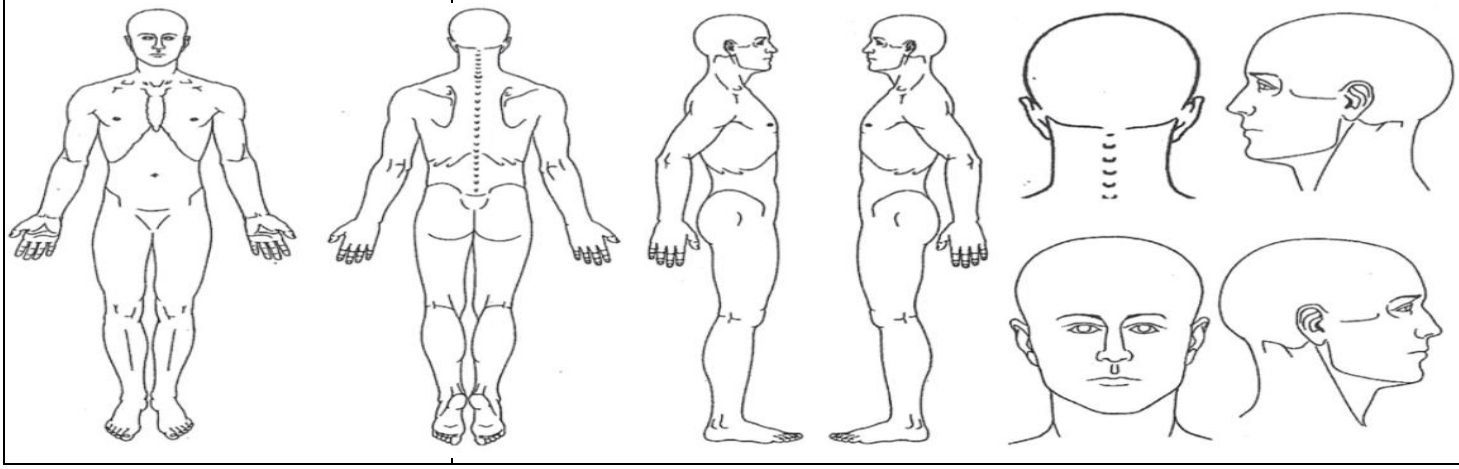
What makes your pain better? (*circle all that apply*):

Heat | Pressure | Cold | Movement | Massage | Rest

Other (*explain*):

Medication (*Type/Frequency/Dosage*):

PLEASE MARK YOUR AREA(S) OF PAIN/SYMPTOMS



FAMILY HISTORY

Circle all that apply:

Arteriosclerosis | Cancer | Diabetes | Seizures | Asthma | Heart Disease | Stroke | Alcoholism | High Blood Pressure

Other (*explain*):

CURRENT MEDICAL INFORMATION

Are you currently on any medications? (*circle one*) (Y) / (N)	*If yes, please list:*
Do you take any vitamins/supplements? (*circle one*) (Y) / (N)	*If yes, please list:*

LIFESTYLE

Do you regularly consume alcohol? (*circle one*) (Y) / (N)	*If yes, # per day:*	
Do you smoke? (*circle one*) (Y) / (N)	*If yes, # per day:*	
Do you engage in regular exercise? (*circle one*) (Y) / (N)	*If yes, list per week:*	Type(s): Duration:

Circle all that apply: Stress | Occupational Hazards | Recreational Drugs | Marijuana

PAST MEDICAL HISTORY

Check any of the following conditions that you currently have, or have had in the past. Please check if you feel that any of the following are a significant part of your medical history:

- ☐ AIDs/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Trauma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Herpes
- ☐ Hepatitis
- ☐ Measles
- ☐ Change in Hair/Skin Texture
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Thyroid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Poor Appetite
- ☐ Chills
- ☐ Nightmares
- ☐ Fatigue
- ☐ Fever
- ☐ Asthma/Wheezing
- ☐ Difficulty Breathing while Lying Down
- ☐ Diarrhea
- ☐ Nausea
- ☐ Painful Urination
- ☐ Heavy Appetite
- ☐ Cold Hands/Feet
- ☐ Insomnia
- ☐ Vertigo/Dizziness
- ☐ Glaucoma
- ☐ Nose Bleeds
- ☐ Shortness of Breath
- ☐ Tachycardia
- ☐ Fainting
- ☐ Constipation
- ☐ Acid Reflux
- ☐ Blood in Urine
- ☐ Craves Cold Drinks
- ☐ Craves Hot Drinks
- ☐ Dry/Wet Cough (circle one)
- ☐ Heavy Sleep
- ☐ Blurred Vision
- ☐ Sinus Problems
- ☐ Headaches
- ☐ Tight Chest
- ☐ Pneumonia
- ☐ Blood Clots
- ☐ Intestinal Pain
- ☐ Vomiting
- ☐ Frequent Urination
- ☐ Anxiety
- ☐ Depression
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Eczema
- ☐ Hives
- ☐ Migraines
- ☐ Numbness
- ☐ Vertigo or Dizziness
- ☐ Irregular Heartbeat
- ☐ Bloody Stools
- ☐ Impotence
- ☐ Easy to Bleed/Bruise
- ☐ Facial Pain
- ☐ Poor Memory
- ☐ Easily Stressed
- ☐ Hair Loss
- ☐ Mumps
- ☐ Chest Pain
- ☐ Low Blood Pressure
- ☐ Heart Palpitations
- ☐ Difficulty Breathing
- ☐ Lymph Nodes Removed
- ☐ Coughing Blood
- ☐ Night Sweats
- ☐ Blood in Urine
- ☐ Poor Circulation
- ☐ Infectious Diseases: _____

☐ Surgeries: _____

☐ Major Traumas: _____

☐ Other: _____

MUSCULOSKELETAL

Please check all that apply:

- ☐ Neck/Shoulder Pain
- ☐ Muscle Pain
- ☐ Upper Back Pain
- ☐ Muscle Spasms
- ☐ Lower Back Pain
- ☐ Rib Pain
- ☐ Joint Pain
- ☐ Limited Range of Motion
- ☐ Other: _____

GYNECOLOGY (WOMEN ONLY)			
Are you pregnant? (*circle one*) Y / N	Date last period began:		Duration of cycle (*day 1 to day 1*):
Age at menopause:	# of pregnancies:	# of live births:	Duration of flow (*days*):

Please check all that apply:

☐ Vaginal Sores ☐ Irregular Periods ☐ PMS ☐ Other: _____

☐ Clots ☐ PCOS ☐ Painful Periods _____

_____

Please list any other pertinent information:

_____

_____

_____

_____

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_____

I agree that the information that I provided on this intake form is true. It is my responsibility to inform the Doctor at any point throughout the course of my treatment if any information has changed.

_____ _____

Signature of Patient Date