Acupuncture New Patient Intake Form

Name: ______________________________________ Date of Birth: ___________ Gender: __________

Address: _____________________________City: _______________State: _______ Zip: ___________

Phone: (home) _______________ (cell) ______________Email: _______________________________

Emergency Contact: _______________________________ Phone: _____________________________

How did you hear about this clinic? ____

Current health concerns that
have been diagnosed by a physician: ____

Present and Past Medical History: Check all that apply, indicate "**P**" if it is present currently:

☐ AIDS/HIV
☐ Alcoholism
☐ Allergies (food, latex)
☐ Asthma
☐ Birth Trauma
☐ Cancer
☐ Diabetes
☐ Drug Addictions
☐ Emphysema
☐ Fibromyalgia
☐ Heart Disease
☐ Hepatitis A/B/C
☐ Herpes
☐ Joint Replacements
☐ Lyme's Disease
☐ Lymph Nodes removed
☐ Multiple Sclerosis
☐ Pacemaker
☐ Polio
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seasonal Allergies
☐ Seizures
☐ Sinus Infections
☐ Tuberculosis
☐ Operations____
☐ Other____

Family Medical History: (Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis)
Mother: ____
Father: ____
Siblings: ____
Grandparents: ____

Exercise & Energy:
How is your energy? ☐ Low ☐ Up & Down ☐ Exhausted Hyperactive ☐ Abundant
What time of day is your energy: Highest? _______________________Lowest? ______________________
What kind of exercise do you do? _________________________ How often? ____________________________

Emotions & Sleep: (check all that apply):
☐ Panic attacks ☐ Depression ☐ Anxiety ☐ Bad temper ☐ Nervousness ☐ Fear attacks
☐ Poor memory ☐ Difficult concentration ☐ Sadness ☐ Sensitive ☐ Worries ☐ Over-Excited ☐ Angry
How long do you normally sleep? _____________hours per night
I have difficulties with (check all that apply): ☐ Falling asleep ☐ Staying asleep ☐ Dream-disturbed sleep
Falling Asleep is: ☐ Sometimes difficult ☐ Sometimes very difficult ☐ Sleepy in daytime
☐ Always difficult ☐ Always very difficult ☐ Take naps
Waking Up: I wake up at about _____am/pm ☐ Not able to fall asleep again ☐ Take naps

Gastrointestinal: (check all that apply):
☐ Belching ☐ Nausea ☐ Vomiting ☐ Vomiting of blood ☐ Ulcers ☐ Rapid Hungering
☐ Hernia ☐ Anorexia ☐ Bloating ☐ Acid regurgitation ☐ Heartburn ☐ Poor Appetite
☐ Indigestion ☐ Severe stomach pain
Bowel movements: How often? _________time(s)/day _________days/week

Urinary:
Urination: How often? ______ times per day. Color: ☐ Pale yellow ☐ Dark yellow/orange
Number of times per night _________
I have or had (check all that apply): ☐ Trouble starting stream ☐ Frequent urination ☐ Incontinence
☐ Retention ☐ Pain ☐ Burning ☐ Dark Color ☐ Foul smell ☐ Urgent ☐ Cloudy ☐ Difficulty
☐ Dribbling when sneezing ☐ Blood in urine ☐ Kidney stones ☐ Urinary tract infections

Women:
At what age did you start menstruating? ____________ Date of your last period __/__/__
Number of days between cycles: ______________
Number of days of flow: ____________
Color: ☐ Pale red ☐ Dark red ☐ Bright red ☐ Purplish
I have/had (check all that apply): ☐ Irregular menstruation ☐ Heavy flow ☐ Light flow ☐ No flow ☐ Clots
Menstrual pain: ☐ Before flow ☐ During flow ☐ After flow ☐ Abdomen ☐ In the back ☐ Breast

Men: (check all that apply):
☐ Prostatitis ☐ Impotence ☐ Penis blood/mucous discharge
Other: ____

Muscles, Joints & Bones:
Do you have pain or tightness? ☐ No ☐ Yes If so, then where? ______________________________
The pain is (check all that apply): ☐ Sharp ☐ Dull ☐ Aching ☐ Numb ☐ Superficial ☐ Deep Pain
☐ Burning ☐ Tingling ☐ Shooting ☐ Pain worse/better with heat ☐ Pain worse/better with cold
☐ Pain worse/better with pressure ☐ Pain worse in am/pm

Eyes, Ears, Nose, Throat, & Head: (check all that apply):
☐ Frequent colds ☐ Chronic runny nose ☐ Frequent sore throat ☐ Chronic cough ☐ Coughing blood
☐ Cough up mucous ☐ Pain inhaling ☐ Shortness of breath on exertion/at rest ☐ Asthma ☐ Nose bleeds
☐ Painful/red eyes ☐ Poor vision ☐ See spots/floaters ☐ Dizziness ☐ Cold sores ☐ Bleeding gums
☐ Dry mouth ☐ Ear pain ☐ Ringing in ears ☐ Clogged/popping in ears ☐ Frequent headaches/migraines

Cardiovascular: (check all that apply):
☐ Chest pain ☐ Palpitation ☐ Varicose veins ☐ Phlebitis ☐ Cold hands and feet ☐ Irregular heart beat
☐ Poor circulation Other:____

Skin & Hair: (check all that apply):
☐ Dry skin ☐ Skin rashes ☐ Itching ☐ Acne ☐ Eczema ☐ Hives ☐ Hair loss ☐ Premature graying
Other:____

Body: Height: _______________________ Weight: ____________________
Body Temperature: ☐ Feeling cold easily ☐ Cold hands ☐ Cold feet ☐ Alternating hot & cold
☐ Feel hot easily ☐ Hot flash ☐ Sensitive to weather changes

What job/work do you do? ____

Please list the issues that motivated you to make this appointment in order of importance.

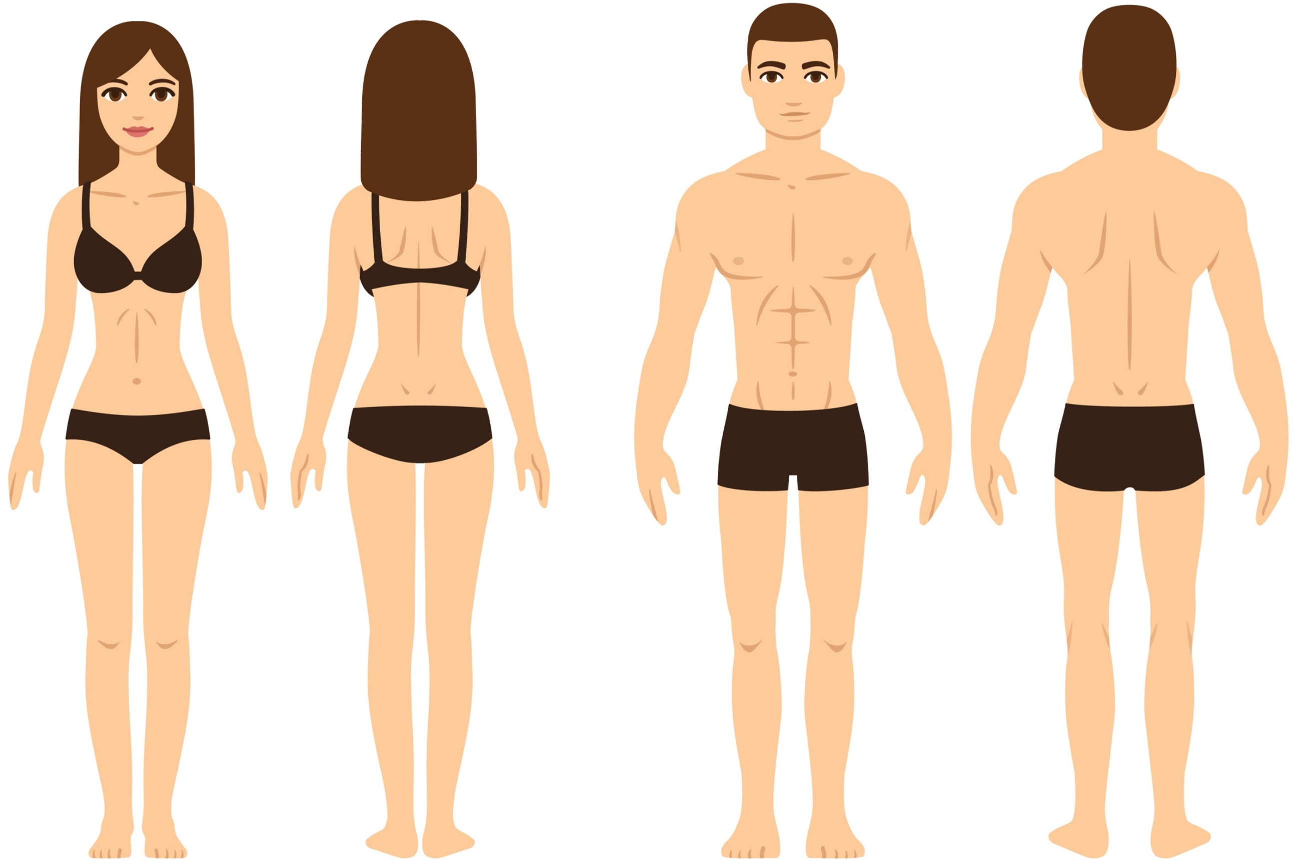
1._________________________________ **4.**_____________________________

2._________________________________ **5.**_____________________________

3._________________________________ **6.**_____________________________

Additional:____

Patient Name:___________________________________



Please show us where it hurts on the diagrams above.

What does your pain feel like?

- ☐ Pain: (circle all that apply: Stiffness / Achy / Sharp / Shooting)
- ☐ Numbness or Tingling
- ☐ Burning
- ☐ Cramping
- ☐ Weakness
- ☐ Dizziness

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Patient Signature Date Provider Signature