



# New Patient Intake Form

Today's Date: \_\_\_\_\_

## General Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Male  Female      Veteran? Yes/No      Height \_\_\_\_\_ Weight \_\_\_\_\_

Married   Single   Partner   Widowed   Divorced      Occupation \_\_\_\_\_

Best Contact Phone \_\_\_\_\_      Second Contact Phone \_\_\_\_\_

Email \_\_\_\_\_      Referred By \_\_\_\_\_

Emergency Contact Name & Phone \_\_\_\_\_

Family Physician \_\_\_\_\_      Contact # \_\_\_\_\_      May we contact? Yes/No

Last complete physical with labs? \_\_\_\_\_      Have you had:  Acupuncture    Chinese Herbal Medicine

Are you under the care of a physician? Yes/No      Who and for what? \_\_\_\_\_

Are you involved with other therapies? Yes/No      Who and for what? \_\_\_\_\_

Up-to date on immunizations? Yes/No      Age-appropriate health screenings? Yes/No

## Focus & Lifestyle

Primary reason for visit today? \_\_\_\_\_

What was the initial cause? \_\_\_\_\_

Onset: Sudden/Gradual      When did it begin? \_\_\_\_\_

What makes it better? \_\_\_\_\_      Worse? \_\_\_\_\_

How does this interfere with daily activities?       Standing       Sitting       Walking       Bending

Emotional       Recreation       Work       Sleeping       Sexuality       Social Life       Relationships

Other \_\_\_\_\_

What therapies have you tried? \_\_\_\_\_

Do you sleep well? Yes/No      Wake up rested: Yes/No      Do you dream? Yes/No      Hours/night \_\_\_\_\_

Energy high point of the day: \_\_\_\_\_      Energy low point of the day: \_\_\_\_\_

Occupational hazards       Tobacco      Type & Frequency \_\_\_\_\_

Stress       Alcohol      Type & Frequency \_\_\_\_\_

Marijuana       Drugs      Type & Frequency \_\_\_\_\_

\_\_\_\_\_       Exercise      Type & Frequency \_\_\_\_\_

Sexually active      Birth Control/STI Prevention Method \_\_\_\_\_

What are your indulgences/cravings? \_\_\_\_\_

What are your hobbies/pleasures? \_\_\_\_\_

What are your health goals? \_\_\_\_\_

Are you interested in:       Pain relief       Performance Care       Maintenance Care       Stress Relief

Preventative Care       Holistic Health       Nutrition       Herbal Therapy       Exercise Therapy

Other \_\_\_\_\_

## Signs & Symptoms

<b>General:</b> <input type="checkbox"/> Chills/Fever <input type="checkbox"/> Prefer hot/cold drinks	<input type="checkbox"/> Cold hands/feet <input type="checkbox"/> Poor/heavy appetite	<input type="checkbox"/> Lack of strength <input type="checkbox"/> Poor circulation	<input type="checkbox"/> Fatigue <input type="checkbox"/> Recent weight loss/gain	<input type="checkbox"/> Night sweat
<b>Head, Ears, Eyes, Nose, Throat:</b> <input type="checkbox"/> Bad Breath <input type="checkbox"/> Eye pain/strain/floaters <input type="checkbox"/> Itchy/red eyes <input type="checkbox"/> Mouth/lip sores <input type="checkbox"/> Dizziness/vertigo	<input type="checkbox"/> Ear pain <input type="checkbox"/> Sore throat <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Swollen glands	<input type="checkbox"/> Sinus pain <input type="checkbox"/> Migraine <input type="checkbox"/> Blurry vision <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Teeth/gum issues	<input type="checkbox"/> Dry mouth/throat <input type="checkbox"/> Headache <input type="checkbox"/> Phlegm <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Thyroid high/low	<input type="checkbox"/> Grinding teeth/TMJ
<b>Heart &amp; Lungs:</b> <input type="checkbox"/> Chest pain/pressure <input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Asthma/wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Short of air	<input type="checkbox"/> Blood clots <input type="checkbox"/> Coughing blood <input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Breast lump/pain <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Bruise easily <input type="checkbox"/> Fainting
<b>Gastrointestinal:</b> <input type="checkbox"/> Diarrhea/cramping/urgency <input type="checkbox"/> Laxative use	<input type="checkbox"/> Abdominal pain/distention <input type="checkbox"/> Gas/belching <input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Peculiar taste	<input type="checkbox"/> Bloody/dark stool <input type="checkbox"/> High/low appetite <input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Acid reflux <input type="checkbox"/> Indigestion <input type="checkbox"/> Constipation
<b>Skin/Hair/Nails:</b> <input type="checkbox"/> Fungal infection <input type="checkbox"/> Profuse/easily sweating	<input type="checkbox"/> Acne <input type="checkbox"/> Hair loss <input type="checkbox"/> Rash	<input type="checkbox"/> Dandruff <input type="checkbox"/> Hives <input type="checkbox"/> Ulcerations	<input type="checkbox"/> Dry/itchy skin <input type="checkbox"/> Poor circulation	<input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis
<b>Genitourinary:</b> <input type="checkbox"/> Incomplete urination <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Unprotected sex	<input type="checkbox"/> Bedwetting <input type="checkbox"/> Kidney stones <input type="checkbox"/> UTI frequency <input type="checkbox"/> Wake to urinate	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Low/high libido <input type="checkbox"/> Urgency <input type="checkbox"/> Venereal disease	<input type="checkbox"/> Frequent urination <input type="checkbox"/> Nocturnal emission <input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Impotence <input type="checkbox"/> Pain
<b>Musculoskeletal:</b> <input type="checkbox"/> Muscle cramps/pain	<input type="checkbox"/> Body heaviness <input type="checkbox"/> Neck/shoulder pain	<input type="checkbox"/> Joint pain <input type="checkbox"/> Numbness	<input type="checkbox"/> Limited use/range of motion <input type="checkbox"/> Upper/Lower back pain	
<b>Neuropsychological:</b> <input type="checkbox"/> Difficult fall/stay asleep <input type="checkbox"/> Seeing therapist	<input type="checkbox"/> Abuse survivor <input type="checkbox"/> Irritable <input type="checkbox"/> Thoughts of hurting self or others	<input type="checkbox"/> Anxiety <input type="checkbox"/> Panic attack	<input type="checkbox"/> Confusion <input type="checkbox"/> Poor memory	<input type="checkbox"/> Depression <input type="checkbox"/> Seizures
<b>OBGYN:</b> Age 1 <sup>st</sup> period _____ PMS Symptoms _____ #Pregnancy _____ #Births _____ Date last period _____ PAP _____	<input type="checkbox"/> Heavy Bleeding Days between periods _____	<input type="checkbox"/> Irregular cycle	<input type="checkbox"/> Painful periods Length period _____ Age Menopause _____	<input type="checkbox"/> Discharge

## Medical History

Allergies to food or medication \_\_\_\_\_

Medications \_\_\_\_\_

Supplements/herbs \_\_\_\_\_

For the following conditions, mark "X" by conditions you have and "F" for a family member:

- |   |   |  |   |                                    |  |
|---|---|--|---|------------------------------------|--|
| <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Mental breakdown   | <input type="checkbox"/> Gonorrhea               | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Cancer    | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Heart attack       | <input type="checkbox"/> Jaundice           | <input type="checkbox"/> HIV/Aids                | <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parasites     |
| <input type="checkbox"/> Blood Transfusion  | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Measles/Mumps      | <input type="checkbox"/> Gout      | <input type="checkbox"/> Diabetes I/II |
| <input type="checkbox"/> Hyper/hypo thyroid | <input type="checkbox"/> Epilepsy/seizures  | <input type="checkbox"/> Heart disease           | <input type="checkbox"/> Syphilis           | <input type="checkbox"/> Obesity   |  |
| <input type="checkbox"/> Kidney stones      | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> High/low blood pressure |   |                                    |  |
| <input type="checkbox"/> Other _____        |   |  |   |                                    |  |

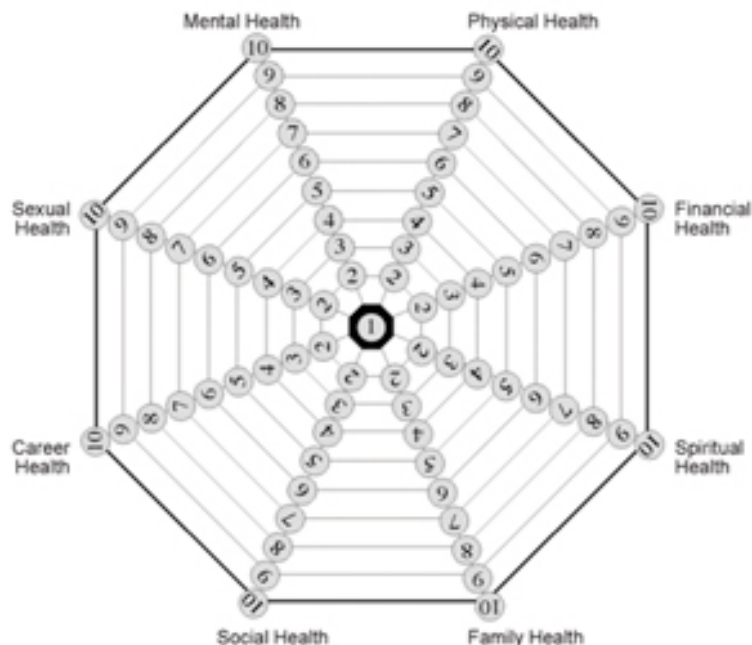
## Web of Wellness

Health and wellness is a balance of several lifestyle components. Many factors affect our lives in various ways and weave a web of health and well being.

Using the diagram to the right, choose your level of satisfaction in each of these areas.

10 = Extremely Satisfied

1 = Unhappy



## Pain

Mark areas of pain, tension, tightness, discomfort

**Pain intensity levels** (indicate which best describes)

None      Moderate      Severe      Excruciating

**Sleep Disturbance**

None      Mild      Severe      Cannot sleep

**Work Impact**

None      25%      50%      Cannot work

**Pain Frequency**

25% of time      50% of time      75% of time      100% of time

**Travel**

Can take long trips      Moderate pain      Cannot travel

**Recreation Impact**

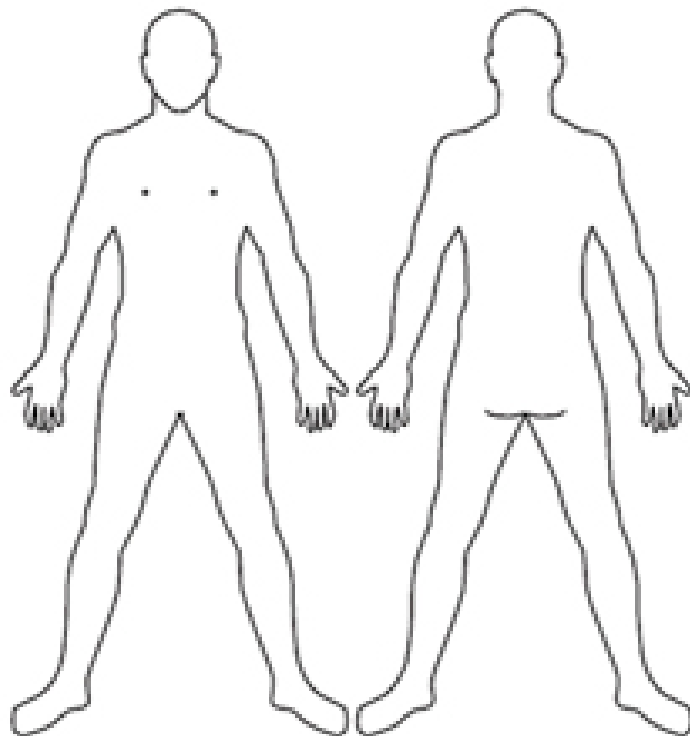
Can participate      Some limitation      No activities

**Walking**

Any distance      <1/2 mile      Cannot walk

**Sitting**

No pain      Some pain      Cannot sit



## Types of Care

According to your signs & symptoms, indicate where your current state of health falls along this Types of Care time line.



### Acute Care

Need immediate help to ease pain, discomfort, and other symptoms fast - most people seek acupuncture at this point.

### Maintenance Care

Facilitates deeper healing. Strengthens the body's response to illness by stimulating natural healing.

### Wellness & Preventative Care

Achieves optimal health and wellbeing, free of disease and illness.