New Patient Intake Form

Name: _____

Address: _____ City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Birth Date: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Marital/Relationship Status: _____

Referred by: _____

Emergency Contact

Name: _____ Phone: _____

Have you tried acupuncture or Chinese medicinals before? YES NO

Reason for visit today: _____

_____

_____

How long have you had this condition? _____

What seemed to be the initial cause? _____

What makes it better? _____ What makes it worse? _____

To what extent does it affect your daily activities? _____

_____

Comments: _____

Are you under the care of a physician now? YES NO Physician's Name: _____

Have you been given a diagnosis by the physician? _____

<u>Past Medical History</u> (if yes, please include dates)

❑AIDS/HIV _____	❑Emphysema _____	❑Pleurisy _____
❑Alcoholism _____	❑Epilepsy _____	❑Pneumonia _____
❑Allergies _____	❑Gout _____	❑Polio _____
❑Appendicitis _____	❑Heart Disease _____	❑Scarlet Fever _____
❑Arteriosclerosis _____	❑Hepatitis _____	❑Seizure _____
❑Asthma _____	❑Herpes _____	❑Stroke _____
❑Birth Trauma _____	❑High Blood Pressure _____	❑STD _____

Past Medical History (cont'd)

❑Cancer_____ ❑Thyroid Disorders_____ ❑MS_____
❑Diabetes _____ ❑Major Trauma_____ ❑TB _____
❑Pacemaker _____ ❑Surgery (List) _____ ❑Other (List) _____
_____ _____
_____ _____
_____ _____

Family Medical History

❑Allergies ❑Cancer ❑High Blood Pressure ❑Other _____
❑Asthma ❑Diabetes ❑Seizure _____
❑Alcoholism ❑Heart Disease ❑Stroke _____

Lifestyle

Describe your typical daily diet: _____
_____
_____

How would you rate your eating habits? ❑Poor ❑Average ❑Excellent
Describe your food intake: ❑Excessive ❑Moderate ❑Insufficient

Please check any of the following habits that apply and write how often and how much you use them.

❑Alcohol _____ ❑Tobacco _____ ❑Coffee or Tea_____
❑Marijuana _____ ❑Drugs _____

List any medications taken within the last two months (drugs, vitamins, herbs, supplements, etc.)
_____
_____
_____

Do you follow a regular exercise program? YES NO If yes, please describe: _____
_____

Do you do any meditation or meditative exercises? _____
_____

Please list any occupational stresses (physical, psychological, chemical): _____
_____

Please check any condition you have experienced in the last six months and indicate the length of time you have had this condition:

General

❑Poor Appetite_____ ❑Poor Sleep_____ ❑Weakness_____ ❑Fever_____
❑Strong Appetite_____ ❑Heavy Sleep_____ ❑Shortness of Breath_____ ❑Chills_____
❑Cravings_____ ❑Disturbing Dreams ❑Edema_____ ❑Night Sweats_____
❑Strong Thirst_____ ❑Fatigue_____ ❑Bruise easily_____ ❑Sweat easily_____
❑Weight Gain_____ ❑Sudden Energy Drop ❑Bleed easily_____ ❑Sweat profusely___
❑Weight Loss_____ ❑Hot Flashes_____ ❑Cold Hands/Feet _____

Head, Eyes, Ears, Nose, Throat

❑Glasses_____ ❑Glaucoma_____ ❑Dry mouth_____ ❑Vertigo_____
❑Eye strain_____ ❑Cataracts_____ ❑Sinus problems_____ ❑Lightheadedness__
❑Eye Pain_____ ❑Teeth problems ❑Excessive phlegm_____ ❑Earaches_____
❑Red eyes_____ ❑Grinding teeth___ ❑Recurrent sore throats__ ❑Ear ringing_____
❑Itchy eyes_____ ❑Jaw pain_____ ❑Swollen glands_____ ❑Poor hearing_____
❑Spots in eyes_____ ❑Facial pain_____ ❑Nose bleeds_____ ❑Blurred vision____
❑Gum problems_____ ❑Night blindness ❑Lip/Tongue sores_____ ❑Migraines_____
❑Peculiar taste in mouth ❑Headaches: where?_____ when?_____

Respiratory

❑Cough_____ ❑Difficulty breathing when lying down_____ ❑Pneumonia_____
❑Asthma_____ ❑Bronchitis_____ ❑Tight chest_____
❑Coughing up blood____ ❑Pain with deep inhalation_____
❑Excessive phlegm: color?_____ Thick or thin?_____

Cardiovascular

❑High blood pressure_____ ❑Chest pain_____ ❑Blood clots_____
❑Irregular heartbeat_____ ❑Low blood pressure_____ ❑Fainting_____
❑Shortness of breath_____ ❑Heart palpitations_____ ❑Phlebitis_____

Gastrointestinal

❑Nausea_____ ❑Diarrhea_____ ❑Burning anus_____ ❑Vomiting_____
❑Constipation_____ ❑Itchy anus_____ ❑Acid regurgitation_____ ❑Hemorrhoids_____
❑Chronic laxative use____ ❑Gas_____ ❑Bloody stools_____ ❑Bloating_____
❑Anal fissures_____ ❑Black stools_____ ❑Rectal pain_____ ❑Belching, hiccups
❑Mucus in stools_____ ❑Bad breath_____ ❑Intestinal pain_____
❑Undigested food in stools_____ ❑Unusual color of stools_____
❑Unusual odor of stools_____
How often do you have a bowel movement?_____
Do you have a tendency toward loose or hard stools?_____

Musculoskeletal

❑Neck pain_____ ❑Hip pain_____ ❑Upper back pain_____ ❑Foot/Ankle pain
❑Shoulder pain_____ ❑Knee pain_____ ❑Lower back pain_____ ❑Hand/wrist pain
❑Muscle weakness_____ ❑Rib pain_____ ❑Muscle pains_____
❑Limited range of motion_____

Any other musculoskeletal problems?_____

Skin and Hair

❑Rashes_____ ❑Eczema_____ ❑Itching_____ ❑Hives_____
❑Psoriasis_____ ❑Dandruff_____ ❑Ulcerations_____ ❑Acne_____
❑Change in hair_____ ❑Hair loss_____ ❑Change in skin texture___ ❑Fungal infections
❑Other problems_____

Neuropsychological

❑Seizures_____ ❑Easily stressed_____ ❑Loss of coordination_____
❑Attempted suicide_____ ❑Numbness_____ ❑Poor memory_____
❑Easily worried_____ ❑Tics_____ ❑Depression_____
❑Irritability_____ ❑Loss of balance_____ ❑Anxiety_____
❑Seeing a therapist_____ ❑Other_____

Genito-urinary

❑Painful urination ❑Incomplete urination ❑Wake to urinate
❑Enlarged prostate ❑Frequent urination ❑Blood in urine
❑Increased libido ❑Decreased libido ❑Impotence
❑Urgent urination ❑Kidney stones ❑Premature ejaculation
❑Inability to hold urine ❑Bedwetting ❑Nocturnal emission

Gynecology

Age at first menses_____ Age at menopause_____
Length of entire cycle (e.g. 28 days) _____ Duration of flow (e.g. 5 days)_____

❑Irregular periods_____ ❑Light menstrual flow_____ ❑Clots_____
❑Unusual periods_____ ❑Heavy menstrual flow_____ ❑Painful periods_____
❑Premenstrual changes_____ ❑Vaginal sores_____ ❑Vaginal odor_____
❑Vaginal discharge (color?)_____ ❑Breast lumps_____

Number of pregnancies_____
Live births_____
Premature births_____
Miscarriages_____
Abortions_____

Describe any problems you had during pregnancy, labor, or delivery_____
_____
_____
Do you use birth control? YES NO If yes, what type?_____
Have you experienced difficulty conceiving? _____

Any other problems you would like to discuss?
_____
_____
_____