NEW PATIENT INTAKE FORM TODAY'S DATE_____

Name Marital Status Birthdate:
Age:
Address M F Height:
Time of Birth:_____
Place of Birth:_____
City, State, Zip
Home Phone_____ Work Phone _____ Occupation:

Emergency Contact:
Referred by:
Reason for Visit Today:

Have you had acupuncture before? Herbs?
Yes No Yes No

How long have you had this condition?
Is it getting worse? Does it bother your: sleep work other (what)
What seemed to be the initial cause?
What seems to make it better?
What seems to make it worse?
Are you under the care of a physician now? What for?
Who is your physician? Physician's phone
Other concurrent therapies?

Family Medical History

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

Your Past Medical History

Circle any of the following conditions you currently have or had in the past.

AIDS or HIV	Diabetes	Multiple Sclerosis	Surgery (list)	Tuberculosis
Alcoholism	Emphysema	Mumps	_____	Typhoid Fever
Allergies	Epilepsy	Pacemaker	_____	Ulcers
Appendicitis	Goiter	Pleurisy	_____	Veneral Dis.
Arteriosclerosis	Gout	Pneumonia	Thyroid Disorders	Whooping Cough
Asthma	Heart Disease	Polio	Major Trauma	Other (specify)
Birth Trauma	Hepatitis	Rheumatic Fever	(Car, fall, etc -list)	_____
(Your own)	Herpes	Scarlet Fever	_____	_____
Cancer	Hi Blood Pres.	Seizures	_____	_____
Chicken Pox	Measles	Stroke	_____	_____

Your Diet (Circle)

Appetite Low	Coffee	Artificial	Sugar	Thirst for water
High	Soft Drinks	Sweetener	Salty Food	# glasses per day _____

Average Daily Menu:

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List Pharmaceuticals taken in past 3 months:
Supplements:

Lifestyle:

Alcohol	Marijuana	Stress	Regular Exercise	
Tobacco	Street Drugs	Occupational Hazards	Type:_____	Frequency_____

General Symptoms:

Poor Appetite	Poor Sleep	Bodily Heaviness	Chills	Bleed or Bruise easily
Heavy appetite	Heavy Sleep	Cold hands or feet	Nightsweats	Peculiar taste Describe
Strongly likes cold	Dream disturb	Poor circulation	Sweats easily	_____
Strongly likes hot	Fatigue	Shortness of breath	Muscle Cramps	_____
Weight loss/gain	Lack of strength	Fever	Vertigo or dizzy	_____

Head, Eyes, Ears, Nose, Throat:

Glasses	Night Blindness	Sores on lips/tongue	Recurrent sore throat	Headaches
Eye pain	Glaucoma	Dry mouth	Swollen glands	Migraines
Red eyes	Cataracts	Excess saliva	Lumps in throat	Concussions
Itchy eyes	Teeth problems	Sinus problems	Enlarged thyroid	Other Head /
Spots in eyes	Grinding teeth	Excess phlegm	Nose bleeds	Neck problems
Poor vision	TMJ	Color of phlegm	Ringing in ears	_____
Blurred vision	Facial pain	_____	Poor hearing	_____
Eye strain	Gum problems	_____	Earaches	_____

Respiratory

Difficulty breathing when lying down	Tight chest	Cough Color of phlegm	Coughs blood
Short of breath	Asthma/wheezes	wet or dry _____	Pneumonia
		thick or thin _____	

Cardiovascular

High Blood Pressure	Low Blood Pressure	Chest Pain	Tachycardia	Phlebitis
Blood clots	Fainting	Breathing problems	Palpitations	Irregular beat

Gastrointestinal

Nausea	Diarrhea	Intestinal pain or cramps	Bowel movements:
Vomiting	Constipation	Itchy anus	
Acid Regurgitation	Laxative use	Burning anus	Frequency_____
Gas	Black stools	Rectal pain	Color _____
Hiccup	Bloody stools	Hemorrhoid	Texture/form_____
Bloating	Mucous in stools	Anal fissures	Odor _____
Bad Breath			

Musculoskeletal

Neck/shoulder pain	Upper back pain	Joint pain	Limit in range of motion
Muscle pain	Low back pain	Rib pain	Limit in use
Knee pain	Hip pain	Elbow pain	
ankle pain	wrist pain		

Skin and Hair

Rashes	Eczema	Dandruff	Change in hair/skin texture	Other hair/skin probl
Hives	Psoriasis	Itching	Fungal Infections	_____
Ulcerations	Acne	Hair loss		_____

Neuropsychological

Seizures	Poor memory	Irritability	Considered/attempted suicide
Numbness	Depression	Easily stressed	Seeing a therapist
Tics	Anxiety	Abuse survivor	Other:_____

Genito-urinary

Pain on urination	Blood in urine	Venereal disease	Increased libido	Impotence
Frequent urine	Can't hold urine	Bedwetting	Decreased libido	Prem Ejac
Urgent urination	Incomplete urine	Wake to urinate	Kidney Stone	Noc Emission

Gynecology

Age menses began	Duration of flow	Vaginal discharge	Breast lumps	Date /last PAP
_____	_____	Color_____	#Pregnancies____	_____
Length of cycle	Irregular periods	Vaginal sores	#Live Births____	" last period
_____	Painful periods	Vaginal odor	Premature Births	_____
	PMS	Clots	Age at Menopause	