New Patient Intake Form Today's Date:

Name: E-Mail Address: Birthdate:
Marital Status: Age:
Address: M☐ F ☐ Ht: Wt:

City/State/Zip:
Home Phone: Alt. Phone: Occupation:
Emergency Contact name and phone:
Referred by:
Reason for visit today: Have you had acupuncture before? yes☐ no☐
Chinese herbal medicine? yes☐ no☐
How long have you had this condition?
Is it getting worse? Does it bother your: sleep☐ work☐ other _____
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? yes☐ no☐ If yes, for what?
Who is your physician? Physician's phone:
Other concurrent therapies:

Health Insurance Company: Policy #
Address Phone
City/State/Zip

Your Medical History (check any of the following that you currently have, or have had in the past)

☐ AIDs/HIV	☐ Diabetes	☐ Multiple Sclerosis	☐ Surgery (list)	☐ Tuberculosis
☐ Alcoholism	☐ Emphysema	☐ Mumps	_____	☐ Thyphoid Fever
☐ Allergies (list below)	☐ Epilepsy	☐ Pacemaker	_____	☐ Ulcers
☐ Appendicitis	☐ Goiter	☐ Pleurisy	_____	☐ Venereal Disease
☐ 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 birth)	☐ Herpes	☐ Scarlet Fever	_____	_____
☐ Cancer	☐ High Blood Pressure	☐ Seizures	_____	_____
☐ Chicken Pox	☐ Measles	☐ Stroke	_____	_____

Allergies: _____
Innoculations: _____

Family Medical History (parents, siblings, grandparents)

☐ Allergies ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure
☐ Seizures ☐ Stroke ☐ Other (list) _____

How many times in an average week do you consume …

Coffee _____ Other caffeinated beverages _____ Soft Drinks _____ Sugar _____

Artificial Sweetener (packs/tsps & type) _____

Do you follow any specific diet or have any food restrictions?

☐ Vegetarian ☐ Vegan ☐ High carb ☐ Low carb ☐ Other _____

Do you regularly consume products that are high in: ☐ sugar ☐ salt

Do you particularly like or have cravings for foods that are: ☐ sour ☐ bitter ☐ sweet ☐ salty

Average Daily Menu

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

Pharmaceuticals taken in the past 2 months: _____

Vitamins/supplements taken in the past 2 months:_____

Lifestyle

☐ Alcohol ☐ Marijuana ☐ Stress ☐ Regular Exercise:
☐ Tobacco ☐ Recreational Drugs ☐ Occupational Hazards Type _____Frequency_____
_____ Type _____Frequency_____

General Symptoms

☐ Poor appetite	☐ Tend to feel cold	☐ Hot flashes	☐ Poor sleep	☐ Sense of heaviness
☐ Heavy appetite	☐ Tend to feel hot	☐ Night sweats	☐ Heavy sleep	☐ Verigo/dizziness
☐ Excessive thirst	☐ Cold hands/feet	☐ Sweat easily	☐ Dream disturbed sleep	☐ Bleed/bruise easily
☐ Prefer cold drinks	☐ Fever	☐ Recent weight gain	☐ Fatigue	☐ Peculiar taste in mouth
☐ Prefer hot drinks	☐ Chills	☐ Recent weight loss	☐ Lack of strength	_____

Head, Eyes, Ears, Nose, Throat

☐ Poor vision	☐ Glasses	☐ Sores on lips/tongue	☐ Recurrent sore throat	☐ Headaches
☐ Eye strain	☐ Night blindness	☐ Dry mouth	☐ Swollen glands	☐ Migraines
☐ Eye pain	☐ Glaucoma	☐ Excessive saliva	☐ Lump(s) in throat	☐ Concussions
☐ Dry eyes	☐ Cataracts	☐ Facial pain	☐ Enlarged thyroid	☐ Other head/neck
☐ Red eyes	☐ Teeth problems	☐ Sinus problems	☐ Nose bleeds	problems:
☐ Itchy eyes	☐ Grinding teeth	☐ Excessive phlegm	☐ Ringing in ears	_____
☐ Floaters/spots in vision	☐ TMJ	Color of phlegm	☐ Poor hearing	_____
☐ Blurred vision	☐ Gum problems	_____	☐ Ear Aches	_____

Respiratory

☐ Shortness of breath	☐ Tight chest	☐ Dry cough	☐ Coughing blood	☐ Other respiratory
☐ Difficulty breathing	☐ Asthma/wheezing	☐ Productive cough:		_____
when lying down	☐ Pneumonia	color of phlegm_____		_____

Cardiovascular

☐ High blood pressure	☐ Chest pain	☐ Heart palpitations	☐ History of heart attack
☐ Low blood pressure	☐ Difficulty breathing	☐ Irregular heartbeat	☐ Other cardiovascular _____
☐ Fainting	☐ Rapid heartbeat	☐ Phlebitis	_____

Gastrointestinal

☐ Nausea	☐ Diarrhea	☐ Intestinal pain/	☐ Crohn's Disease	☐ Other G/I
☐ Vomiting	☐ Loose stools	cramping	☐ Diverticulitis/osis	_____
☐ Acid reflux	☐ Constipation	☐ Itchy anus		
☐ Gas	☐ Laxative use	☐ Burning anus	**Bowel movements**:	
☐ Hiccup	☐ Black Stools	☐ Rectal pain	Daily frequency:_____	
☐ Bloating	☐ Mucous in stools	☐ Hemorrhoid(s)	Texture/form:_____	
☐ Bad breath	☐ Bloody stools	☐ Anal fissures	Color:_____ Odor:_____	

Skin and Hair

☐ Rashes ☐ Eczema ☐ Dandruff ☐ Dry skin ☐ Fungal infection
☐ Hives ☐ Psoriasis ☐ Itching ☐ Oily skin ☐ Other hair/skin
☐ Ulcerations ☐ Acne ☐ Hair loss ☐ Change in hair/ skin texture problems_____
_____

Musculoskeletal

☐ Neck pain ☐ Mid back pain ☐ Muscle cramps ☐ Joint Pain (which joint?)_____
☐ Shoulder pain ☐ Low back pain ☐ Rib pain ☐ Limited use
☐ Upper back pain ☐ Muscle pain ☐ Limited range of motion ☐ Other musculoskeletal_____

Neuropsychological

☐ Seizures ☐ Attention difficulties ☐ Easily stressed ☐ Seeing a therapist
☐ Numbness ☐ Hyperactivity ☐ Depression ☐ Other Neuropsych:
☐ Tics ☐ Irritability ☐ Considered/ attempted suicide _____
☐ Poor memory ☐ Anxiety _____

Genitourinary

☐ Pain on urination ☐ Blood in urine ☐ Wake to urinate ☐ Increased libido ☐ Nocturnal emission
☐ Frequent urination ☐ Incontinence/ # of times/night_____ ☐ Decreased libido ☐ Kidney stone
# of times/day_____ unable to hold urine ☐ Bedwetting ☐ Impotence ☐ Other_____
☐ Urgent urination ☐ Incomplete urination ☐ Venereal disease ☐ Premature ejaculation _____

Gynecology

Date last period began ___/___/___ ☐ Irregular periods # of pregnancies _____
Age menses began _____ ☐ Painful periods # of live births _____
Length of cycle (day 1 to day1) _____ ☐ PMS # of premature births _____
Duration of flow _____ ☐ Clots Age at menopause _____
☐ Vaginal discharge ☐ Breast lumps ☐ Other _____
Color:_____ Odor: _____ ☐ Vaginal sores _____

Other

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