stress free
ACUPUNCTURE

NEW PATIENT INTAKE FORM

First Name:	Last Name:	Middle:	Date:
Home Address:	City:	Zip:	Birthdate: Age:____
Email Address:			Phone: ( )
Emergency Contact Name:	Relationship:		Emergency Phone: ( )

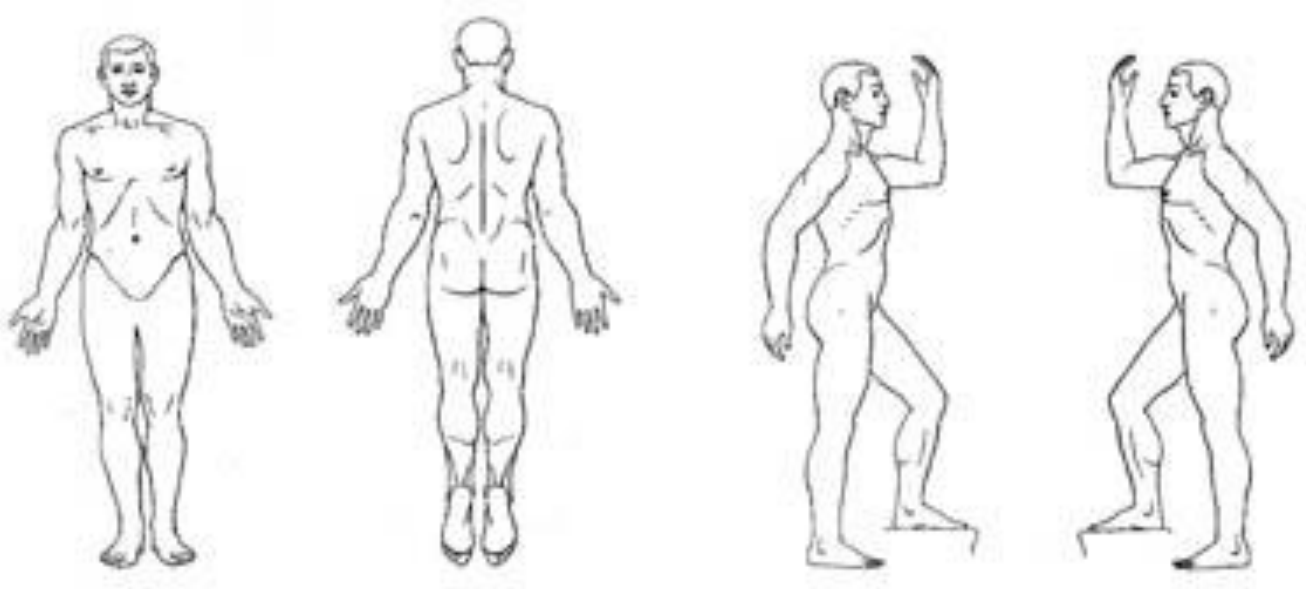
Height:	Weight:	Sex: □ Male □ Female	Occupation:

Is this your first time getting Acupuncture? □ Yes □ No Chinese Herbal Medicine? □ Yes □ No
How was your previous experience? _____
How did you hear about us? _____Referral Name:_____

REASON FOR VISIT: (What you are seeking treatment for)

Chief Complaint:	Any other symptoms:
When did it start?	How did it start?
How does your health condition interfere with your activities of daily living (ADL)?	
What does your body need in order to heal?	What are you healthcare goals?
Please rate your commitment to resolving your chief complaint (0-10) : _____	
Are you prepared to make the appropriate lifestyle changes to meet your goals? □ Yes □ No	

PAIN ASSESSMENT: Are you in pain? □ Yes □ No



----------LOCATION: Please mark the spot where you feel the pain with "X" ----------

Patient Name:_____ Date: _____

Onset:	**When did PAIN first start?**	**□ Acute - All of a sudden** **□ Chronic - Progressive over time**
Palliative/ Provocative:	**What makes PAIN better?**	**What makes PAIN worse?**
Quality:	**What does PAIN feel like?**	**□ Sharp □ Dull □ Aching □ Stabbing** **□ Burning □ Throbbing □ Twisting □ Heavy** **□ Numbness □ Tingling □ Pins and Needles**
Radiation:	**Does the PAIN travel? □ Yes □ No**	**If yes, where does it radiate to?**
Severity:	**□ Mild □ Moderate □ Severe**	**Rate on the PAIN scale (0-10):**_____ (0 = Pain free. 10 = Worst pain possible)
Time:	**When do you feel it most? _____AM/PM** **□ Morning □ Afternoon □ Night**	**□ Constant (90% of the time) □ Frequent (75%)** **□ Intermittent (50%) □ Occasional (25%)**

MEDICAL HISTORY: Primary Care Physician (MD):_____ **Phone**: ( )_____

Current conditions treated for:	Date of Diagnosis:	Medications (dosage):	Health care provider:
1.			
2.			
3.			
4.			
5.			

Please check if any of the following apply to you now or in the past.

□ Allergies (foods, medications, pollen, chemicals) List:_____
□ Skin: □ Herpes □Shingles □ Staph/MRSA □ Ringworm □ Scabies □ Warts/HPV □ Yeast □ Athlete's foot
□ Cardiac Pacemaker □ Bleeding Disorders □ Taking Blood Thinners □ Seizure Disorders □ Fainting Disorder
□ Pregnant □ Trying to get pregnant □ Easily Bruise □ Neuropathy □ Diabetes □ Dementia □ Alzheimer's
□ HIV+/AIDS □ Hepatitis-A □ Hepatitis-B □ Hepatitis-C □ Sexually Transmitted Diseases/STD: _____
□ Heart Disease □ High Blood Pressure □ Low Blood Pressure □ Anemia □ Stroke □ Cancer:_____
□ Kidney Disease □ Bone Disease □ Liver Disease □ Gallbladder Disease □ Autoimmune:_____
□ Asthma □ Tuberculosis □ Lung Disease □ Influenza □Norovirus □ Pneumonia □ Chronic respiratory disease

Any major illnesses, surgeries, hospital stays, injuries, traumas, accidents, implants:	Date/year occurred:
1.	
2.	
3.	
4.	
5.	

List current prescriptions, over the counter medications, supplements, vitamins, herbs, minerals, etc:

Drug Name or Brand Name:	Dosage/Frequency:	Taking it for:	Taking it since:
1.			
2.			
3.			
4.			
5.			

IMAGING/TESTS:	DATE:	RESULTS (area that was imaged):
X-Ray		
MRI		
CT (CAT) Scan		
Ultrasound		
Cholesterol		
Blood Sugar		
Other:_____		

Patient Name:_____ Date:_____

FAMILY MEDICAL HISTORY	Age:	Conditions:	If deceased, cause of death:
1. Mother			
2. Father			
3. Sibling:_____			
4. Maternal Grandparent			
5. Paternal Grandparent			

DIET: Do you have any special diet restrictions? □ Yes □ No Please explain:_____

FOOD	What time did you eat?	What did you eat yesterday?	What do you usually eat?
Breakfast			
Lunch			
Dinner			
Snacks			

DRINK: □ Water _____glasses per day □ Soda _____cans/day □ Coffee _____cups/day
□ Juice_____ □ Energy/caffeine drinks_____ □ Tea_____ Other:_____

LIFESTYLE: Part of any healthy lifestyle or wellness program? □ Yes □ No What kind? _____

Do you EXERCISE? □ Yes □ No Number of days per week: _____ **Minutes each session:** _____

List types of physical activities: _____

What do you do for LEISURE? Hobbies? _____

How many hours do you SLEEP? _____ **Go to bed at:** _____ **Wake up at:** _____ **Insomnia: □ Yes □ No**

Do you SMOKE tobacco? □ Yes □ No How much do you smoke on average? _____

Do you drink ALCOHOL? □ Yes □ No Please explain (type, amount, frequency):_____

List any recreational DRUGS:_____

Do you have any ADDICTIONS? □ Yes □ No Please explain: _____

How is your STRESS level? □ None □ Low □ Moderate □ Severe □ Periodic Rate (0-10): _____

Please explain:_____

Dominant EMOTION: □ Anger □ Fear □ Anxiety □ Overthinking □ Worry □ Sadness □ Depression □ Joy

Based on your daily routines, where do you see your health in 5 years? _____

How would you like to improve in each of these areas of your life? What would you like to change? Explain.

1. Spiritual Health	
2. Mental Health	
3. Physical Health	
4. Relationships	
5. Life Purpose	
6. Moral Health	
7. Environment	
8. Work/Career	
9. Financial Health	

Patient Name: _____ Date: _____

Energy: □ Up and down □ Low energy □ Extreme fatigue □ High energy □ Excess energy at night
□ Wake up tired in the morning □ Tired in the afternoon □ Feels heavy □ Feels cold □ Burned-out

HT: □ Palpitations □ Chest pains □ Mental confusion □ Restlessness □ Anxiety □ Night sweats
□ Insomnia □ Trouble falling asleep □ Trouble staying asleep □ Frequent dreams □ Wake up unrefreshed
□ Fast heart beat (>100 b/m) □ Slow heart beat (<50 b/m) □ Irregular heart beat □ Sores on tip of tongue

SP/PA: □ Abdominal bloating □ Gas/flatulence □ Tired after eating □ Lack of appetite
□ Abrupt weight gain □ Abrupt weight loss □ Indigestion □ No taste □ Sweet taste □ Pale lips □ Dry lips
□ Always worrying □ Over-thinking everything □ Long term memory loss □ Inability to focus/concentrate
□ Weak muscles □ Atrophy of muscles □ Bruise easily □ Hernia:_____ □ Organ prolapse:_____
□Whole body feels heavy □ Fluid retention □ Edema of _____ □ Swollen feet/legs □ Swollen hands
□ Phlegm (color):_____ □ Mental sluggishness □ Brain fog □ Dizziness □ Snoring □ Swollen joints

ST: □ Burning sensation after eating □ Acid reflux (GERD) □ Heartburn □ Ulcers □ Hiccups □ H. Pylori
□ Frequent Belching □ Borborygmus (gurgling noise in the abdomen) □ Always hungry □ Tend to overeat
□ Stomach ache □ Bad breath □ Nausea □ Vomiting □ Sour taste □ Prefers cold or hot food: _____
□ Ulcers/canker sores in the mouth □ Bleeding gums □ Inflamed gums □ Painful gums □ Jaw pain/ TMJ pain
□ Strong thirst □ No thirst □ Thirst for cold drinks □ Thirst for warm drinks □ Desire to drink small sips

LU: □ Chills □ Fever □ Simultaneous chills and fever □ Alternating chills and fever □ Easily catches cold
□ Cough □ Dry cough □ Productive cough □ Coughing blood □ Sinus congestion □ Sneezing □ Wheezing
□ Sore throat □ Shortness of breath □ Difficult inhale □ Difficult exhale □ Weak voice □ Hoarse voice
□ Dry Nose □ Dry throat □ Dry mouth □ Dry skin □ Brittle dry hair □ Nosebleed □ Chest congestion
□ Excessive sweating □ Spontaneous sweating □ Bronchitis □ Pneumonia □ Emphysema □ Pleurisy
□ Overall body aches □ Prolonged period of sadness and Grief □ Skin issues:_____
□ Coughing up mucus (color): □ Clear □ White □ Yellow □ Bloody streaks □ Nasal discharge color:_____

KD: □ Cold hands □ Cold fingers □ Cold feet □ Cold toes □ Feels cold all the time whole body
□ Tendency to feel cold □ Tendency to feel hot □ Sweaty hands □ Sweaty feet □ Sweat easily
□ Lack of sweat □ Night sweats □ Afternoon hot flush □ Hot flashes □ Heat in hands, feet, and chest
□ Always feels thirsty □ Frequent cavities □ Teeth problems □ Sore achy/weak knees □ Low back pain
□ Short term memory loss □ Excessive hair loss □ Premature greying of hair □ Low pitched ringing in ears
□ Poor hearing □ General weakness □ Chronic fatigue □ Kidney stones □ Kidney infection □ KD disease
□ Living in chronic fear □ Easily startled □ Lack of will power □ Lack of drive and determination

UB: □ Incontinence (lack of bladder control) □ Wake up more than once in the middle of night to urinate
□ Scanty urination □ Profuse/excessive urination □ Frequent urination □ Difficult/incomplete urination
□ Urgency to urinate □ Painful urination □ Burning urination □ Weak urine stream □ Bed wetting
□ Dribbling after urination □ Urinary tract infections □ Bladder infections □ Yeast infections
Color of urine: □ Light yellow □ Dark yellow □ Clear □ Cloudy/milky urine □ Reddish urine

INT: How many bowel movements per day?_____ □ Normal is at least one a day, well formed, easy exit
□ Loose stools □ Diarrhea □ Early morning diarrhea □ Constipation □ Chronic laxative use □ Foul smell
□ Hemorrhoids □ Anal fissures □ Rectal pain □ Burning pain □ Tenesmus: urgency but inability to pass stool
□ Incomplete stools □ Stools like rabbit pellets □ Fecal incontinence (inability to control bowel movements)
□ Mucus in stools □ Undigested food in stool □ Blood in stools □ Black tar-like stools □ Dry stools
□ IBS □ Celiac disease (gluten sensitive) □ Diverticulitis (IBD): □ Crohn's disease □ Ulcerative colitis

LV/GB: □ Pain below ribs □ Tightness in chest □ Bitter taste in mouth □ Numbness/tingling sensation
□ Muscle twitching/cramping □ Seizures/convulsions □ Neck/Shoulder tension □ Joint pains □ Lump in throat
□ Dizziness/vertigo □ High pitched ringing in the ears □ Alternating constipation and diarrhea
□ Anger easily □ Depression □ Frustration □ Irritability □ Mood swings □ Feel "wound up" □ Teeth grinding
□ Sighing □ Difficulty planning one's life □ Nervous □ Timid □ Propensity to be startled □ Lack of courage

Patient Name: _____ Date:_____

Eyes: □ Itchy eyes □ Blood shot eyes □ Hot/burning eyes □ Dry eyes □ Watery eyes □ Scratchy/gritty
□ Blurred vision □ Floaters/spots in eyes □ Poor night vision □ Nearsighted □ Farsighted

Headaches: Onset time of day:_____ Better with:_____ Worse with:_____
□ Occipital/back of head □ Forehead/frontal □ Temples/side □ Vertex/top □ Whole head
□ Pain behind the eyes □ Heavy head □ Feels like brain hurts □ Pounding/throbbing headache
□ Muzzy head □ Headache with dizziness □ Stabbing pain like a piercing sharp nail or screw
□ Tension headache like a tight band around the head □ Acute □ Chronic for how long? _____
Migraines: □ Nausea □ Vomiting □ Extreme sensitivity to light and sound □ Aura: _____

Men's Health: □ Enlarged prostate (BPH) □ Hernia □ Premature ejaculation □ Erectile dysfunction
□ Coldness/numbness of genitals □ Painful testicles □ Swollen testicles
□ Low sperm count □ Poor sperm motility □ Low libido □ High libido

Women's Health: □ Pregnant now □ Trying to get pregnant □ Miscarriages:_____ □ Abortions:_____

Normal cycle is 28-32 days and normal period is 3-5 days of bleeding.

Menarche	Cycle	Period	# Pregnancies	# Births	Menopause
Age:	days	days			Age:

Is your menses cycle regular? _____ Current day of cycle if Day 1 is the day you start bleeding? _____
□ Early period (around 7 days earlier) □ Delayed period (around 7 days later) □ Irregular (early and late)
Menses flow: □ Normal □ Heavy □ Light □ Amenorrhea (No period for over 3 months w/o pregnancy)
Blood color: □ Pale red □ Dark red □ Bright red □ Fresh-red □ Purple □ Black □ Brown
Blood quality: □ Congealed blood w/ clots (color): _____ □ Watery blood □ Turbid blood
□ Dysmenorrhea (Painful periods): □ Pain before period □ Pain during period □ Pain after period
□ Vaginal discharge (Leukorrhea) Color: □ White □ Yellow □ Greenish □ Pink □ Yellow + pus/blood
□ Watery discharge □ Thick discharge □ Fishy smell □ Leathery smell

□ Painful intercourse □ Vaginal dryness □ Excess vaginal discharge □ Vaginal itching □ Cramps □ PMS
□ Bleeding or spotting between periods □ Breast lumps □ Breast distention □ Uterine fibroids □ Ovarian cysts
□ Polycystic ovarian syndrome (PCOS) □ Endometriosis □ Infertility □ Hysterectomy (removal of uterus)

□ Menopause: □ Hot flashes □ Night sweats □ Insomnia □ Anxiety/depression □ Mood swings □ Palpitations
□ Problems focusing and learning □ Urinary problems □ Hair loss □ Dry skin □ Vaginal dryness

What questions/concerns do you have?

1.

2.

3.

Thank you for completing this confidential, medical history questionnaire. Your honest, complete answers will assist us in providing you with the best possible health care.

Patient Full Name: _____ (Please print)

Patient Signature: _____ Date: _____

Office Signature: _____ Date: _____