

ACUPUNCTURE NEW PATIENT INTAKE

Date: _____

Name (F) _____ (M) _____ (L) _____

Sex: M / F AGE: _____ DOB _____ Height: _____ Weight: _____

Address, City, State, Zip: _____

Phone: _____ Cell: _____ Status: Single / Married / Divorce / Widowed (circle one)

Occupation: _____ Employer: _____ Phone: _____

Primary Insurance: _____ Insurance type: PPO POS HMO Deductible Amount: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Allergies: (Drug, Food, Environment) _____

Email Address: _____ Who referred you? _____

Present Medical History

Have you been treated with:

- AIDS
- HIV+
- Hepatitis _____

Past Medical History

- Stroke
- Diabetes
- Heart Disease
- High Blood Pressure
- Low Blood Pressure
- Arthritis
- Anemia
- Epilepsy
- Kidney Disease
- Cancer _____
- Asthma
- Other _____

Heart

- High Blood Pressure
- Low Blood Pressure
- Irregular Heartbeat
- Dizziness
- Chest Pain
- Night Sweating
- Insomnia
- Excessive Dreams
- Cold Hands or Feet
- Oversleep
- Swelling of hands or feet
- Palpitations
- Poor Memory
- Easily Awaken

Other _____

Lung

- Cough
- Cough Blood
- Asthma
- Bronchitis
- Pneumonia
- Common Cold
- Loss of voice
- Sinus Problem
- Phlegm
- Depression
- Skin Problems
- Sore Throat
- Spontaneous Sweating
- Pain with deep Breath
- Difficulty in Breathing

Other _____

Spleen & Stomach

- Stomach Pain
- Gas Fullness
- Heartburn
- Over Acids
- Nausea
- Vomiting
- Belching
- Indigestion
- Foul Breath
- Prolapsed
- Bruise(easily)
- Constipation
- Hemorrhoids
- Loose Stool
- Diarrhea
- Abdominal Distention
- Abdominal Pain or Cramps
- Fatigue
- Thirsty

Appetite: _____

Digestion: _____

Bowel Movement : _____ times/day

Family Medical History

(Parent, Grandparent, sister/brother)

- Cancer
- Diabetes
- Heart Disease
- Seizures
- Stroke
- Asthma
- Hypertension
- Hypotension
- Other _____

Liver

- Easily Upset
- Headaches
- Facial Redness
- Easily Sigh
- Bitter Taste in mouth
- Pain in the Ribs
- Dizziness
- Twitching or Spasm of Musc
- Brittle Nail
- Numbness
- Eye Problem

Other _____

Kidney

- Ear Ringing
- Hearing Loss
- Hair Loss
- Lower Back Pain
- Knee Pain
- Joint Pain
- Edema (water Retention)
- Night Urination
- Decreased Sex Drive
- Incontinent
- Urination
- Problem: _____

Other _____

For Men

- Prostate Infection
- Prostate cancer
- Enlarged Prostate
- Impotency

Other _____

Are you taking any medication Y/N What kind ?

1 _____ to treat _____

2 _____ to treat _____

3 _____ to treat _____

4 _____ to treat _____

5 _____ to treat _____

6 _____ to treat _____

7 _____ to treat _____

8 _____ to treat _____

9 _____ to treat _____

10 _____ to treat _____

Use of alcohol: Never / Rarely / Moderate / Daily Use of Tobacco: Never / Rarely / Moderate / Current? Packs/day

Use of drugs: Never/Type/Frequency _____

Previous Hospitalizations/Surgeries/Serious Illnesses ? When?

CHIEF COMPLAINTS:

FOR WOMEN

Menstruation

- None (when stopped _____)
- Abdomen Pain
- Low Back Pain
- Breast Pain
- Excessive Amount
- Normal Amount
- Hot Flash
- Little Amount
- Clots
- Color: _____
- Length of Periods _____ days
- Length of each cycle _____ days

Other Symptoms: _____

Discharge

- Color: _____
- Amount: _____
- Other: _____

Menopause

- Hot Flash
- Night sweating

Pregnancy

- Number of Pregnancies: _____
- Birth: _____
- Premature Birth: _____
- Abortion: _____

Other symptom or Diagnoses: _____

Miscarriage: _____

C-Section: _____