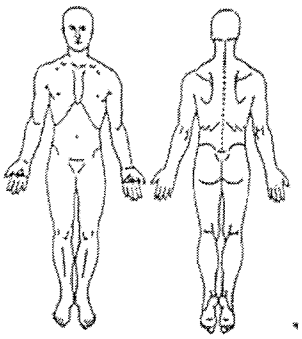
Acupuncture New Patient Intake Form

Name: _____ Date: _____ Social Security #: _____
Date of Birth: _____ Age: _____ Email: _____
Address: _____ City, State, Zip _____
Home Phone#: _____ Work: _____ Cell: _____
Occupation: _____ ☐Please check here if we can email you updates and a newsletter.
Marital Status: ☐M ☐S ☐W ☐D Height: _____ Weight: _____ Allergies: _____
Emergency Contact Name: Phone: _____ Relationship: _____
Physician: (Name)_____ (Phone) _____

General Questions:

PLEASE MARK YOUR AREA OF PAIN



Have you had acupuncture before? ☐Yes ☐No
Chief Complaint: _____
How long have you had this condition? _____
Is it getting worse? ☐Yes ☐No, Does it bother your: ☐Sleep ☐Work ☐Other
What seems to be the initial cause? _____
What seems to make it better? _____
What seems to make it worse? _____
Are you experiencing pain right now? ☐Yes ☐No
Describe your pain: ☐Dull ☐Sharp ☐Stabbing ☐Shooting ☐Burning ☐Other_____
What makes your pain better? ☐Heat ☐Pressure ☐Movement ☐Cold ☐Massage ☐Rest

Family Medical History:

☐Arteriosclerosis ☐Cancer ☐Diabetes ☐Seizures ☐Asthma ☐Heart Disease ☐Stroke
☐Alcoholism ☐High Blood Pressure ☐Other:_____

Are you currently on any medications? ☐No ☐Yes If Yes. Please List: _____
Do you take any vitamins/supplements? ☐No ☐Yes If Yes, Please List: _____

Lifestyle:

☐Alcohol # per day_____ ☐Stress ☐Marijuana
☐Tobacco # per day_____ ☐Drugs ☐Occupational Hazards
☐Regular Exercise:
Type _____ Frequency_____
Type _____ Frequency_____

Your Past Medical History: (Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history)

☐AIDs/HIV ☐Diabetes ☐Measles ☐Thyroid Disorders ☐Alcoholism ☐Emphysema ☐Mumps ☐Tuberculosis
☐Allergies ☐Epilepsy ☐Pacemaker ☐Thyroid Fever ☐Appendicitis ☐Goiter ☐Pneumonia ☐Ulcers
☐Arteriosclerosis ☐Gout ☐Polio ☐Venereal Disease ☐Asthma ☐Heart Disease ☐Rheumatic Fever ☐Whooping Cough
☐Epstein-Barr Virus (Mono) ☐MRI w/Contrast ☐Birth Trauma (Your Birth) ☐High Blood Pressure ☐Scarlet Fever
☐Cancer ☐Herpes ☐Seizures ☐Chicken Pox ☐Hepatitis ☐Stroke

☐ **Major Trauma:**

_____

_____

☐ **Surgery:**

_____

_____

☐ **Other:**

_____

_____