ACUPUNCTURE NEW PATIENT INTAKE

Date:_____

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

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

Address: _____

City: _____ State: _____ Zip:_____

Home Phone:_____ Cell Phone:_____

Cell carrier to receive a text for confirmation calls_____ Email Address:_____

Marital Status: Single / Married / Divorced / Widowed / Other (circle one) Occupation:_____

Emergency Contact: _____ Phone: _____

Whom may we thank for referring you? _____

Family Physician:_____ Phone #:_____

Present Medical History

Past Medical History
- □ Stroke
- □ Diabetes
- □ Heart Disease
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Arthritis
- □ Anemia
- □ Epilepsy
- □ Kidney Disease
- □ Cancer_____
- □ Asthma
- □ Other_____

Family Medical History
(Parent, Grandparent, Sister/Brother)
- □ Cancer _____
- □ Diabetes
- □ Heart Disease
- □ Seizures
- □ Stroke
- □ Asthma
- □ Hypertension
- □ Hypotension

Other_____

Kidney
- □ Night Urination
- □ Decreased Sex Drive
- □ Incontinence
- □ Urination Problems
- □ Other_____

Heart
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Irregular Heartbeat
- □ Dizziness
- □ Chest Pain
- □ Swelling of hands or feet
- □ Other_____

Sleep
- □ Night Sweating
- □ Insomnia
- □ Excessive Dreams
- □ Cold Hands or Feet
- □ Oversleep
- □ Palpitations
- □ Poor Memory
- □ Easily Awaken
- □ Other_____

Ears, Eyes & Nose
- □ Ringing ears
- □ Hearing Loss
- □ Ear Pain
- □ Congested nose
- □ Runny nose
- □ Eye Pain
- □ Blurred vision
- □ Watery eyes
- □ Itchy eyes
- □ Other_____

Lung
- □ Cough
- □ Cough with Blood
- □ Asthma
- □ Bronchitis
- □ Pneumonia
- □ Common Cold
- □ Loss of voice
- □ Sinus Problems
- □ Phlegm
- □ Sore Throat
- □ Pain with deep Breath
- □ Difficulty in Breathing
- □ Other_____

Other
- □ Easily Upset
- □ Headaches
- □ Facial Redness
- □ Easily Sigh
- □ Bitter Taste in mouth
- □ Pain in the Ribs
- □ Dizziness
- □ Twitching or Spasm of Muscles
- □ Brittle Nail
- □ Numbness
- □ Hair Loss
- □ Joint Pain
- □ Edema (water retention)
- □ Bruise(easily)
- □ Other_____

Spleen & Stomach
- □ Stomach Pain
- □ Gas Fullness
- □ Heartburn
- □ Over Acids
- □ Nausea
- □ Vomiting
- □ Belching
- □ Indigestion
- □ Foul Breath
- □ Prolapsed
- □ Constipation
- □ Hemorrhoids
- □ Loose Stool
- □ Diarrhea
- □ Abdominal Distention
- □ Abdominal Pain or Cramps
- □ Fatigue
- □ Thirsty
- □ Other_____

Appetite:_____

Digestion:_____

Bowel Movement :___times/day

For Men
- □ Prostate Infection
- □ Prostate cancer
- □ Enlarged Prostate
- □ Impotency
- □ Other_____

Are you taking any medications? **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_____

Allergies (seasonal/food/animal):_____

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

Use of drugs: Never/Rarely/Moderate/Daily Type _____

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
- □ Other:_____

Pregnancy

- □ Number of Pregnancies:_____
- □ Births:_____
- □ Premature Births:_____
- □ Abortions:_____

Other symptom or Diagnoses: _____

Miscarriages: _____ C-Sections: _____ Other:_____