New Patient Intake Form Date _____

Name: _____ Date of Birth _____ Age _____

Marital Status _____ Occupation _____

Address _____ City _____ State ___

Zip code _____ Phone_____ Email _____

Major Medical Complaint

_____

Surgical History

_____

Reason for visit today

_____

How long have you had condition? _____

Have you tried acupuncture or herbs? (which) _____

Is it getting worse? _____

Does it bother your sleep? _____ Work? _____ Other? (what?) _____

What was initial cause? _____

What makes it better? _____ Worse? _____

Are you under the care of a Physician? _____ If yes, for what? _____

Physician's name and number _____

Other therapies? _____

Health Insurance Info:

Primary Insurance: Health? _____ Auto? _____ Workers Comp? _____

Please supply us with a copy of your insurance card.

Insurance Company Name _____

Address _____ City _____

State _____ Zip _____ Phone _____

Policy # _____ Group # _____

Family Medical History

- ❑ Allergies
- ❑ _____
- ❑ _____
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Cancer
- ❑ _____
- ❑ Diabetes
- ❑ Heart Disease
- ❑ High blood pressure
- ❑ Seizures
- ❑ Stroke

Your Past Medical History

- ❑ Aids/Hiv
- ❑ Alcoholism
- ❑ Allergies
- ❑ Appendicitis
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Birth Trauma (yours)
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Goiter
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Measles
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Seizures
- ❑ Stroke
- ❑ Surgery (list)
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ Thyroid Disorders
- ❑ Major Trauma (car, fall, etc. List)
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other (specify)
- ❑ _____
- ❑ _____

Your Diet

- ❑ Appetite
- ❑ High _____ Low _____
- ❑ Coffee
- ❑ Soft Drinks
- ❑ Do you eat breakfast? _____
- ❑ Typical foods eaten _____
- ❑ Artificial Sweeteners
- ❑ Sugar
- ❑ Salty food
- ❑ Thirst for Water # glasses per day _____

Pharmaceuticals taken in last 2 months

- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

Vitamins/Herbs or Supplements taken in last 2 months

- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

Your Lifestyle

- ❑ Alcohol
- ❑ Tobacco
- ❑ Marijuana
- ❑ Drugs
- ❑ Stress
- ❑ Occupational Hazards
- ❑ Regular Exercise
  - Type__
  - Frequency _____

General Symptoms

- ❑ Poor Appetite
- ❑ Heavy Appetite
- ❑ Strongly dislike cold drinks
- ❑ Strongly dislike hot drinks
- ❑ Recent weight loss or gain
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream disturbed sleep
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Bodily heaviness
- ❑ Cold hands and feet
- ❑ Poor circulation
- ❑ Shortness of breath
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Muscle cramps
- ❑ Vertigo/dizziness
- ❑ Bleed or bruise easily
- ❑ Peculiar taste (describe)
  - _____

Head, Eyes, Ears, Nose, Throat

- ❑ Glasses
- ❑ Eye Strain
- ❑ Eye Pain
- ❑ Red Eyes
- ❑ Itchy Eyes
- ❑ Spots in eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Night Blindness
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Teeth problems
- ❑ Grinding Teeth
- ❑ TMJ
- ❑ Facial pain
- ❑ Gum Problems
- ❑ Sores on lips or tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Sinus Problems
- ❑ Excessive Phlegm
- ❑ Recurrent Sore Throat
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Enlarged thyroid
- ❑ Nose bleeds
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Headaches
- ❑ Migraines
- ❑ Concussions
- ❑ Other head or neck problems

Respiratory

- ❑ Difficulty breathing when lying down
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Asthma/wheezing
- ❑ Cough
- ❑ Coughing blood
- ❑ Pneumonia

Cardiovascular

- ❑ High blood pressure
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Fainting
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Tachycardia
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heartbeat

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Acid regurgitation
- ❑ Gas
- ❑ Hiccup
- ❑ Bloating
- ❑ Bad breath
- ❑ Diarrhea
- ❑ Constipation
- ❑ Laxative use
- ❑ Black stools
- ❑ Bloody stools
- ❑ Mucous in stools
- ❑ Intestinal pain or cramping
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Rectal pain
- ❑ Hemorrhoid
- ❑ Anal fissure
- ❑ Bowel movements
  - Frequency _____
  - Color _____
  - Odor _____
  - Form _____

Musculoskeletal

- ❑ Neck/shoulder pain
- ❑ Muscle pain
- ❑ Upper back pain
- ❑ Low back pain
- ❑ Joint pain
- ❑ Rib pain
- ❑ Limited range of motion
- ❑ Limited use
- ❑ Other _____

Skin and Hair

- ❑ Rashes
- ❑ Hives
- ❑ Ulcerations
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Dandruff
- ❑ Itching
- ❑ Hair loss
- ❑ Fungal infections
- ❑ Other skin/hair problems
  - _____

Neuropsychological

- ❑ Seizures
- ❑ Numbness
- ❑ Tics
- ❑ Poor memory
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily stressed
- ❑ Abuse survivor
- ❑ Considered/attempted suicide
- ❑ Seeing therapist
- ❑ Other
  - _____

Genito-Urinary

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stone
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission

Gynecology

- ❑ Age menses began
  - _____
- ❑ Length of cycle
  - _____
- ❑ Duration of flow
  - _____
- ❑ Irregular periods
- ❑ Painful periods
- ❑ PMS
- ❑ Vaginal discharge
- ❑ Vaginal odor
- ❑ Clots
- ❑ Breast lumps
- ❑ # pregnancies _____
- ❑ # live births _____
- ❑ Age of menopause _____
- ❑ Date of last PAP _____
- ❑ Date of last period _____