New Patient Intake Form *(This is a confidential questionnaire)*

Today's Date:____/____/____

Name: _____
Address:_____
City, Zip:_____
Phone#:_____
Email:_____

☐F ☐M DOB____/____/____
Ht:_____ Wt:_____ Age:_____
# of children:_____ Occupation:_____
Marital status:_____

Have you had acupuncture before?: ☐Y ☐N
Chinese Herbal Medicine?: ☐Y ☐N

Reason for visit today:

If you are in pain, please circle your present pain level:

0 1 2 3 4 5 6 7 8 9 10
no pain — intolerable pain

How long have you had this condition?:_____
Is it getting: worse☐ staying the same☐ better☐
What seems to make it better?
What seems to make it worse?

Does it bother your ☐sleep ☐work ☐other

Did it develop gradually?☐ suddenly?☐
Other concurrent therapies:

All medications you are taking:_____

Supplements:_____

☐Allergies

☐Asthma
☐AIDS/HIV
☐Alcoholism
☐Arthritis
☐Artificial joints
☐Autoimmune dis.
☐Diabetes
☐Fibromyalgia

☐Heart Disease
☐Hepatitis
☐Hypertension
☐High Cholesterol
☐Stroke
☐Seizures
☐Thyroid Problems
☐Pacemaker
☐Pregnant, breast feeding, or planning a pregnancy
☐Cancer:_____

List any other medical conditions you had in the past or currently have:

List surgeries with dates:

List major accidents/injuries with dates:

List any major medical conditions in your family history (parents,grandparents, children):

Lifestyle:

Stress Level:
☐Low
☐Moderate
☐High
☐Excessive

What is causing the stress?:_____

Glasses of water consumed per day:____
Coffee/Tea per day:_____
Alcohol consumption per week:____
Smoker? ☐Yes ☐No
Exercise?☐Yes ☐No
type of exercise:_____
times per week:_____

Trying to lose weight? Y☐ N☐

Women Only:

Length of cycle:____
Duration of flow:____

☐Irregular periods
☐Painful periods
☐PMS
☐Fibroids or cysts
☐Birth control pills

Age of Menopause:____

Symptom Survey:

- ☐ poor appetite
- ☐ heavy appetite
- ☐ like cold drinks
- ☐ like hot drinks
- ☐ recent weight loss
- ☐ recent weight gain
- ☐ poor sleep
- ☐ heavy sleep
- ☐ lots of dreams
- ☐ fatigue
- ☐ lack of strength
- ☐ anxiety
- ☐ poor memory
- ☐ depression
- ☐ body heaviness
- ☐ cold hands & feet
- ☐ poor circulation
- ☐ fever
- ☐ chills
- ☐ night sweats
- ☐ hot flashes
- ☐ sweat easily
- ☐ muscle cramps
- ☐ vertigo/dizziness
- ☐ easily stressed
- ☐ bruise easily
- ☐ headache/migraine
- ☐ breathing difficulty
- ☐ wheezing
- ☐ eye problems
- ☐ night blindness

- ☐ teeth problems
- ☐ grind teeth
- ☐ TMJ
- ☐ facial pain
- ☐ sinus problems
- ☐ chronic sore throat
- ☐ excess phlegm
- ☐ swollen glands
- ☐ ringing in ears
- ☐ poor hearing
- ☐ low blood pressure
- ☐ heart palpitations
- ☐ tachycardia
- ☐ fainting
- ☐ nausea
- ☐ vomiting
- ☐ acid reflux
- ☐ gas
- ☐ hiccup
- ☐ bloating
- ☐ irritability
- ☐ diarrhea
- ☐ constipation
- ☐ blood in stool/urine
- ☐ abd. pain/cramping
- ☐ hemorrhoids
- ☐ kidney stones

- ☐ neck/shoulder pain
- ☐ upper back pain
- ☐ lower back pain
- ☐ joint pain
- ☐ foot pain
- ☐ carpal tunnel
- ☐ skin rash
- ☐ hives
- ☐ eczema/psoriasis
- ☐ acne
- ☐ shingles
- ☐ fungal infection
- ☐ numbness
- ☐ tingling
- ☐ tics
- ☐ frequent urination
- ☐ wake up to urinate
- ☐ decreased libido
- ☐ impotence
- ☐ prostate disorders

Other:_____
_____
_____
_____
_____
_____

◆ *I have read the above information and certify it to be true to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.*

◆ *I understand it is my responsibility to inform this office of any changes in my medical status.*

◆ *I understand that the policy of this office requires payment in full for all services rendered at the time of visit. I authorize the release of any information requested to process the claim.*

◆ *I understand that an appointment commits the physician's time to me and unless 24 hours advanced notice is given, I am financially responsible for canceled or missed appointments.*

_____ ____/____/____

Patient's signature *Date*