New Patient Intake Form

Today's Date_____/_____/_____

Have you had Acupuncture Before? ☐ Yes ☐ No Herbal Medicine? ☐ Yes ☐ No

Reason for Visit Today_____

How long have you had this condition?_____ Is it getting worse? ☐ Yes ☐ No

Does it bother your ☐ Sleep ☐ Work ☐ Other (what?) _____

What seemed to be the initial cause?_____

What seems to make it better?_____

What seems to make it worse?_____

Are you under the care of a physician now? ☐ Yes ☐ No If yes for what?_____

Who is your physician? _____Physician's phone_____

Other concurrent therapies_____

Pharmaceuticals taken past 2 months_____

Other Supplements taken past 2 months_____

Family Medical History

☐Allergies ☐ Cancer

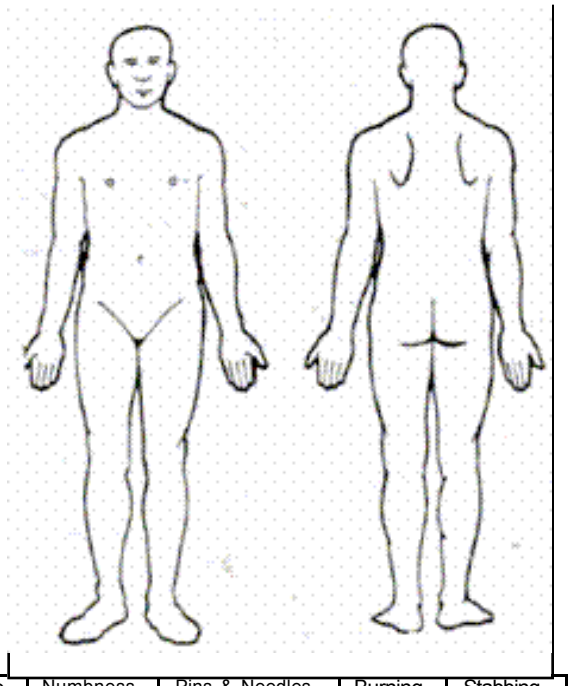
_____ _____

_____ _____

☐Diabetes ☐Seizures

☐Heart disease ☐ Stroke

☐ High blood pressure



Ache	Numbness	Pins & Needles	Burning	Stabbing
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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
☐ Tuberculosis
☐ Measles
☐ Allergies
☐ Seizures
☐ Goiter
☐ Arteriosclerosis
☐ High blood pressure
☐ Chicken Pox
☐ Scarlet Fever
☐ Cancer
☐ Herpes
☐ Other (please specify)

☐ Diabetes
☐ Alcoholism
☐ Mumps
☐ Epilepsy
☐ Ulcers
☐ Pleurisy
☐ Heart disease
☐ Thyroid disorder
☐ Whooping cough
☐ Pneumonia
☐ Rheumatic fever
☐ STD
☐ Surgery

☐ Multiple Sclerosis
☐ Emphysema
☐ Typhoid Fever
☐ Pacemaker
☐ Appendicitis
☐Stroke

☐ Gout
☐ Polio
☐ Asthma

☐ Hepatitis
☐ Major Trauma

_____ _____ _____
_____ _____ _____
_____ _____ _____

Your Lifestyle

☐ Alcohol
☐ Tobacco
☐ Marijuana
☐ Drugs
☐ Stress
☐ Occupational Hazards

Regular exercise
Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms

☐ Poor appetite
☐ Heavy appetite
☐ Strongly like cold drinks
☐ Strongly like hot drinks
☐ Recent weight loss/gain

☐ Poor sleep
☐ Heavy sleep
☐ dream disturbed sleep
☐ Fatigue
☐ Lack of strength

☐ Bodily heaviness
☐ Cold hands & feet
☐ Poor circulation
☐ Shortness of breath
☐ Fever

☐ Chills
☐ Night Sweats
☐ Sweat easily
☐ Muscle cramps
☐ Vertigo or dizziness

☐ Bleed or bruise easily
☐ Peculiar tastes (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
Color of 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
Wet or dry?_____
Thick or thin?_____

☐ 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

☐ Diarrhea
☐ Constipation
☐ Laxative use
☐ Black stools
☐ Bloody stools
☐ Mucous in Stool

☐ Intestinal pain or cramping
☐ Itchy anus
☐ Burning anus
☐ Rectal pain
☐ Hemorrhoid
☐ Anal Fissures

Bowel movements

Frequency _____
Color _____

☐ Bad Breath

Musculoskeletal

☐ Neck/shoulder pain
☐ Muscle pain

☐ Upper back pain
☐ Low back pain

☐ Joint pain
☐ Rib pain

☐ Limited range of motion
☐ Limited use

☐ Other (describe)
_____

Skin and Hair

☐ Rashes
☐ Hives
☐ Ulcerations

☐ Eczema
☐ Psoriasis
☐ Acne

☐ Dandruff
☐ Itching
☐ Hair loss

☐ Change in hair/skin texture
☐ Fungal infections

Other hair/skin problems
_____
_____

Neuropsychological

☐ Seizures
☐ Numbness
☐ Tics

☐ Poor memory
☐ Depression
☐ Anxiety

☐ Irritability
☐ Easily Stressed

☐ Considered/attempted suicide
☐ Seeing a therapist

Other (specify)
_____
_____

Genito-Urinary

☐ Pain on urination
☐ Frequent urination
☐ Urgent urination

☐ Blood in Urine
☐ Unable to hold urine
☐ Incomplete urination

☐ Venereal disease
☐ Bedwetting
☐ Wake to urinate

☐ Increased Libido
☐ Decreased Libido
☐ Kidney stone

☐ Impotence
☐ Premature ejaculation
☐ Nocturnal emission

Gynecology

Age Menses began
_____
Length of cycle (day 1 to 1)
_____

Duration of flow
_____
☐ Irregular periods
☐ Painful periods
☐PMS

☐ Vaginal discharge (color)_____
☐ Vaginal sores
☐ Vaginal odor
☐ Clots

☐ Breast lumps
pregnancies_____
☐ Live births_____
☐ Premature births____.
Age at Menopause_____

☐ Date of last PAP
_____
Date last period began
_____

Other_____

Stop Here

Pulse:_____ Tongue_____

Other:_____

Dx: _____

Points_____

_____

Tx Plan: _____/ Week ☐Based on medical necessity ☐As prescribed by PTP ☐As long as symptoms ☐Maintenance

Modalities: ☐Acupuncture ☐E-Stim ☐I/R ☐Mech. Tract. ☐Man Therapy ☐Cupping ☐Ther/exer

Short term goals: ↓Mms Spasm ↓ Inflammation ↑ROM ↓Pain

Long term goals: ↑Function ↑Strength ↑Balance ↑Stability

Herbs/Formulas:_____

Refer to ☐ Chiro ☐Ortho ☐ Neuro ☐ Internist ☐ Opth ☐ Other_____