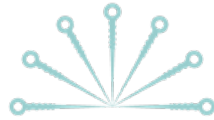

ACUPUNCTURE
STUDIO

# New Patient Intake Form

Name:________________________ Date of Birth:________________ Gender: ☐ Male ☐ Female

Address:___________________________ City:_______________ State:______ Zip:__________

Email Address:______________________________ Phone ______________________________

Emergency Contact: Name____________________________ Phone________________________

How did you hear about this studio?___________________________________________________

**Reason for today's visit:___________________________________________________________**

☐ Yes, I have been treated by acupuncture before. Date of last treatment:___________________

☐ Yes, I am currently under a Physician's care for:_______________________________________

Name of Physician:__________________________ Phone:________________________________

☐ Yes, I am currently taking prescription drugs. Please list below:

| DRUG NAME & DOSAGE | FOR WHAT PURPOSE / CONDITION |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

☐ Yes, I am currently taking supplements and/ or vitamins. Please list below:

| SUPPLEMENT / VITAMIN NAME & AMOUNT | FOR WHAT PURPOSE / CONDITION |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

□Medications-Describe_________________________________________
□Bites/Stings-Describe_________________________________________
□Seasonal-Describe_____________________________________________
□Animals-Describe______________________________________________
□Other-Describe_______________________________________________

**Family Medical History** (Please check if any of the following applies to any family members)

| | | | |
|---|---|---|---|
| □AIDS | □Alcoholism | □Allergies | □Cancer |
| □Asthma | □Diabetes, Type I or II | □Heart Disease | □High Blood Pressure |
| □Seizures | □Stroke | □Mental Illness | □Other:________________ |

**Describe:**

Mother's Health: ____________________________________________ Living/Deceased
Father's Health: ____________________________________________ Living/Deceased
Siblings?______________ Health:______________________________ Living/Deceased
Grandparent's Health: _______________________________________ Living/Deceased

**Personal Health History** (Please check if any of the following apply)

| | | |
|---|---|---|
| □AIDS | □Diabetes | □Hepatitis |
| □Alcoholism | □Emphysema | □High Blood Pressure |
| □Asthma | □Epilepsy | □Multiple Sclerosis |
| □Allergies | □Endocrine Disorder | □Thyroid Disease |
| □Arteriosclerosis | □Gout | □Childhood Fevers |
| □Birth Trauma (yours) | □Heart Disease | □Childhood Illnesses |

□Major Surgeries (Please list all with approx. dates):_____________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

□Significant Trauma (Auto accidents, falls, etc. Please list with approx, date of injury):_________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

**Current Symptoms** (Please check if any of the following apply)

☐Headaches ☐Urination Difficulties ☐Constipation/Diarrhea
☐Vision Problems ☐Infertility ☐Skin Disorders
☐Jaw/Teeth Pain ☐Impotence ☐PMS
☐Ear Pain ☐Muscular Pain ☐Menstrual Disorders
☐Sinus Pain/Problems ☐Joint Dysfunction/Pain ☐Menopausal Problems
☐Throat Pain/Problems ☐ High/Low Blood Pressure ☐Anxiety
☐Breathing Difficulties ☐Depression ☐Chest Pain
☐Chills ☐Overly Emotional ☐Excess Thirst
☐Fever ☐Fatigue ☐Lack of Thirst
☐Indigestion ☐Dizziness ☐Spontaneous Sweating
☐Insomnia ☐Weight Loss ☐Night Sweating
☐Nervousness ☐Weight Gain ☐Lack of Sweating
☐Other:____________________________________________________________

****Please indicate any areas of pain on the diagram located on the back of this form****

**Life Style** (Please check any of the following that apply)

☐Live Alone ☐Work 9-5 ☐Exercise Seldom
☐Live with Spouse/Significant Other ☐Work 2nd Shift ☐Exercise Occasionally
☐Live with Roommate(s) ☐Work 3rd Shift ☐Exercise Often
☐Live with Parents ☐Work Inconsistent Hours ☐Enjoy Hobby
☐Live with Children Manage Own Business ☐Religious
☐Enjoy your Work ☐Unemployed ☐Spiritual Connection
☐Enjoy your Home ☐Student Full Time ☐Student Part Time
☐Enjoy your Social Life ☐Have Family Support ☐Have Financial Support

**Diet and Personal Habits** (Please check if any of the following apply)

☐Currently use Tobacco, # of packs per Day?________ ☐Currently use alcohol, # of drinks per week?_______________
☐Former Tobacco Use, Year Quit?______ ☐Currently use recreational drugs
☐Exercise Regularly ☐Vegetarian
☐Vegan ☐Healthy Diet
☐Eat a lot of Fried Foods ☐Eat a lot of Diary
☐Eat a lot of Sweets ☐Eat a lot of Red Meat
☐Normal eight for Height ☐Underweight
☐Very Overweight ☐Overweight

**Any additional information about yourself** (Please write here)

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Please check if you experience any of the following on a regular basis:

**Head, Eyes, Ears, Nose, Throat**

☐Glasses
☐Night Blindness
☐Eye Strain
☐Eye Pain
☐Red Eyes
☐Itchy Eyes
☐Spots in Eyes
☐Spots in Visions
☐Blurred Vision
☐Glaucoma
☐Cataracts
☐Nosebleeds
☐Heaviness of Head
☐Ear Ringing
☐Hearing Loss
☐Earaches
☐Ringing in Ears
☐Headaches
☐Migraines
☐Concussion
☐Throat Drainage
☐Throat Tickle
☐Sore Throat
☐Swollen Glands
☐Lump in Throat
☐Enlarged Thyroid
☐Teeth Removed
☐Numerous Cavities
☐Teeth Grinding
☐TMJ
☐Gum Problems
☐Lip Sores
☐Mouth Sores
☐Excessive Saliva
☐Facial Pain
☐Facial Numbness
☐Sinus Problem
☐Sinus Drainage

**Respiratory**

☐Difficulty Breathing
☐Shortness of Breath
☐Chronic Cough
☐Acute Cough
☐Tight Chest
☐Asthma
☐Wheezing
☐Pneumonia
☐Pleurisy
☐Phlegm/Congestion
☐Rattling Sound with Breath
☐Can't Sleep Laying Down

**Cardiovascular**

☐Hypertension (High Blood Pressure)
☐Chest Pain
☐Palpitations
☐Slow Heart Rate
☐Blood Clots
☐Rapid Heart Rate
☐Edema (Swelling)
☐Pacemaker
☐Hypertension (Low Blood Pressure)
☐Fainting
☐Irregular Heart Rate

**Gastrointestinal**

☐Nausea
☐Vomiting
☐Acid Regurgitation/Reflux
☐Gas/Flatulence
☐Rectal Pain/Itching
☐Fissures
☐Bowel Movement 1X/Day
☐Bowel Movement Greater Than 1X/Day
☐Diarrhea
☐Constipation
☐Use Laxatives
☐Hiccups
☐Bloating
☐Bad Breath
☐Vomiting Blood
☐Bowel Movement less than 1X/Day
☐Dark Colored Stool
☐Light Colored Stool
☐Mucus in Stools
☐Blood in Stools
☐Use Fiber
☐Use Digestive Enzymes
☐Intestinal Pain
☐Poor Appetite

**Genito-Urinary**

| | | |
|---|---|---|
| □Pain with Urination | □Bed Wetting | □Impotence |
| Frequent Urination | □Wake to Urinate | □Premature Ejaculations |
| □Urgent Urination | □Frequent UTI's | □Nocturnal Emission |
| □Incomplete Urination | □Sexually Transmitted Diseases | □Blood in Urine |
| □Increased Libido (Men) | □Decreased Libido (Men) | □Dribbling |
| □Kidney Stones | | |

**Musculo-Skeletal**

| | | |
|---|---|---|
| □Muscle Weakness | □Chronic Pain (long-term Pain) | □Limited Range of Motion |
| □Muscle Cramps | □Acute Pain | □Arthritis |
| □Muscle Spasms | □Injuries | □General Aches |
| □Joint Pain | □Muscle Atrophy | □Location of Pain____________________ |
| □Joint Instability | □Falls | |

**Neurological**

| | | |
|---|---|---|
| □Fainting/Syncope | □Dizziness | □Vertigo |
| □Drowsiness | □Loss of Balance | □Poor Memory |
| □Tremor | □Convulsions | □Paralysis |
| □Stroke/CV/TIA | □Seizures | □Numbness |

**Neurophysiological**

| | | |
|---|---|---|
| □Depression | □Worry Easily-Anxious | □Abuse Survivor |
| □Irritable | □Unresolved Grief | □Receiving Counseling |
| □Easily Stressed | □Frightened Easily | □Received Counseling |
| □Easily Frustrated | □Numbness | □Poor Memory |

**Skin and Hair**

| | | |
|---|---|---|
| □Rashes | □Psoriasis | □Hair Loss |
| □Hives | □Acne | □Hair Changes |
| □Ulcerations | □Itching | □Hair Breaking |
| □Eczema | □Dandruff | □Thin Slow Growing Nails |
| □Fungal Infection ` | □Premature Graying | □Skin Changes |

**Vitality and Immunes System**

| | | |
|---|---|---|
| □Frequent Colds | □Chronic Mental Cloudiness | □Slow Wound Healing |
| □Frequent Flu | □Low Energy | □Tender/Achy All Over |
| □Less Ability to Adapt | □Lethargic | |

**Gynecology** ☐**N/A**

| | | |
|---|---|---|
| ☐ Pregnant | ☐Decreased Libido | ☐Hysterectomy |
| ☐ Could be Pregnant | ☐Increased Libido | ☐Excess Vaginal Discharge |
| ☐ Pregnancies #______ | ☐PMS | ☐Vaginal Odor |
| ☐ Miscarriages #______ | ☐Pain Before Menstruation | ☐Vaginal Sores |
| ☐ Abortions #_______ | ☐Pain During Menstruation | ☐Vaginal Dryness |
| ☐Pre-Mature Births #___ | ☐Pain After Menstruation | ☐Vaginal Itching |
| ☐Use Birth Control Pills | ☐Bone Density Changes | ☐Vaginal Pain |
| ☐Use Birth Control, Other | ☐Fibrocystic Breasts | ☐Spotting Between Cycles |
| ☐Use No Contraceptives | ☐Breast Lumps | ☐Blood Clots |
| ☐Use Hormone Replacement Therapy | ☐Breast Tenderness | ☐Heavy Bleeding-Weeks |
| ☐ Menopausal | ☐ Mastectomy | ☐ Regular Self Breast Exams |
| ☐ Peri-Menopausal | ☐ Lumpectomy | |

--Age of Menarche ? _____________Years /Old
--Age of Menopause?_____________ Years /Old
--Date of Last PAP?_______________
--Date of Last Mammogram?______________

**Current Menses:**

Length of Cycle?_______ # Days per Month
Duration of Flow?______# Days of Bleeding