

New Patient Intake Form

Welcome! Please fill out the following confidential questionnaire to help me determine the best treatment plan for you.

Name:		Date:
Home Address:		
City	State:	Zip:
Preferred Phone:		
E-mail:		
Occupation		
How did you hear about this office?		
Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Height:	Birth Date: Age:
Marital Status: Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnership <input type="checkbox"/>	Number of Children:	
Emergency Contact:	Phone:	
Have you received acupuncture therapy before? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, when?	With Whom?	
For what condition?		
What are the main issues for which you are seeking treatment today?		
1)		
2)		

Please list any medications you are currently taking.

Medication:	Reason:	How long?

Please list any supplements you are currently taking.

Supplement:	Reason:	How Long?

Please indicate the use and frequency of the following:

	Yes	No	How much? How often?
Coffee/Tea	<input type="checkbox"/>	<input type="checkbox"/>	
Recreational drug	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	
Water	<input type="checkbox"/>	<input type="checkbox"/>	
Soda	<input type="checkbox"/>	<input type="checkbox"/>	

List any allergies, food sensitivities or cravings that you have:

List any accidents, surgeries, or hospitalizations (include year):

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How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad
Significant other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you experienced any of the following signs / symptoms?

No mark = never experience Check mark = sometimes experience Plus sign = frequently experience

<input type="checkbox"/> excessive appetite	<input type="checkbox"/> lack of appetite	<input type="checkbox"/> loose stool/diarrhea	<input type="checkbox"/> headaches
<input type="checkbox"/> digestive problems	<input type="checkbox"/> vomiting/nauseated	<input type="checkbox"/> belching/burping	<input type="checkbox"/> claustrophobia
<input type="checkbox"/> heartburn/reflux	<input type="checkbox"/> bloating	<input type="checkbox"/> nasal problems	<input type="checkbox"/> skin problems
<input type="checkbox"/> low back pain	<input type="checkbox"/> knee problems/pain	<input type="checkbox"/> hearing impairment	<input type="checkbox"/> easily bruised
<input type="checkbox"/> insomnia	<input type="checkbox"/> palpitations	<input type="checkbox"/> cold hands/feet	<input type="checkbox"/> nightmares
<input type="checkbox"/> laughing w/o reason	<input type="checkbox"/> chest pains	<input type="checkbox"/> poor memory	<input type="checkbox"/> vivid dreams
<input type="checkbox"/> sadness/depression	<input type="checkbox"/> eye problems	<input type="checkbox"/> jaundice	<input type="checkbox"/> mental restlessness
<input type="checkbox"/> diff. digesting greasy foods	<input type="checkbox"/> cough	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> dental problems
<input type="checkbox"/> fatigue	<input type="checkbox"/> edema	<input type="checkbox"/> asthma	<input type="checkbox"/> decreased sense of smell
<input type="checkbox"/> ear ringing	<input type="checkbox"/> kidney stones	<input type="checkbox"/> decreased sex drive	<input type="checkbox"/> hair loss
<input type="checkbox"/> gallstones	<input type="checkbox"/> soft/brittle nails	<input type="checkbox"/> easily angered	<input type="checkbox"/> urinary problems
<input type="checkbox"/> bitter taste in mouth	<input type="checkbox"/> difficult making decisions	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> easily/frequently gets sick
<input type="checkbox"/> colitis/diverticulitis	<input type="checkbox"/> constipation	<input type="checkbox"/> depression	<input type="checkbox"/> blood in stool/hemorrhoids
<input type="checkbox"/> usually feel warm	<input type="checkbox"/> usually feel cold	<input type="checkbox"/> anxiety	<input type="checkbox"/> light or clay colored stool
<input type="checkbox"/> dizziness	<input type="checkbox"/> obsession in work, relationships, etc.		

Females:

Age of menarche (1st period):	Age of last period (menopause):
Number of days in cycle:	Number of days of flow:
Color of flow:	Clots? yes <input type="checkbox"/> no <input type="checkbox"/>

Have you been diagnosed with any of the following conditions?

<input type="checkbox"/> Fibroids	<input type="checkbox"/> Fibrocystic Breasts	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Ovarian cysts	<input type="checkbox"/> Pelvic Inflammatory Disease (PID)	<input type="checkbox"/> HPV

Are any of the following associated with your menstrual cycle?

<input type="checkbox"/> Cramping	<input type="checkbox"/> Headaches	<input type="checkbox"/> Discharge	<input type="checkbox"/> Increased appetite
<input type="checkbox"/> Stabbing pain	<input type="checkbox"/> Mood changes	<input type="checkbox"/> Nausea	<input type="checkbox"/> Hot flashes

Date of last gynecologic exam:	Pap smear:
Mammogram:	Results:
Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	# of pregnancies: # of abortions:
Do you wake at night to urinate?	if so, how many times?

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Males:

Date of last prostate exam:

PSA results:

Other lab results

Dribbling urine

Incontinence

Groin pain

Delayed stream

Testicular pain

Decreased libido

Other

Explain:

Do you wake up at night to urinate? Yes No if so, how many times

Is there anything else you would like to explain regarding your condition?

How did you hear about our services?

Cancellation Policy:

Appointments must be cancelled or changed within 24 hours of your appointment time. Without notice, the full cost of the visit will be incurred.

I understand the above cancellation policy (please sign) 