New Patient Intake Form

Salena Hanrahan
acupuncture & herbal medicine

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 ☐ Female ☐ Height:	Birth Date:	Age:
Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnership ☐		Number of Children:
Emergency Contact:		Phone:
Have you received acupuncture therapy before? Yes ☐ No ☐		
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	☐	☐	
Recreational drug	☐	☐	
Tobacco	☐	☐	
Alcohol	☐	☐	
Water	☐	☐	
Soda	☐	☐	

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	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐
Diet	☐	☐	☐	☐	☐
Sex	☐	☐	☐	☐	☐
Self	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Spirituality	☐	☐	☐	☐	☐

Have you experienced any of the following signs / symptoms?

No mark ☐ = never experience | Check mark ☑ = sometimes experience | Plus sign ✚ = frequently experience

☐ excessive appetite	☐ lack of appetite	☐ loose stool/diarrhea	☐ headaches
☐ digestive problems	☐ vomiting/nauseated	☐ belching/burping	☐ claustrophobia
☐ heartburn/reflux	☐ bloating	☐ nasal problems	☐ skin problems
☐ low back pain	☐ knee problems/pain	☐ hearing impairment	☐ easily bruised
☐ insomnia	☐ palpitations	☐ cold hands/feet	☐ nightmares
☐ laughing w/o reason	☐ chest pains	☐ poor memory	☐ vivid dreams
☐ sadness/depression	☐ eye problems	☐ jaundice	☐ mental restlessness
☐ diff. digesting greasy foods	☐ cough	☐ shortness of breath	☐ dental problems
☐ fatigue	☐ edema	☐ asthma	☐ decreased sense of smell
☐ ear ringing	☐ kidney stones	☐ decreased sex drive	☐ hair loss
☐ gallstones	☐ soft/brittle nails	☐ easily angered	☐ urinary problems
☐ bitter taste in mouth	☐ difficult making decisions	☐ high cholesterol	☐ easily/frequently gets sick
☐ colitis/diverticulitis	☐ constipation	☐ depression	☐ blood in stool/hemorrhoids
☐ usually feel warm	☐ usually feel cold	☐ anxiety	☐ light or clay colored stool
☐ dizziness	☐ 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 ☐ no ☐

Have you been diagnosed with any of the following conditions?

☐ Fibroids	☐ Fibrocystic Breasts	☐ Endometriosis
☐ Ovarian cysts	☐ Pelvic Inflammatory Disease (PID)	☐ HPV

Are any of the following associated with your menstrual cycle?

☐ Cramping	☐ Headaches	☐ Discharge	☐ Increased appetite
☐ Stabbing pain	☐ Mood changes	☐ Nausea	☐ Hot flashes

Date of last gynecologic exam:	Pap smear:
Mammogram:	Results:
Are you pregnant? Yes ☐ No ☐	# 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) X