

# New Patient Intake Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Emergency Contact Name & Number: \_\_\_\_\_

## Health Insurance Info:

Insurance Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

## Current Condition:

Age and Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Reason for today's visit: \_\_\_\_\_  
Have you had acupuncture before? Y N Chinese Herbal medicine? Y N  
How long has the condition existed? \_\_\_\_\_  
Is it getting worse? \_\_\_\_\_  
Can you determine the initial cause? \_\_\_\_\_  
Does anything make it better? \_\_\_\_\_  
Does anything make it worse? \_\_\_\_\_  
Are you under a physician's care currently? Y N For what? \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Other Therapies: massage chiropractic naturopath physical therapy other

## Past Medical History: (circle all that apply)

AIDS/ HIV	Alcoholism	Allergies	Appendicitis	Arteriosclerosis	Asthma	Cancer
Chicken Pox	Diabetes	Emphysema	Gout	Heart Disease	Hepatitis	Herpes
Measles	MS	Mumps	Pace Maker	Pneumonia	Seizures	Stroke
Scarlet Fever	Ulcers	Tuberculosis		Thyroid Disorders	High Blood Pressure	

Please List: Surgeries \_\_\_\_\_ Major Traumas \_\_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_\_

## Diet: (circle all that apply)

High Appetite Low Appetite Coffee Soda Sugar Salt Thirst  
Cravings? Y N what? \_\_\_\_\_  
# of glasses of water per day \_\_\_\_\_ Supplements/ Vitamins \_\_\_\_\_

**Lifestyle: (circle all that apply)**

Alcohol      Tobacco      Recreational Drugs      Stress      Work Hazards  
Exercise: Types and Frequency \_\_\_\_\_

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**General Condition: (circle all that apply)**

Likes cold drinks      Likes Hot Drinks      Recent Weight Change      Fatigue Easily  
Poor Sleep      Heavy Sleep      Cold Hands or Feet      Shortness of Breath  
Feverishness      Chills      Night Sweats      Easily Sweats  
Muscle Cramps      Vertigo/Dizziness      Bleed/ Bruise Easily      Bad Breath

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**Ears, Nose and Throat: (circle all that apply)**

Eye strain      Red Eyes      Itchy eyes      Sees Spots      Blurred Vision      Cataracts  
Glaucoma      Grinds Teeth      TMJ      Sores in Mouth      Dry Mouth      Excess Saliva  
Sinusitis      Swollen Glands      Earaches      Nose Bleeds      Ringing in Ears      Migraines

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**Respiratory: (circle all that apply)**

Shortness of Breath      Tight Chest      Asthma/Wheezing      Pneumonia  
Cough?-      wet/dry      phlegm/ no phlegm      thick/thin      color \_\_\_\_\_

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**Cardiovascular: (circle all that apply)**

High Blood Pressure      Blood Clots      Chest Pain      Difficulty Breathing  
Low Blood Pressure      Irreg. Heartbeat      Fainting      Heart Palpitations

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**Gastrointestinal: (circle all that apply)**

Nausea      Vomiting      Heart Burn      Bloating      Bad Breath  
Diarrhea      Constipation      Hemorrhoids      Black Stools      Bloody Stools  
Gas      Itchy Anus      Burning Anus

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**Musculoskeletal: (circle all that apply)**

Neck/shoulder Pain      Upper Back Pain      Lower Back Pain      Joint Pain  
Muscle Pain      Limited Range of Motion      Other \_\_\_\_\_

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**Skin and Hair: (circle all that apply)**

Rashes/Hives      Eczema      Psoriasis      Acne      Dandruff      Itching  
Hair Loss      Fungal Infection      Other \_\_\_\_\_

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**Neuropsychological: (circle all that apply)**

Seizures      Abuse Survivor      Poor Memory      Considered Suicide      Irritability  
Anxiety      Numbness      Seeing a Therapist      Easily Stressed      Depression

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**Genito-urinary: (circle all that apply)**

Urination:      Painful      Frequent      Urgent      Bloody      Incomplete      Incontinence  
                 Venereal Disease      Kidney Stones      Impotence      Bedwetting      Nocturnal Emissions

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**Gynecology: (circle all that apply)**

Irregular Periods      Painful Periods      Vaginal Sores      Vaginal Odor      PMS  
Breast Lumps      Clots  
Age Menses Began \_\_\_\_\_      Length of Cycle \_\_\_\_\_      Duration of Flow \_\_\_\_\_  
Vaginal Discharge Color \_\_\_\_\_      Date of Last Period \_\_\_\_\_  
# of Births \_\_\_\_\_      # of Pregnancies \_\_\_\_\_      Date of Last PAP \_\_\_\_\_