NEW PATIENT REGISTRATION & INTAKE FORM Date: : _____/_____/_____

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. Thank you.

Name:_____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Permission to Email / Call Appt Reminders: Y / N Permission to Email Receipts & Newsletter Y / N
Height: _____ Weight: _____ Occupation: _____
Family Physician: _____ Referred by: _____
Emergency Contact: _____ Emergency Contact Phone: _____
Relationship status (optional): ❑Single ❑ Married/Partnered ❑Separated ❑ Divorced ❑Widowed
Have you been treated by acupuncture or Traditional Chinese Medicine before? ❑ Yes ❑ No

What is/are **the main problem(s**) you would like help with?

_____
_____
_____

On a scale of 0 to 10, how much does this impact your daily life? (0 is no impact and 10 is the most.)
Please Circle: 0 1 2 3 4 5 6 7 8 9 10
How long ago did this problem begin? _____
To what extent does this problem interfere with your daily activities? _____
_____
Have you been given a diagnosis for this problem? If so, what? _____
_____
What kinds of treatment have you tried? _____
_____
Are you under the care of a physician now? Y / N If Yes, for what diagnosis?_____
Name of your Primary Care Physician (PCP)? _____
Clinic Name & Phone#_____

Past Medical History: ❑Cancer_____ ❑High Blood Pressure_____ ❑Thyroid Disease_____
(please include date) ❑Seizures _____❑Rheumatic Fever _____ ❑Heart Disease _____
❑Hepatitis _____❑Venereal Disease _____ ❑Diabetes _____
Your Past Medical History (include only your hospitalizations, illnesses, accidents, traumas, etc.):

_____
_____
_____
_____
_____
Significant Dental Work (type and date): _____
_____
Allergies (drugs, chemicals, foods/results): _____
_____
Family Medical History (check): ❑ Diabetes ❑ High Blood Pressure ❑Stroke ❑Asthma
❑ Cancer ❑ Heart Disease ❑Seizures ❑Allergies ❑ Other: _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

_____

_____

Occupational Stress (chemical, physical, psychological, etc): _____

_____

Do you have a regular exercise program? ❑ Yes ❑ No Please describe: _____

_____

Have you ever been on a restricted diet? ❑ Yes ❑ No What kind? _____

_____

Please describe your average daily diet:
Morning: _____
Afternoon: _____
Evening: _____
How many packs of cigarettes do you smoke per day? _____
How much coffee, tea or cola do you drink per week? _____
How much alcohol do you drink per week? _____
Please describe any use of drugs for non-medical purposes: _____

Please check any symptoms you have had in the last three months:

General

- ❑ Chills
- ❑ Fevers
- ❑ Sweat easily
- ❑ Night sweats
- ❑ Localized weakness
- ❑ Bleed or bruise easily
- ❑ Peculiar tastes or smells
- ❑ Strong thirst (cold or hot)
- ❑ Thirst, no desire to drink
- ❑ Fatigue
- ❑ Sudden energy drop
  Time of day? _
- ❑ Edema
  Where: _____
- ❑ Poor sleeping
- ❑ Tremors
- ❑ Poor balance
- ❑ Cravings
- ❑ Change in appetite
- ❑ Poor appetite
- ❑ Weight gain
- ❑ Weight loss

Skin and Hair

- ❑ Rashes
- ❑ Itching
- ❑ Change in hair or skin
- ❑ Ulcerations
- ❑ Eczema
- ❑ Oozing on skin lesion
- ❑ Hives
- ❑ Pimples
- ❑ Recent moles
- ❑ Loss of hair
- ❑ Dandruff

Other hair or skin problems:

_____

_____

_____

Head, Eyes, Ears, Nose and Throat

- ❑ Dizziness
- ❑ Migraines
- ❑ Headaches
  When: _____
  Where: _____
- ❑ Facial pain
- ❑ Glasses
- ❑ Poor vision
- ❑ Night blindness
- ❑ Blurry vision
- ❑ Color blindness
- ❑ Blind field
- ❑ Spots in front of eyes
- ❑ Eye pain
- ❑ Eye strain
- ❑ Cataracts
- ❑ Eye dryness
- ❑ Excessive tear
- ❑ Discharge from eyes
- ❑ Poor hearing
- ❑ Ringing in ears
- ❑ Earaches
- ❑ Discharge from ear
- ❑ Nose bleeds
- ❑ Sinus congestion
- ❑ Nasal drainage
- ❑ Grinding teeth
- ❑ Teeth problems
- ❑ Jaw clicks
- ❑ Concussions
- ❑ Recurrent sore throats
- ❑ Hoarseness
- ❑ Sores on lips or tongue

Other head or neck problems

_____

_____

_____

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest discomfort/pain
- ❑ Heart palpitations
- ❑ Cold hands or feet
- ❑ Swelling of hands
- ❑ Swelling of feet
- ❑ Blood clots

- ❑ Fainting
- ❑ Difficulty in breathing

Other heart or blood vessel problems _____

_____

_____

Respiratory

- ❑ Shortness of Breath (SOB)
- ❑ Cough
- ❑ Asthma/wheezing
- ❑ Pain with a deep breath
- ❑ Difficulty in breathing when lying down
- ❑ Production of phlegm. What color: _____
- ❑ Coughing blood
- ❑ Pneumonia
- ❑ Bronchitis

Other lung problems: ____

_____

_____

Gastrointestinal

- ❑ Bad breath
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn
- ❑ Belching
- ❑ Indigestion
- ❑ Diarrhea
- ❑ Constipation
- ❑ Chronic laxative use
- ❑ Blood in stools
- ❑ Black stools
- ❑ Abdominal pain or cramps
- ❑ Gas
- ❑ Rectal pain
- ❑ Hemorrhoids

Other stomach or intestinal problems: _____

_____

_____

Genito-Urinary

- ❑ Pain on urination
- ❑ Urgency to urinate
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Decrease in flow
- ❑ Unable to hold urine
- ❑ Dribbling
- ❑ Kidney stones
- ❑ Impotency
- ❑ Change of sexual drive
- ❑ Sores on genitals
- ❑ Do you wake up to urinate? ❑ Yes ❑ No
- ❑ How often: _____
- ❑ Any particular color to your urine? _____

Other genital or urinary system problems: _____

_____

Pregnancy and Gynecology

- ❑ Number of pregnancies: _____
- ❑ Number of births: ____
- ❑ Number of premature births: _____
- ❑ Number of miscarriages: _____
- ❑ Number of abortions: _____
- ❑ Age at first menses: _____
- ❑ Period between menses (days): _____
- ❑ Duration of menses (days): _____
- ❑ First day of last menses: _____
- ❑ Heavy periods
- ❑ Light periods
- ❑ Painful periods
- ❑ Irregular periods
- ❑ Changes in body/psyche prior to menstruation
- ❑ Clots
- ❑ Menopause: Age: _____ Year: ____
- ❑ Vaginal discharge
- ❑ Postcoltal bleeding
- ❑ Vaginal sores. Date of last Pap: _____
- ❑ Breast lumps
- ❑ Nipple discharge
- ❑ Do you practice birth control? ❑ Yes ❑ No

What type and for how long?

_____

_____

Musculoskeletal

- ❑ Neck pain
- ❑ Shoulder pain
- ❑ Back pain
- ❑ Elbow pain
- ❑ Hand/wrist pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Muscle pain
- ❑ Muscle weakness

Neuropsychological

- ❑ Seizures
- ❑ Areas of numbness
- ❑ Weakness
- ❑ Sleep disorder
- ❑ Concussion
- ❑ Bad temper
- ❑ Loss of control/violence potential
- ❑ Vertigo
- ❑ Lack of coordination
- ❑ Depression
- ❑ Easily susceptible to stress
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Anxiety
- ❑ Substance abuse

Have you ever been treated for emotional problems?
❑Yes ❑ No

Have you ever considered or attempted suicide?
❑Yes ❑ No

Other neurological or psychological problems _

_____

_____

Please note the degree of severity of your problem now:

|----------|

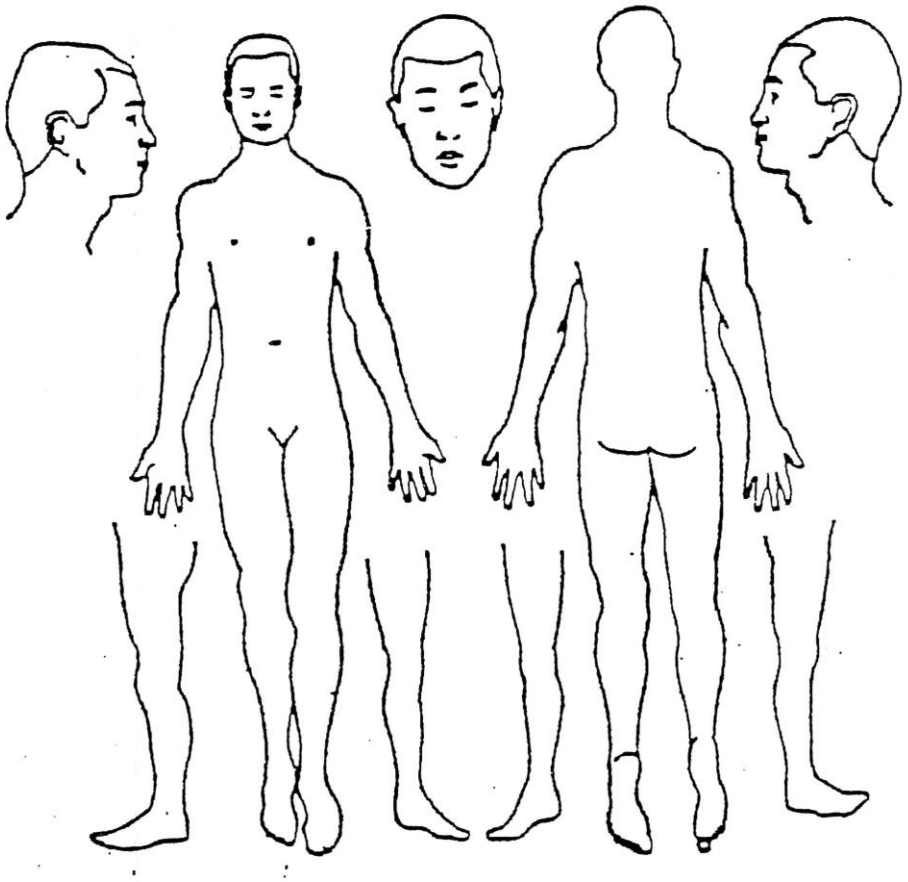
No Problem Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

|----------|

No Problem Worst Imaginable

Indicate painful or distressed areas:



Comments (Please indicate any other problem you would like to discuss): _____

_____

_____

_____

_____

To the best of my knowledge the information provided on this form is true and accurate.

Signature:_____

Printed Name:_____

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