New Patient Intake Form

Name: _____ Date: _____
Address: _____ DOB: _____
City, State, Zip: _____ Home phone: _____
Email: _____ Cell: _____
Occupation: _____ Work phone: _____
Emergency Contact: (name & phone) _____
Referred by:_____ Have you had acupuncture/herbal medicine? _____
Reason for today's visit: _____
How long have you had this condition? _____
What other treatment have you received for this condition? _____
_____
Please list your family physician & phone number:_____
Allergies: _____
Height: _____ Weight: _____

Family History: (mark all that apply)

☐ Arteriosclerosis	☐ Cancer	☐ Hypertension	☐ Asthma
☐ Diabetes	☐ Seizures	☐ Alcoholism	☐ Heart Disease
☐ Stroke			

Your Past Medical History: (mark all that apply)

☐ Aids/HIV	☐ Pacemaker	☐ Alcoholism	☐ Rheumatic Fever
☐ Cancer	☐ Thyroid Disorders	☐ Diabetes	☐ Tuberculosis
☐ Emphysema	☐ Arteriosclerosis	☐ Food allergies	☐ Kidney or Gallstones
☐ Multiple Sclerosis	☐ Stroke	☐ Ulcers	☐ Fractures
☐ Epilepsy/seizures	☐ Venereal Disease	☐ Heart Disease	☐ Seasonal allergies
☐ Hypertension	☐ Hernias	☐ Herpes	☐ Hepatitis

When was your last physical? _____
List any major traumas? _____
Major Surgeries: _____
Have you had a colonoscopy? ☐ Yes / ☐ No An EGD? (for upper digestive tract) ☐ Yes / ☐ No

Please list your current daily medications / supplements: _____
_____
_____

Please describe your average daily menu:

Breakfast : Lunch: Dinner:

☐ Coffee	☐ Tea	☐ Sugar	☐ Artificial sweetener	☐ Chocolate

Do you want information on nutritional counseling to create a healthier lifestyle?

☐ Yes	☐ No	☐ Not at this time

History of Pain

Please rate your pain below using the scale:

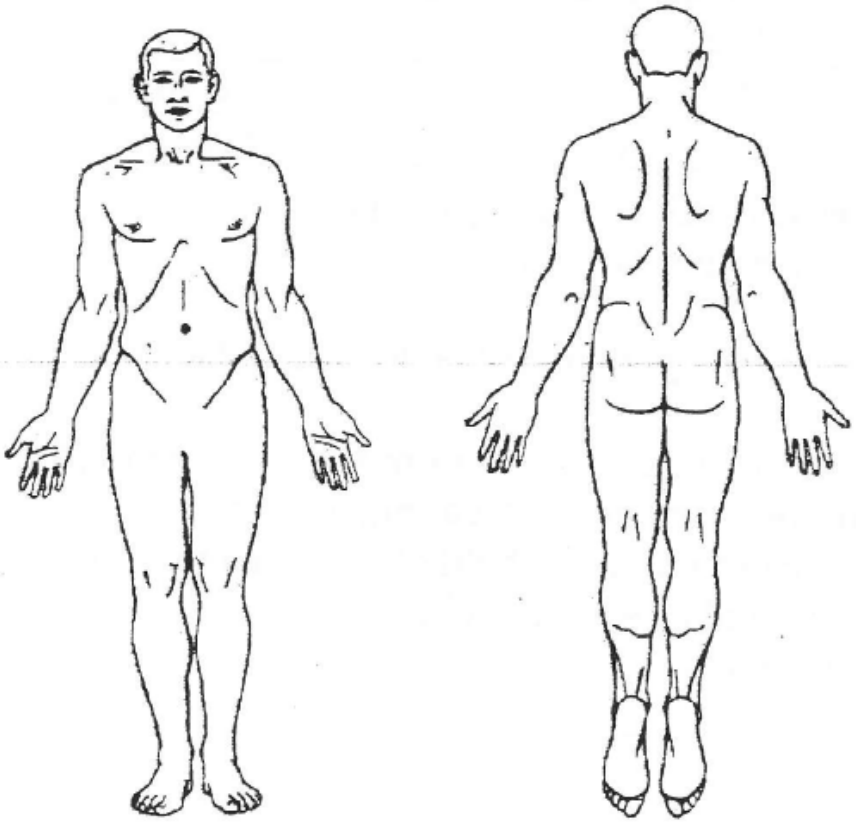
0 = none	5 = moderate	10= severe

0 1 2 3 4 5 6 7 8 9 10 (circle one number or the range)

Please describe your pain. (mark all that apply)

☐ Stabbing/sharp	☐ Dull/aching	☐ Numbness/tingling	☐ Throbbing
☐ Spasm	☐ Burning	☐ Heaviness	☐ Pulling/tight
☐ Fixed Location	☐ Moves around	☐ Pain is constant	☐ Pain comes & goes
☐ Worse in morning	☐ Worse end of day	☐ Worse at night	☐ Better w/movement
☐ Worse w/movement	☐ Interrupts sleep	☐ Worse sitting	☐ Worse standing
☐ Worse lying down	☐ Worse lifting/grasp	☐ Worse w/pressure	☐ Better w/pressure
☐ Better w/heat	☐ Better w/cold	☐ Worse walking	☐ Worse driving

PLEASE MARK THE LOCATIONS OF YOUR PAIN ON THE MODEL BELOW:



Please check all that apply

Respiratory

☐ Cough	☐ Short of breath	☐ Asthma	☐ Chest tightness
☐ Difficult inhale	☐ Difficult exhale	☐ Sneezing	☐ Sinus congestion
☐ Nasal congestion	☐ Sore throat	☐ Frequent colds	☐ Loss of voice
☐ Weak voice	☐ Hoarse voice	☐ Other	

Dizziness

☐ Standing up	☐ Severe, loss of balance	☐ worse w/fatigue

Sweating

☐ Spontaneous	☐ Night	☐ Daytime	☐ Hands & feet
☐ Only head	☐ Only arms/legs	☐ Only hands	☐ Only feet

Head/eyes/ears/throat

☐ Headaches	☐ Frontal	☐ Temple	☐ Back of neck
☐ Top of head	☐ Whole head	Frequency?	☐ Migraines
☐ Bleeding gums	☐ Mouth sores	☐ Tongue sores	
☐ TMJ	☐ Ringing in ears		

Gastrointestinal

☐ Poor appetite	☐ Gnawing hunger	☐ Stomach rumbling	☐ Indigestion
☐ Acid reflux	☐ Nausea/vomiting	☐ Belching	☐ Gas
☐ Bloating/distention	☐ Abdominal pain	☐ Stomach pain	☐ Intestinal pain
☐ Bad breath	☐ Diarrhea	☐ Constipation	☐ Laxative use
☐ Rectal pain	☐ Hemorrhoid	☐ Bitter taste	☐ Always hungry
☐ Sticky sweet taste	☐ Other		

Bowel Patterns

Frequency: _____

Please describe the stool: (mark all that apply)

☐ Soft & formed	☐ Loose pieces	☐ Hard dry	☐ Pebbles
☐ Alternates	☐ Foul odor	☐ Black, tarry	☐ Blood streaked
☐ Stool floats	☐ Other		

Urine patterns

Frequency: _____

☐ Urgency	☐ Pain/burning	☐ Scant amount	☐ Too frequent
☐ Dribbling	☐ Blood in urine	☐ Yellow	☐ Clear
☐ Dark	☐ Cloudy	☐ Incontinent	

Cardiovascular

☐ High blood pressure	☐ Low blood pressure	☐ Palpitations	☐ Chest pain
☐ Dizziness	☐ Irregular heartbeat	☐ Rapid heart rate	☐ Sweat easily

Sleep

☐ Easy to fall asleep	☐ Sleep through night	☐ Difficult to wake up
☐ Difficulty falling asleep	☐ Difficult staying asleep	☐ Vivid disturbed dreams

Up during the night ? ☐ Yes / ☐ No
If Yes then:
Frequency: _____
What wakes you?:_____
What time? _____

Energy level

Please rate your energy level below using the scale:

0 = no energy	10= running a marathon

0 1 2 3 4 5 6 7 8 9 10 (circle one number or the range)

☐ Fatigue	☐ Fatigue on waking	☐ Body feels heavy
☐ Limbs feel heavy	☐ Fatigue, sleepy after eating	

Neuro

☐ Tics	☐ Trembling	☐ Poor memory	☐ Fuzzy thinking
☐ Indecisive	☐ Nervous	☐ Frequent sighing	☐ Easily startled
☐ Depression	☐ Anxiety	☐ Easy anger	☐ Easy irritability

General symptoms

☐ Thirsty all the time	☐ Thirsty but don't drink	☐ Prefer hot drinks only
☐ Prefer cold drinks only	☐ Feel too full to drink	☐ Feel weak, lack of strength
☐ Feel hot mostly	☐ Feel cold mostly	☐ Cold hands/feet
☐ Hot hands/feet	☐ Hot flashes	☐ Feel warm in the evening
☐ Bleed, bruise easily	☐ Nosebleeds	☐ Varicose veins
☐ Dry skin	☐ Itchy skin	☐ Dry scalp
☐ Dry hair	☐ Teeth feel dry	☐ Sticky saliva
☐ Dry mouth	☐ Psoriasis	☐ Eczema
☐ Acne	☐ Rashes	☐ Lymphatic swellings
☐ Nodules, masses	☐ Boils, carbuncles, sores	☐ Hair loss
☐ Easily cracked nails	☐ Nail ridges	☐ Facial edema
☐ Warm in head/chest/neck	☐ Feet swell	☐ Overall edema

Cravings (mark all that apply)

☐ Sweet	☐ Salty	☐ Sour
☐ Spicy/hot	☐ Bitter	☐ Chew ice

Pain issues (mark all that apply)

☐ Muscle spasms	☐ Numbness/tingling	☐ Head/neck	☐ Upper body
☐ Neck tight/tense	☐ Chest	☐ Below the sternum	☐ Along the ribcage
☐ Stomach	☐ Abdominal	☐ Groin	☐ Leg/foot/ankle
☐ Joint pain	☐ Low back	☐ Knee soreness	☐ Bone pain

Social

☐ Single	☐ Partnered	☐ Divorced
☐ Abuse survivor	☐ Considered/attempted suicide	☐ Seeing a therapist

Your lifestyle: (mark all that apply)

☐ Alcohol	☐ Marijuana	☐ Stress
☐ Tobacco	☐ Drugs	☐ Occupational hazards

Regular exercise:_____frequency:_____
Type _____ frequency:_____

For Men: (mark all that apply)

☐ Impotence	☐ Nocturnal emission	☐ Premature ejaculation
☐ Increased libido	☐ Decreased libido	☐ ED

When was your last prostate exam? _____

Gynecology for Women:

Age menses began: _____Length of cycle:_____Duration of flow:_____
# of Pregnancies: _____# Live births: _____Premature births:_____
Date last period began: _____Date of last PAP:_____Age at menopause: _____

☐ Irregular periods	☐ Painful periods	☐ PMS
☐ Small clots	☐ Large clots	☐ Hot flash/night sweats
☐ Increased libido	☐ Decreased libido	☐ Vaginal discharge
☐ Frequent yeast infections		

When was your last complete pelvic exam?_____
Other:
_____

Thank you for completing the questionnaire.