NEW PATIENT CONFIDENTIAL INTAKE FORM

This is a CONFIDENTIAL questionnaire to help determine the the best treatment plan for you.

PERSONAL INFORMATION

Today's Date: _____/_____/_____

Name: _____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Single: ____ Married: ____ Divorced: ____ Widowed: _____ Domestic Partnership: _____

Street Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____

Home Number: (_____) _____-_____ Cell Number: (_____) _____-_____

Work Number: (_____) _____-_____ Email Address: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone Number: (_____) _____-_____

Primary Care Physician (PCP): _____

PCP Phone Number: (_____) _____-_____ City/State:_____

Date of Last Medical Examination: _____/_____

Blood Pressure: _____ /_____ When was this reading taken: _____

Occupation: _____

Have you been treated with acupuncture before? YES _____ NO _____

If Yes, when? _____

For what condition(s) and what was the outcome? _____

_____

CHIEF COMPLAINT

Reason for Today's Visit (please describe your primary issue or health concern):

_____

_____

_____

How long have you had this issue? _____

Have you had a medical evaluation for your condition(s)? Yes No

If yes, when and what was the diagnosis? _____

_____

_____

What other care have you received and/or are receiving to treat your condition?

_____

_____

_____

Does anything improve your condition(s)?

_____

_____

_____

Does anything worsen your condition(s)?

_____

_____

_____

SYMPTOM OVERVIEW BY SYSTEM

Please check all symptoms that you are **CURRENTLY** experiencing and/or **EXPREIENCE FREQUENTLY**

MUSCULOSKELETAL

- ☐ Joint clicking
- ☐ Limited range of motion
- ☐ Pain
- ☐ Stiffness
- ☐ Swelling
- ☐ Weakness

Other_____

_____

RESPIRATORY

- ☐ Chest pain/tightness
- ☐ Cough
- ☐ Coughing up blood (hemoptysis)
- ☐ Shortness of breath (dyspnea)
- ☐ Sore throat
- ☐ Mucus
- ☐ Wheezing

Other_____

_____

CARDIOVASCULAR

- ☐ Chest pain and/or pressure
- ☐ Cold hands/feet
- ☐ Poor circulation
- ☐ Bruise easily
- ☐ Fainting (syncope)
- ☐ Palpitations
- ☐ Fatigue
- ☐ Swelling of ankles and/or legs

Other_____

_____

DIGESTIVE

- ☐ Abdominal distention/bloating
- ☐ Abdominal pain
- ☐ Acid regurgitation and/or heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Rectal bleeding
- ☐ Gas
- ☐ Indigestion
- ☐ Jaundice (yellow tint to skin and/or eyes)
- ☐ Nausea
- ☐ Vomiting
- ☐ No appetite
- ☐ Constant hunger

Other_____

_____

EYES, EARS, NOSE, THROAT

- ☐ Loss of vision
- ☐ Eye pain
- ☐ Tearing
- ☐ Eye dryness
- ☐ Eye redness
- ☐ Ringing in ear
- ☐ Ear discharge
- ☐ Ear itching
- ☐ Ear pain/infections
- ☐ Loss of hearing
- ☐ Ringing/buzzing in ear (tinnitus)
- ☐ Problems with balance (vertigo)
- ☐ Impaired sense of smell
- ☐ Nasal stuffiness
- ☐ Nose bleeds
- ☐ Sinus pain/infections

Other_____

_____

NEUROLOGICAL

- ☐ Confusion
- ☐ Difficulty concentrating
- ☐ Dizziness
- ☐ Dysphasia (impaired ability to speak)
- ☐ Gait Disturbance, balance issues when walking
- ☐ Frequent Headaches
- ☐ Numbness and/or tingling
- ☐ Loss of consciousness/fainting
- ☐ Paralysis
- ☐ Problems coordinating movements
- ☐ Severe forgetfulness
- ☐ Tremors
- ☐ Visual disturbance
- ☐ Weakness

Other_____

_____

PSYCHOLOGICAL

- ☐ Feelings of grief
- ☐ Feelings of sadness
- ☐ Anxiety
- ☐ Difficulty managing anger
- ☐ Feeling manic
- ☐ Feeling worried
- ☐ Feelings of panic
- ☐ Feeling overwhelmed
- ☐ Mood swings
- ☐ Lack of emotion

Other_____

_____

UROGENITAL

- ☐ Incontinence
- ☐ Difficulty w/ flow
- ☐ Dribbling
- ☐ Urgent urination
- ☐ Frequent urination
- ☐ Burning sensation
- ☐ Pain on urination
- ☐ Blood in urine
- ☐ Cloudy urine

Other_____

_____

INTEGUMENTARY (SKIN)

- ☐ Hair loss
- ☐ Dry hair
- ☐ Brittle nails
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dry skin
- ☐ Itching
- ☐ Unusual sweating

Other_____

_____

SLEEP

- ☐ Difficulty falling asleep
- ☐ Wake-up and cannot fall back to sleep
- ☐ Dream disturbed sleep
- ☐ Not rested upon waking in the morning

Other_____

_____

MISCELLANEOUS

- ☐ Extremely low energy/fatigue

Other_____

_____

FOR MEN ONLY

- ☐ Fertility concerns
- ☐ Prostate issues
- ☐ Sexual dysfunction
- ☐ Unusual discharge

Other_____

_____

Do you have a pacemaker or implantable cardioverter defibrillator (ICD)?

YES _____ NO _____

FOR WOMEN ONLY

- ☐ Abnormal vaginal bleeding/bleeding between periods
- ☐ Irregular menstruation
- ☐ Scanty menses
- ☐ No menses
- ☐ Pain with menses
- ☐ Premenstrual symptoms
- ☐ Unusual discharge
- ☐ Fertility concerns
- ☐ Menopausal symptoms
  - ☐ Hot flashes
  - ☐ Night sweats
  - ☐ Loss of sex drive
  - ☐ Vaginal dryness
  - ☐ Age of last menses _____
- ☐ Pelvic pain
- ☐ Sexual dysfunction
- ☐ Pain during or after sexual relations
- ☐ Changes in hair distribution

Other_____

_____

Age at first menses: _____

Start date of last menses: _____/_____

# of days of one cycle: _____

# of days of flow: _____

Are you pregnant OR trying to become pregnant?

YES _____ NO_____

Have you ever been pregnant?

YES _____ NO _____

If YES,

How many pregnancies? _____

How many births? _____

How many miscarriages? _____

How many abortions? _____

Please use the body diagram below to indicate areas of your symptoms. Mark all affected areas using the symbols below on the anatomical diagram.

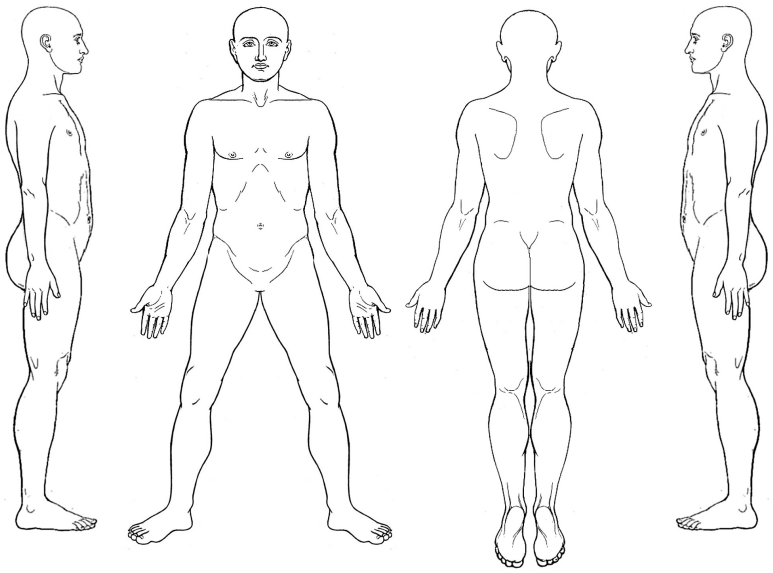
Aching: *****

Burning: XXXXX

Numbness: …..

Pins & Needles: OOOOO

Stabbing: /////



HEALTH HISTORY

Do you have or have you had any of the following?
Please circle "P" for PAST and "C" for CURRENT.

P	**C**	Alcoholism
P	**C**	Allergies
P	**C**	Anemia
P	**C**	Arthritis
P	**C**	Asthma
P	**C**	Bleeding Disorder
P	**C**	Blood Clots
P	**C**	Blood Disease
P	**C**	Cancer
P	**C**	Chronic Fatigue Syndrome
P	**C**	COPD
P	**C**	Diabetes
P	**C**	Eating Disorder
P	**C**	Fibromyalgia
P	**C**	Gall Stones
P	**C**	Heart Disease
P	**C**	Hepatitis/Liver Disease
P	**C**	Herpes
P	**C**	High Blood Pressure
P	**C**	HIV/AIDs
P	**C**	Immune Disorder
P	**C**	Kidney Stones
P	**C**	Low Blood Pressure
P	**C**	Lyme Disease
P	**C**	Mental Illness
P	**C**	Migraines
P	**C**	Multiple Sclerosis
P	**C**	Polio
P	**C**	Poor Memory
P	**C**	Rheumatic Arthritis
P	**C**	Rheumatic Fever
P	**C**	Sciatica
P	**C**	Seizures/Epilepsy
P	**C**	Shingles
P	**C**	Sinus Infection
P	**C**	Stroke
P	**C**	Substance Abuse
P	**C**	Thyroid Disease
P	**C**	Tuberculosis
P	**C**	Ulcer
P	**C**	Venereal Disease/ST

Other_____

_____

Please describe anything significant/traumatic about your birth: _____

_____

_____

Please list in chronological order any diseases, injuries, surgeries, and/or hospitalizations:

Childhood Illnesses (0-12 years):

Age: _____ _____

Age: _____ _____

Age: _____ _____

Adolescence Illnesses (13-17 years):

Age: _____ _____

Age: _____ _____

Age: _____ _____

Adulthood Illnesses (18-35 years):

Age: _____ _____

Age: _____ _____

Age: _____ _____

Adulthood Illnesses (36+ years):

Age: _____ _____

Age: _____ _____

Age: _____ _____

Please list all medications (prescriptions, over-the-counter drugs), supplements and herbs you are taking:

Medication, Supplements, Herbs:	For What Issue/Concern:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family (e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.)

Mother: _____

Father: _____

Siblings: _____

Maternal Grandparents: _____

Paternal Grandparents: _____

LIFESTYLE INFORMATION

Please indicate the use and frequency of the following:

Alcohol	YES _____	NO _____	How often? _____
Recreational Drugs	YES _____	NO _____	How often? _____
Prescription drugs not prescribed by your physician	YES _____	NO _____	How often? _____
Tobacco	YES _____	NO _____	How often? _____
Coffee/Tea (caffeinated)	YES _____	NO _____	How often? _____
Exercise	YES _____	NO _____	How often? _____