Acupuncture New Patient Intake

Name____Date of Birth_______________Today's Date________________

Referred By_____________________________Have you had acupuncture before? ☐ Yes ☐ No

Reason for today's visit____

____

How long have you had this condition?____

What was the initial cause?____

____

Is it getting worse?______________________ Does it bother your ☐ Sleep ☐ Work ☐ Other ______________________

What seems to make it better?____

What seems to make it worse?____

Are you under the care of a physician for this condition?____

Other concurrent therapies____

____

Medications and Supplements, please list____

____

____

____

Height__________Weight___________

Health History

Musculoskeletal

- ☐Neck/Shoulder pain
- ☐Muscle pain
- ☐Upper back pain
- ☐Low back pain
- ☐Joint pain
- ☐Rib pain
- ☐Limited range of motion
- ☐Limited use

Neuropsychological

- ☐Seizures
- ☐Numbness
- ☐Tingling
- ☐Tics
- ☐Poor memory
- ☐Depression
- ☐Anxiety
- ☐Irritability
- ☐Easily stressed
- ☐Abuse survivor
- ☐Considered/attempted suicide
- ☐Seeing a therapist

Head, Eyes, Ears, Nose, Throat

- ☐Glasses/Correction
- ☐Eye strain
- ☐Eye pain/itchy
- ☐Eye dryness
- ☐Spots in eyes
- ☐Poor vision
- ☐Blurred vision
- ☐Eye redness
- ☐Night blindness
- ☐Glaucoma
- ☐Cataract
- ☐Teeth problems
- ☐Grinding teeth
- ☐TMJ
- ☐Facial pain
- ☐Gum problems
- ☐Mouth/gum sores
- ☐Dry mouth
- ☐Excessive saliva
- ☐Sinus problems
- ☐Excessive phlegm

Color___________________
- ☐Headaches
- ☐Migraines
- ☐Recurrent sore throat
- ☐Swollen glands
- ☐Lump in throat
- ☐Enlarged thyroid
- ☐Nose bleeds
- ☐Ringing in ears
- ☐Poor hearing
- ☐Earaches

Cardiovascular

- ☐High Blood Pressure
- ☐Blood clots
- ☐Low Blood Pressure
- ☐Fainting
- ☐Chest pain
- ☐Difficulty breathing
- ☐Phlebitis
- ☐Tachycardia
- ☐Heart palpitations
- ☐Irregular heartbeat

Respiratory

- ☐Difficulty breathing when lying down
- ☐Shortness of breath
- ☐Tight chest
- ☐Asthma/wheezing
- ☐Cough

Wet or Dry?_____________
Thick or thin?___________
Color___________________
- ☐Coughing blood
- ☐Pneumonia

Gastrointestinal

- ☐Nausea
- ☐Vomiting
- ☐Acid reflux
- ☐Gas
- ☐Hiccup
- ☐Belching
- ☐Bad breath
- ☐Diarrhea
- ☐Constipation
- ☐Laxative use
- ☐Black stool
- ☐Blood in stool
- ☐Mucus in stool
- ☐Intestinal pain/cramps
- ☐Itchy anus
- ☐Burning anus
- ☐Rectal pain
- ☐Hemorrhoid
- ☐Anal fissure

Bowel movements:
Frequency_______________
Color___________________
Texture: Formed/Loose
Other___________________
Odor___________________

Genito-Urinary

- ☐Pain on urination
- ☐Frequent urination
- ☐Urgent urination
- ☐Bedwetting
- ☐Blood in urine
- ☐Unable to hold urine
- ☐Incomplete urination
- ☐Wake to urinate
- ☐Venereal disease
- ☐Kidney stone
- ☐Decreased libido
- ☐Increased libido
- ☐Impotence
- ☐Premature ejaculation
- ☐Nocturnal emissions

Skin & Hair

☐Rashes
☐Hives
☐Urticaria
☐Eczema
☐Psoriasis
☐Acne
☐Dandruff
☐Itching
☐Hair loss
☐Change in hair or skin texture
☐Fungal infections

General Symptoms

☐Poor Appetite
☐Heavy Appetite
☐Prefer cold drinks
☐Prefer hot drinks
☐Recent weight gain or loss
☐Poor Sleep
☐Heavy Sleep
☐Dream disturbed sleep
☐Fatigue
☐Lack of strength
☐Bodily heaviness
☐Cold hands/feet
☐Poor circulation
☐Shortness of breath
☐Fever
☐Peculiar taste
☐Chills
☐Night Sweats
☐Sweats easily
☐Muscle cramps
☐Vertigo or dizziness
☐Bleed or bruise easily

Your Past Medical History **(check any conditions you currently have or have had in the past)**

☐AID/HIV
☐Alcoholism
☐Allergies
☐Appendicitis
☐Arteriosclerosis
☐Asthma
☐Birth Trauma (your own birth)
☐Cancer
☐Chicken Pox
☐Diabetes
☐Emphysema
☐Epilepsy
☐Goiter
☐Gout
☐Heart Disease
☐Hepatitis
☐Herpes
☐HighBloodPressure
☐Measles
☐Multiple Sclerosis
☐Mumps
☐Pacemaker
☐Pleurisy
☐Pneumonia
☐Polio
☐Rheumatic Fever
☐Scarlet Fever
☐Seizures
☐Stroke
☐Surgery (list)
____
____
____
____
____
☐Thyroid Disorder
☐Major Trauma (car, fall, etc. - list)
____
____
____
☐Tuberculosis
☐Typhoid Fever
☐Ulcers
☐Venereal Disease
☐Whooping Cough
☐Other (list)
____
____
____
____
____

Family Medical History

☐ Allergies____

☐ Atherosclerosis. ☐ Asthma ☐ Alcoholism

☐ Diabetes

☐Cancer____

☐ Heart Disease. ☐ High Blood Pressure ☐ Seizures ☐ Stroke

Your Lifestyle

☐ Alcohol
☐ Tobacco
☐ Vape
☐Marijuana
☐Drug use
☐Stress
☐Occupational Hazards

Regular Exercise:
____
____
____
___

Your Dietary Habits

Appetite ☐Low ☐High ☐Moderate	☐Coffee ☐Soft Drinks	☐Artificial sweeteners ☐Sugar ☐Salty foods	Thirst for water #glasses per day: ____________		

Average Daily Diet

Morning	Snack	Noon	Snack	Evening	Snack
____________ ____________ ____________ ___	____________ ____________ ____________ ___	____________ ____________ ____________ ___	____________ ____________ ____________ ___	____________ ____________ ____________ ___	____________ ____________ ____________ ___

Gynecology

Age menses began ____________________ Cycle Length (day 1 today 1) ____________________days Date last period began ____________________	Duration of flow ________________days ☐Irregular periods ☐Painful periods ☐PMS ☐Painful intercourse	☐Vaginal discharge color______________ ☐Vaginal sores ☐Vaginal odor ☐Clots in menses ☐Breast lumps	#Pregnancies__________ #Live births___________ Premature births________ Age at menopause_______ Date of last PAP ____________________

Pain Assessment

Please mark the areas of your body where you feel pain on the diagrams above.
Indicate using a pain scale of 1-10 the degree of pain and discomfort you feel for each area.