NEW PATIENT INTAKE

All information is confidential and under HIPPA compliance

Date:___________

Name (F) ___________________________(M)________________(L)_______________________________ Sex: M / F

AGE: ____ DOB____/____/________Height:______Weight:______ Email : ____

Address: ____City:_______________________State: ______ Zip: __________

Contact Phone: (H)_______________________(C)___________________________ (W)_______________________________

Emergency Contact: ____________________________ Relation: _______________________ Phone: ____________________

Who referred you? ____

Or circle one: T.V. / Website / Newspaper / Magazine / Facebook / Google / Acupuncture Directory

Allergies: (Drug, Food, Environment) ____

Present Medical History

Have you been treated with:

- ☐ AIDS
- ☐ HIV+
- ☐ Hepatitis___________

Past Medical History

- ☐ Stroke
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Arthritis
- ☐ Anemia
- ☐ Epilepsy
- ☐ Kidney Disease
- ☐ Cancer_______________
- ☐ Asthma

Other___________________

Family Medical History

(Parent, Grandparent, sister/brother)

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Asthma
- ☐ Hypertension
- ☐ Hypotension

Other___________________

Heart

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Dizziness
- ☐ Chest Pain
- ☐ Night Sweating
- ☐ Insomnia
- ☐ Excessive Dreams
- ☐ Cold Hands or Feet
- ☐ Oversleep
- ☐ Swelling of hands or feet
- ☐ Palpitations
- ☐ Poor Memory
- ☐ Easily Awaken

Other___________________

Liver

- ☐ Easily Upset
- ☐ Headaches
- ☐ Facial Redness
- ☐ Easily Sigh
- ☐ Bitter Taste in mouth
- ☐ Pain in the Ribs
- ☐ Dizziness
- ☐ Twitching or Spasm of Musc
- ☐ Brittle Nail
- ☐ Numbness
- ☐ Eye Problem

Other____________________

Lung

- ☐ Cough
- ☐ Cough Blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Common Cold
- ☐ Loss of voice
- ☐ Sinus Problem
- ☐ Phlegm
- ☐ Depression
- ☐ Skin Problems
- ☐ Sore Throat
- ☐ Spontaneous Sweating
- ☐ Pain with deep Breath
- ☐ Difficulty in Breathing

Other_________________

Kidney

- ☐ Ear Ringing
- ☐ Hearing Loss
- ☐ Hair Loss
- ☐ Lower Back Pain
- ☐ Knee Pain
- ☐ Joint Pain
- ☐ Edema (water Retention)
- ☐ Night Urination
- ☐ Decreased Sex Drive
- ☐ Incontinent
- ☐ Urination Problem:_____________

Spleen & Stomach

- ☐ Stomach Pain
- ☐ Gas Fullness
- ☐ Heartburn
- ☐ Over Acids
- ☐ Nausea
- ☐ Vomiting
- ☐ Belching
- ☐ Indigestion
- ☐ Foul Breath
- ☐ Prolapsed
- ☐ Bruise(easily)
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Loose Stool
- ☐ Diarrhea
- ☐ Abdominal Distention
- ☐ Abdominal Pain or Cramps
- ☐ Fatigue
- ☐ Thirsty

Appetite:_________________

Digestion:________________

Bowel Movement :

___________________times/day

Other symptom or Diagnoses: ____

____

____

Are you taking any medication **Y / N** What kind ?

1____________________to treat______________________ 2____________________to treat_____________________

3____________________to treat______________________ 4____________________to treat_____________________

5____________________to treat______________________ 6____________________to treat_____________________

Use of alcohol:Never / Rarely / Moderate / Daily Use of Tobacco: Never / Rarely / Moderate / Current? Packs/day

Use of drugs: Never/Type/Frequency____

Previous Hospitalizations/Surgeries/Serious Illnesses ? When? (Brief explanation)

____

____

CHIEF COMPLAINTS:____

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____

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FOR MEN

- ☐ Prostate Infection
- ☐ Prostate cancer
- ☐ Enlarged Prostate
- ☐ Impotency
- ☐ Infertility
- ☐ STD___________________________
- ☐ Yeast Infection
- ☐ Other____

FOR WOMEN

Menstruation

- ☐ None (when stopped____________)
- ☐ Abdomen Pain
- ☐ Low Back Pain
- ☐ Breast Pain
- ☐ Excessive Amount
- ☐ Normal Amount
- ☐ Hot Flash
- ☐ Little Amount
- ☐ Clots
- ☐ Color:___________________
- ☐ Length of Periods ______days
- ☐ Length of each cycle ___ days

Other Symptoms:___________________
____

STD (explain)_______________________________

Discharge for Yeast Infection

- ☐ Color:____________________
- ☐ Amount:__________________
- ☐ Other:____________________

Menopause

- ☐ Hot Flash
- ☐ Night sweating

Pregnancy

- ☐ Number of Pregnancies:______________
- ☐ Birth:_______________________________
- ☐ Premature Birth:____________________
- ☐ Abortion:____________________________
- ☐ Infertility: __________________________
- ☐ Miscarriage:__________________________