



New Patient Intake Form

Name _____ Date _____

Birthday ___/___/___ Age _____ Male / Female (please circle) Ht/Wt ___/___

Address _____ City, Zip _____

Home Phone _____ Work Phone _____ Occupation _____

Emergency Contact _____ Phone Number _____

Referred by _____

Reason for visit today/Chief complaint _____

Have you had acupuncture, chiropractic or complementary medicine before? Yes No

How long have you had this condition? _____ Does it bother you: Sleep Work Other

What seems to make it better? _____ Worse? _____

Are you under the care of a Physician? Yes No Physician's Name _____

Other current Therapies/Medications _____

Family Medical History (please check those that apply)

Allergies Arthritis Asthma Alcoholism Cancer _____

Diabetes Drug Abuse Epilepsy High Blood Pressure

Heart Disease Kidney Disease Stroke

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

AIDS/HIV Alcoholism Allergies Anemia Appendicitis

Asthma Cancer Chicken Pox Diabetes Emphysema

Epilepsy Goiter Gout Heart Disease Hepatitis

High Blood Pressure Herpes Measles Multiple Sclerosis Mumps

Nephritis Pacemaker Pneumonia Rheumatic Fever Scarlet Fever

Stroke Thyroid Dysfunction Tuberculosis Ulcers GI Disorders

Surgery _____

Injuries

Broken Bones Concussion or Head Injury Sprains Loss of Consciousness

Please explain _____

Lifestyle

Alcohol Tobacco Drugs Stress Occupational Hazards

Caffeine- cups/day _____ Regular Exercise

Type _____

Frequency _____

General Symptoms

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|--|---|---|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Chills | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Peculiar taste (describe) |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Dream disturbed sleep _____ | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Vertigo or dizziness |
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Head, Eyes, Ears, Nose, Throat

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|--|---|---|---|--|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Red eyes | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Poor vision |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> TMJ | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Recurring sore throat |
| <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Fainting | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Sinus | | | | |
| <input type="checkbox"/> Entire head | | | | |
| <input type="checkbox"/> Back of head | | | | |
| <input type="checkbox"/> Forehead | | | | |
| <input type="checkbox"/> Temples | | | | |
| <input type="checkbox"/> Migraine | | | | |
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Respiratory

- | | | | | |
|--|------------------------------------|---|--|---|
| <input type="checkbox"/> Tight chest | <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty breathing when lying down |
| <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Pneumonia | | | |
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Cardiovascular

- | | | | | |
|--|---|---|--|--------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pain around ribs | <input type="checkbox"/> Recent stroke | <input type="checkbox"/> Recent Heart Attack | |
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Gastrointestinal

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|--------------------------------------|---|---|---------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Gas | <input type="checkbox"/> Hiccups |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Laxative use |
| <input type="checkbox"/> Black stool | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Mucus in stool | <input type="checkbox"/> Itchy anus | <input type="checkbox"/> Intestinal pain/cramps |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bowel movements: Frequency _____ Color _____ Consistency _____ | | | |
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Musculoskeletal

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|---|--|--|--|-----------------------------------|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Rib pain |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Limited use | <input type="checkbox"/> Limited Range of motion | |
| <input type="checkbox"/> Other- describe | | | | |
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Skin and Hair

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|---------------------------------|--------------------------------------|-----------------------------------|---|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Changes in hair/skin | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Itching | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Fungal infection |
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Neuropsychological

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|--|---------------------------------------|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tics | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irritability | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Seeking a therapist | <input type="checkbox"/> Other _____ | | | |
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Genito-Urinary

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|---|---|---|---|--|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Impotence | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Prostate enlargement |
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Gynecology

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|---|---|--|--|---------------------------------------|
| <input type="checkbox"/> Age menses began _____ | <input type="checkbox"/> Duration of flow _____ | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> Vaginal ulcers | <input type="checkbox"/> Breast lumps |
| | | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Cramping | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Menopause | <input type="checkbox"/> Tumors | <input type="checkbox"/> Pregnancy _____ | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Are you or do you think you are pregnant | | | | |
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