

New Patient Intake

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

Patient Name _____

Date _____

How did you hear about us? _____

General Information

Address _____		City _____	State _____
Home Phone _____		Occupation _____	Zip _____
Work Phone _____		SS# _____	Date of Birth _____
Mobile Phone _____	E-mail _____	Receive email communications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact _____		Relationship _____	Phone _____
Have you had Acupuncture or Oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No		Family Physician _____	Phone _____
What was your experience? <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> No change		<input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single	
Are you presently under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Who and what for? _____	
Are there any other therapies which you are involved in? <input type="checkbox"/> Yes <input type="checkbox"/> No		Who and what for? _____	

Insurance Information

Insurance Company _____	Phone _____	Date Called _____
ID # _____	Co-Pay \$ _____	Covered % _____
Visit # _____	Deductible Amount _____	
Contact Name _____	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	

Focus

What is the primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities? ☐ Work ☐ Standing ☐ Sexually ☐ Other
☐ Sleep ☐ Emotional ☐ Recreation
☐ Walking ☐ Relationships ☐ Bending
☐ Sitting ☐ Social Life ☐ Stretching

What have you done about this? _____

Are you interested in: ☐ Pain Relief ☐ Holistic Health ☐ Stress Relief ☐ Other
☐ Preventative Care ☐ Stretching/Yoga ☐ Herbal Therapy
☐ Oriental Nutrition ☐ Maintenance Care

What are your health goals? _____

List any past or future surgeries: _____

List any significant trauma & when it occurred
(e.g. auto accident, falls, emotional, sexual, etc.): _____

List exercise and sport activities you
have been or are currently involved in: _____

Medical History

Do you have any allergies? ☐ Yes ☐ No If so, to what?

Do you take medication? ☐ Yes ☐ No If so, what types and how often?

Do you take supplements? ☐ Yes ☐ No If so, what types and how often?

Please indicate if you or any family members have or had any of the following conditions:

<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Drug reaction	<input type="checkbox"/> Mental breakdown	<input type="checkbox"/> Gonorrhea/Herpes	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Jaundice	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Hypo/hyper thyroid
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Parasites	<input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Premature graying
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anemia	<input type="checkbox"/> Measles	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Kidney Stone	<input type="checkbox"/> Obesity	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Cancer	

Do you sleep well? ☐ Yes ☐ No Do you dream? ☐ Yes ☐ No

Do you have a high point during the day? ☐ Yes ☐ No When? Do you have a low point during the day? ☐ Yes ☐ No When?

What are your indulgences?

What are your hobbies/pleasures?

Female Concerns

Date of last menstruation _____ Is your cycle regular? ☐ Yes ☐ No Is your cycle painful? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No Birth control? ☐ Yes ☐ No How long?

☐ PMS ☐ Clotting ☐ Vaginal sores ☐ Vaginal pain ☐ Discharge Other _____

Male Concerns

☐ Testicle pain ☐ Penis pain ☐ Penis sores ☐ Discharge ☐ Premature ejaculation ☐ Nocturnal emission ☐ Impotence

Other _____

Signs/Symptoms

<input type="checkbox"/> Abdominal pain/distention	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Muscle cramps/pain	<input type="checkbox"/> Sinus pressure
<input type="checkbox"/> Abuse survivor	<input type="checkbox"/> Dark stools	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Skin fungal infection
<input type="checkbox"/> Acid regurgitation	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Hiccup	<input type="checkbox"/> Neck/shoulder pain	<input type="checkbox"/> Spots in eyes
<input type="checkbox"/> Acne	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Night sweat	<input type="checkbox"/> Sweat easily
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dizziness/vertigo	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Dry throat/mouth	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Numbness	<input type="checkbox"/> Sudden energy drop
<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Intestinal pain/cramps	<input type="checkbox"/> Odorous stools	<input type="checkbox"/> Swollen glands
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Ear aches	<input type="checkbox"/> Irritable	<input type="checkbox"/> Pain upon urination	<input type="checkbox"/> Teeth/gum problems
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Enlarged thyroid	<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Peculiar tastes	<input type="checkbox"/> Ulcerations
<input type="checkbox"/> Breast lump/pain	<input type="checkbox"/> Eye pain/strain/tension	<input type="checkbox"/> Itchy skin	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Upper back pain
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Excessive phlegm	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Urgent urination
<input type="checkbox"/> Chest pains	Color of _____	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Chills	<input type="checkbox"/> Excessive saliva	<input type="checkbox"/> Laxative use	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Wake to urinate
<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Limited range of motion	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Weight loss/gain
<input type="checkbox"/> Concussion	<input type="checkbox"/> Fever	<input type="checkbox"/> Loss of hair	<input type="checkbox"/> Rash	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Confusion	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Redness of eyes	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Gas/belching	<input type="checkbox"/> Migraine	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Cough	<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Mouth sores	<input type="checkbox"/> Short temper	_____
	<input type="checkbox"/> Headache	<input type="checkbox"/> Mucus in stools	<input type="checkbox"/> Shortness of breath	_____

Pain

Use the diagram and pain key to the right to indicate areas and type of pain.
Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

☐ No Pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work - Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation - Can do:

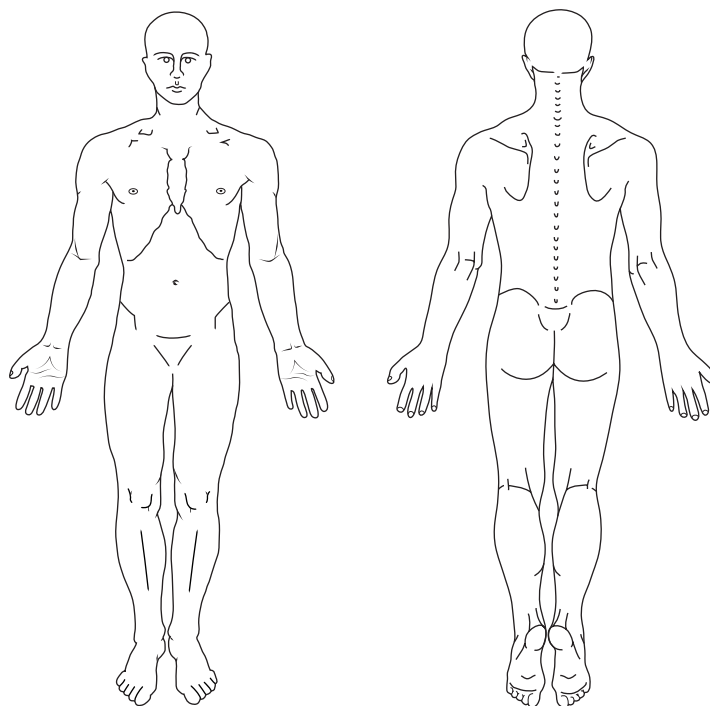
☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after 1/2 mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit



Pain Key

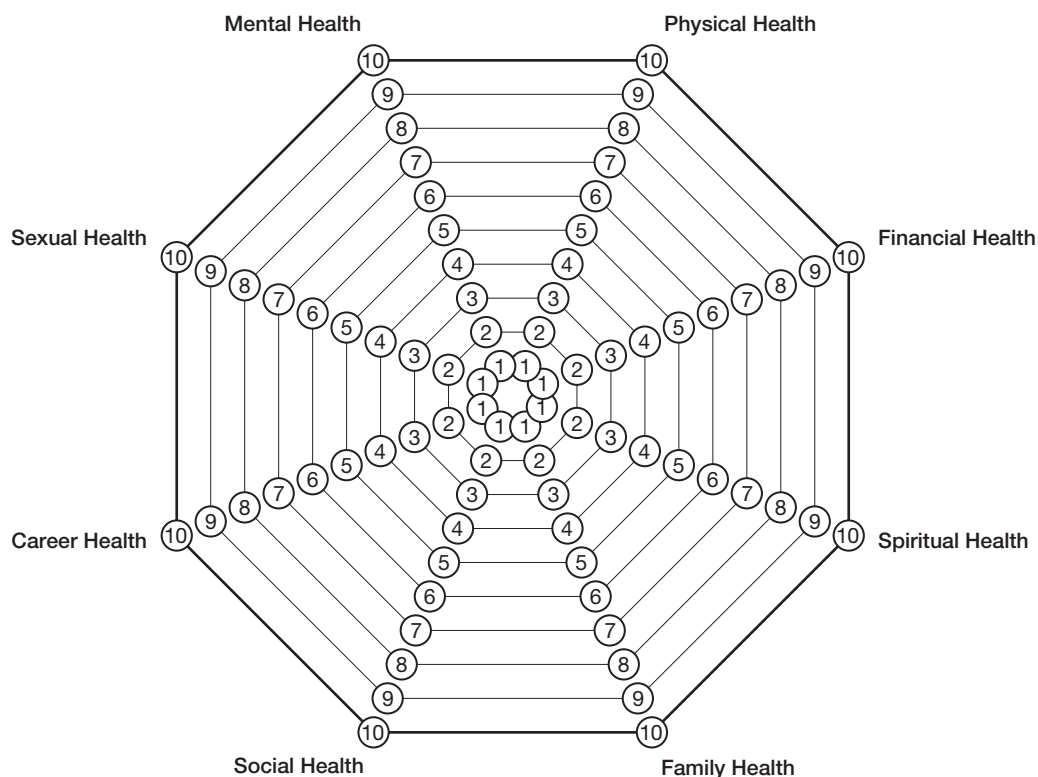
Ache	Numbness	Pins & Needles	Burning	Stabbing
^ ^ ^ ^	== ==	0 0 0 0	X X X X	/ / / /

Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____, have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Signature _____ Date _____

