

NEW PATIENT INTAKE FORM

Today's Date _____ / _____ / _____

Name	SS#	Birthdate
Address	Marital Status	Age
Email		Ht
City, State, Zip	Occupation	Wt
Home Phone	Work	Cell
Emergency Contact's Name & Phone		
Referred by		
Reason for visit today	Have you had acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chinese herbal medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
How long have you had this condition?		
Is it getting worse?	Does it bother your <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Other (specify)	
What seemed to be the initial cause?		
What seems to make it better?		
What seems to make it worse?		
Are you under the care of a physician now? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what?	
Physician's name	Physician's phone	
Other concurrent therapies		

Health Insurance Info:

Insurance Co. Name	Policy #
Address	Phone
City, State, Zip	

Medicare Info:

Insurance Co. Name	Policy #
Address	Phone
City, State, Zip	

Family Medical History

<input type="checkbox"/> Allergies (list)	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Cancer (type)	<input type="checkbox"/> Diabetes (Type: _____)	<input type="checkbox"/> Seizures
_____	<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stroke
_____	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

<input type="checkbox"/> AIDs/HIV	<input type="checkbox"/> Diabetes (Type: _____)	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Surgery (list)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker (Date: _____)	_____	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pleurisy	_____	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid disorders	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Polio	<input type="checkbox"/> Major trauma	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Birth trauma (your own birth)	<input type="checkbox"/> Hepatitis (Type: _____)	<input type="checkbox"/> Rheumatic fever	(Car, fall, etc--list)	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes (Type: _____)	<input type="checkbox"/> Scarlet fever	_____	_____
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizures	_____	_____
	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke	_____	_____

Your Diet

Appetite <input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> Coffee/Tea <input type="checkbox"/> Soft Drinks/Fruit Juices	Protein Intake <input type="checkbox"/> Low <input type="checkbox"/> High	<input type="checkbox"/> Artificial Sweeteners	<input type="checkbox"/> Sugar <input type="checkbox"/> Salty foods	Thirst for water: # glasses per day: _____
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Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmaceuticals taken in the last 2 months: _____
Vitamins/supplements taken in the last 2 months: _____

Practitioner Use Only