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**

General Information

Address City State

Home Phone Occupation Zip

Work Phone Mobile Phone SS# Date of Birth

Email Address

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:

Emails ☐ Yes ☐ No
Texts ☐ Yes ☐ No
Mail ☐ Yes ☐ No

Emergency Contact Relationship Phone

Have you had Acupuncture or Oriental medicine before? ☐ Yes ☐ No

Family Physician Phone

What was your experience? ☐ Very good ☐ Good ☐ No change

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

Are you presently under a doctor's care? ☐ Yes ☐ No Who and what for?

Are there any other therapies which you are involved in? ☐ Yes ☐ No Who and what for?

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:

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

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

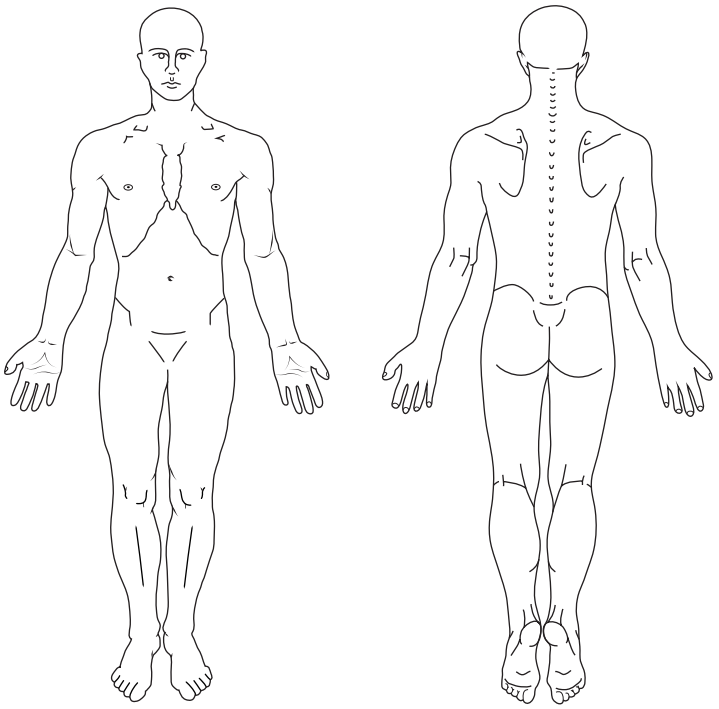
☐ All activities ☐ Some activities ☐ No activities

Walking

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

Sitting

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



Pain Key

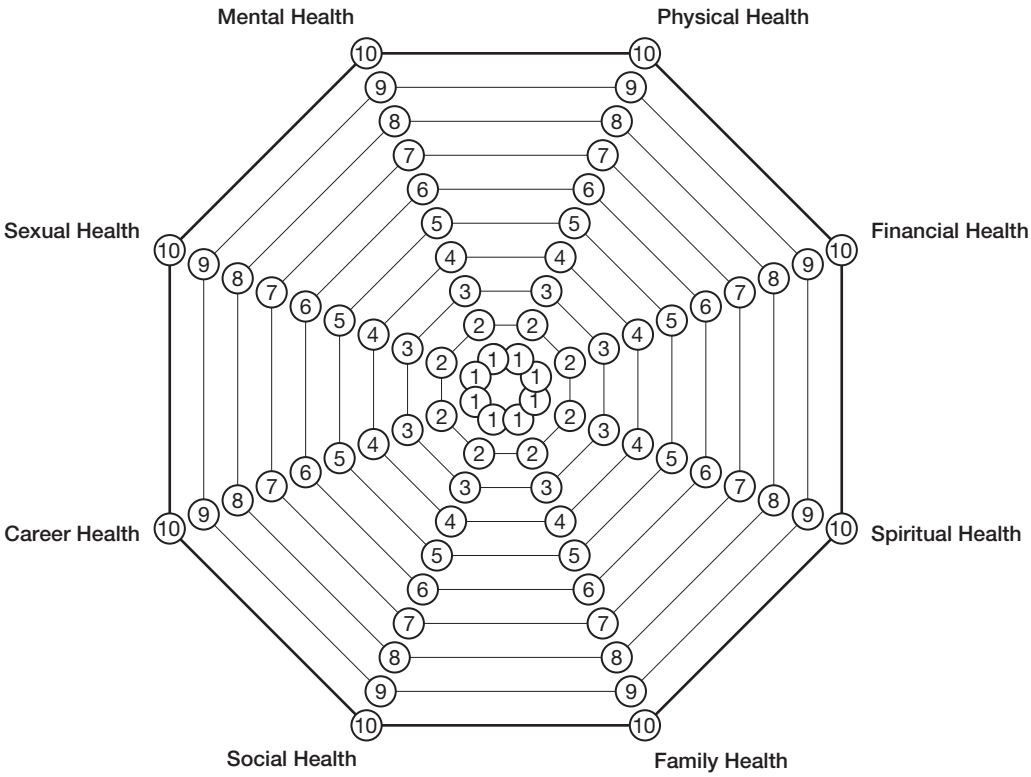
Ache	Numbness	Pins & Needles	Burning	Stabbing
^ ^ ^ ^	= = = =	0 0 0 0	X X X X	/ / / /

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 _____