Acupuncture New Patient Intake Form

Primary Contact Details
Name:
Email :
Best number to contact you:
Home Address
Address Line1 *:
Address Line2 :
City * :
State * : WA
Country * : United States
Zip Code * :

Emergency Contact Name :
Emergency Contact Number :

Height:

Weight:

Occupation:

How did you hear about us:

Primary Care Provider name:

Other family members seen here:

Do we have permission to coordinate care and release information to your PCP and other members of your care team?

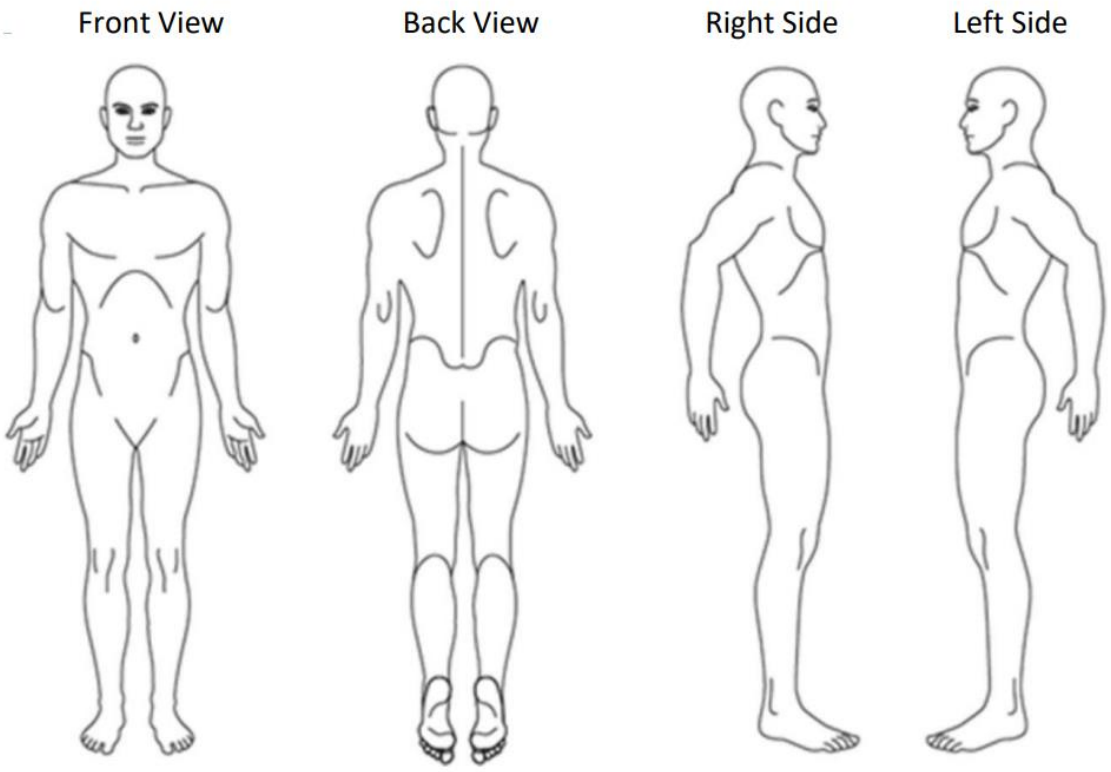
History of Present Illness

Your doctor must know the answer to each question, please give as much detail as possible.

What is your primary goal for your first visit?

What is your primary symptom?

Where do you feel the symptom?



When did the symptom start?

How often does it occur?

How long does the symptom last when present?

Is it worse at any particular time of the day?

Severity when at its worst (10 being the worst pain imaginable):

Do you notice it to be getting worse, better, or is it stable over time?

Quality of pain:

What things make it worse? For example, movement, stress, certain foods, etc.

What things make it better?

Have you had similar complaint in past? When?

Have you noticed any other symptoms develop since these primary symptoms began? If so, list them here.

Previous treatment: other professionals, medications, types of treatment, AND the results.

If your complaint does not fit well in the questions above, feel free to write a narrative of the complaint below:

If time allows we may address any secondary complaints, please list them here and describe them briefly.

Health History

Chronic health problems (For example, high blood pressure, heart problems, both past and present):

Allergies

Allergen	Type	Severity	Reactions

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

Recreational drug use, both past and present:

Past surgeries:

Past hospitalizations:

Past imaging (x-rays, MRI, etc):

Previous diagnostics (lab tests, etc). Please bring with you to the visit, if possible.

Life stresses (relationships, job, finances, etc.):

Current stress coping habits (meditation, exercise, etc):

Sleep behavior (sleepwalking, insomnia, quality of sleep, etc):

Employment history (especially relevant if there were possible toxin exposures):

Dietary restrictions (Gluten-free, dairy free, foods you won't eat):

Alcohol use (quantity, frequency, and type):

Caffeine use (coffee, tea, soda, also list amounts):

Water intake (in oz or cups per day):

Tobacco use, past and present:

Exercise habits
Types of exercise (activity and frequency):

Active hobbies (gardening, hiking, etc), list activity and frequency:

If you do not exercise frequently, what are some of the major obstacles that prevent you from doing so?

Family History:
Personal Health History:

Mother's Health History:

Father's Health History:

Siblings Health History

Grandparents Health History

Please add any additional family history here if it did not fit in the previous questions:

Review of Symptoms
Next we will review each one of your body systems. Please check each symptom that is significant and currently present.
Constitutional Symptoms:

Neurological:

Respiratory:

Chest and Cardiovascular:

Head, Eyes, Ears, Nose, and Throat:

Gastrointestinal:

Musculoskeletal:

Skin and Hair:

Genitourinary:
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Female reproductive history
Are you currently pregnant?

If so, how many weeks?

Number of pregnancies:

Number of living children:

Number of abortions:

Number of known miscarriages:

Have you been through menopause?

At what age?

Do you have a regular menstrual cycle?

What is the average number of days between cycles?

What is the average number of days menstrual flow?

Do you experience menstrual pain? If so, rate the pain on a scale of 1-10.

Do you experience excessive bleeding during your period?

Do you experience abnormal or excessive vaginal discharge during your period?

Do you experience severe PMS symptoms? If so, list them here:

By signing below you verify that all the above information is true and accurate to the best of your knowledge.

PATIENT SIGNATURE: