Annie Acupuncture and Herbal Medicine

New Patient Intake Form

Please take a moment to fill out this form to the best of your knowledge. Please add details where required or necessary. **All responses will be kept confidential.**

Patient Name_______________________________________ Age_____ Date of birth____/____/_______ (mm/dd/yyyy)
Gender (circle): M / F Occupation ____
Address ____ City ____________________ State ______ Zip _________
Telephone: (H)___________________________ (W)_____________________________ (C) ____________________________
E-mail ______________________________________
Marital Status (circle): Married / Single / Widow / Separated # of children_________
Emergency contact: Name _____________________________________ Telephone: (H) ____________________________
(W) ___________________________ (C)___________________________ Relationship to you ____________________________
What is your main condition that you would like to get help with? ____
____
How long have you had this problem? ___________________________ Caused by ____________________________________
Have you been given a diagnosis for this problem? If so, what is it? ____
What kinds of treatment have you tried for the problem? ____
Have you had acupuncture treatment before? ____
How did you hear about this clinic? ____

PATIENT MEDICAL HISTORY

Have you had any of the conditions below? Please check all that apply:

Hepatitis_____	AIDS/HIV_____	Tuberculosis_____	Drug Addiction_____	Allergies (food) _____
Herpes_____	Alcoholism_____	Pacemaker_____	Diabetes_____	Seasonal Allergies___
Heart Disease_____	Asthma______	Glaucoma_____	Dizziness_____	Migraines_____
High Cholesterol____	Epilepsy_____	Seizures______	Sinusitis_____	Thyroid Disease_____
Cancer_____	High Blood Pressure_____		Bleeding Tendency_____	

How was your childhood health? ____
Do you have any significant family medical history? If yes, please provide more detailed information below
____
____
Are you currently taking any medications or are you currently under the care of another physician? (Include prescriptions, over-the-counter drugs, vitamins, herbs, etc. taken within the last 3 months)
____
____
Please list any Surgeries/Significant Trauma:
____
____

CURRENT HEALTH STATUS

Emotional status:

Normal_____	Depressed_____	Sensitive_____	Irritable_____
Overly excited_____	Panic attacks_____	Mental confusion_____	Anxiety_____
Sadness_____	Easily susceptible to stress_____		

Current Energy:

Normal_____	Fatigue_____	Up and down_____	Exhausted_____
Hyperactive_____	Shortness of breath______	Easily catch colds_____	

Sleep:

Normal_____	Insomnia_____	Frequent dreams______	Early wakeup_______
Restlessness_____	Wake unrefreshed _____	Other_________________	

Temperature:

Normal_____	Chill _____	Cold hands______	Cold Feet______
Hot flashes______	Alternate hot and cold____	Heat in hands, feet, chest_______	
Sensitive to weather changes______			

Sweat:

Normal_____	Sweat too easily_____	Difficult to sweat______	Sweat too much_____
Sweat too little_____	Night sweating______	Spontaneous sweating____	Thirsty_____

Skin &Hair:

Dry_____	Oily_____	Dandruff_____	Acne_____
Ulcerations_____	Rashes_____	Itching_____	Eczema___
Loss of hair_____	Psoriasis______	Change in hair or skin texture? ______	

Digestion:

Normal_____	Get hungry quickly_____	Poor appetite_____	Nausea____
Bloating_____	Hiccups_____	Belching_____	Heartburn_____
Stomach pain______	Abdominal Pain_____	Acid Regurgitation_____	Ulcers _____
Bad breath_____	Hemorrhoids _____	Bleeding, swollen or painful gums_____	

Bowel Habits:

Normal_____	Times per day_____	Constipated_____	Diarrhea_____
Loose_____	Hard and dry_____	With blood_____	With Mucous____
Intestinal gas_____	Strong smell_______	Undigested food in stool_____	

Urination:

Normal_____	Frequent_____	Urgent_____	Burning_____
Painful urination_____	Dark color_____	Cloudy_____	Blood in urine_____
Difficult______	Dripping____	Scanty_____	Incontinent_____
Foul smell_____	Unable to Hold Urine _____	Frequent Night Urination_____	

MUSCULOSKELETAL

Neck pain_____	Shoulder Pain_____	Upper Back Pain_____	Mid Back Pain_____
Low Back Pain______	Arm Pain_____	Leg Pain_____	Hand/wrist Pain_____
Foot/ankle Pain______	Joint Pain (location) ___________________________________		

Quality of pain:

Aching_____	Sharp_____	Dull_____	Cramping_____
Burning_____	Fixed_____	Moving _____	Other______

What makes the pain better: Pressure_____ Heat_____ Cold_____ Exercise_____ Rest _____
What makes the pain worse: Pressure_____ Heat_____ Cold_____ Exercise_____ Rest _____
Does weather affect the pain? Type of weather: ____
Any other muscle, joint, or bone problems: ____

FEMALE REPRODUCTIVE

Are you pregnant? ______ Is it possible you are pregnant? ______ # of Pregnancies________
# of Live Births______ # of Miscarriages______ # of Abortions__________

Birth control? ______ What type and for how long? ____
Fertility Problems____

Menstrual Cycle:

Age of first menses _______ Duration of menses __________ Time between menses__________
Date of last menses _____________ Irregular period _____________
Amount of flow: Light _____ Medium _____ Heavy _____ Clots_____
Color: Pale _____ Dark _____ Bright _____ Purplish_____ Brown rust_____ Normal_____
Pain: Before (flow) _____ During_____ After_____ Dull_____ Sharp_____
Bleeding between periods ______

PMS (please describe):____

Menopause: Age ______ Symptoms____

Vaginal discharge:

Color_____________ Amount____________ Oder________ Vaginal Sores________ Cysts________
Polyps________ Endometriosis________

Breast: Breast Lumps_____ Breast Swelling_____ Breast Tenderness______ When? ____________________

MALE REPRODUCTIVE

Erectile Dysfunction____________ Prostate Problems____________ Impotence____________
Genital Sores____________ Premature ejaculation____________
Other____

HABIT

Do you smoke? Yes_____ No_____ If yes, ___________ per day for_______ years
Do you use recreational drugs or alcohol on regular basis? Yes____ No____
Do you drink coffee? Yes_____ No_____ If yes, how much per week? ______________________

OTHER

Please let me know of any other problems you would like to discuss____
____

Patient (or Guardian's) Signature______________________________________ Date________________________