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New Patient Intake Form

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

IDENTIFICATION:

Name _____ Sex M ___ F___ Date _____ Email _____

Address _____ City _____ State _____ Zip _____

Telephone: Home ( ) _____ Work ( ) _____ Cell ( ) _____

Date of Birth _____ Place of birth _____ Age _____ Height _____ Weight _____

Single _____ Married _____ Separated/Divorced _____ Widowed _____ Co-Habitating _____

Education _____ Occupation _____

INITIAL VISIT:

Who referred you to me? _____

What is the reason for your visit today? _____

How long have you had this condition? _____ Have you ever experienced this before? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your Sleep ___ Work ___ Other (what?) _____

Are there any other problems you are having? _____

FAMILY HISTORY – Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	self	mother	father	sibling	spouse	children
cancer or tumors						
diabetes						
blood or bleeding disorders/anemia						
seizures						
high blood pressure/heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
age of death						
hepatitis						
kidney disorders						
thyroid disorders						
musculo-skeletal disorder						
blood transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS: For each item, please indicate how much, how many, or how often.

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

Marijuana _____

Other recreational drugs _____

Food cravings _____

Dietary restrictions _____

Exercise _____ How often? _____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.) _____

_____

DIET: What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

MEDICAL: If you have ever been hospitalized for a serious medical illness or operation, please write the most recent ones below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Date of last physical examination: _____

Name of physician: _____

Address of physician: _____

Phone number of physician: _____

Have you ever been treated with acupuncture and/or Chinese herbal medicine before? Yes/No

MEDICINES:

What prescription drugs are you currently taking: For what condition?

_____ _____
_____ _____
_____ _____
_____ _____

What over-the-counter medications, herbs, or supplements are you currently taking: For what condition?

_____ _____
_____ _____
_____ _____
_____ _____

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

General
__ Insomnia
__ Dreams/ nightmares
__ Irritability
__ Depression
__ Mood swings
__ Fatigue
__ Poor memory
__ Strongly like cold drinks
__ Strongly like hot drinks
__ Recent weight loss/gain
__ Cold hands & feet
__ Chills
__ Fever

Head & Neck
__ Headaches
__ Migraines
__ Stiff neck
__ Dizziness
__ Fainting
__ Swollen glands

Ears
__ Ringing
__ Hearing loss
__ Infections
__ Earache
__ Hearing aids
__ Vertigo

Eyes
__ Glasses/ contact lenses
__ Blurred vision
__ Poor night vision
__ Spots or floaters
__ Eye inflammation
__ Double vision
__ Glaucoma
__ Cataracts

Nose, Throat & Mouth
__ Sinus infection
__ hay fever/ allergies
__ Frequent sore throat
__ difficulty swallowing
__ Mouth & tongue ulcers
__ Frequent colds
__ Nosebleed
__ Dry nose
__ Nasal congestion
__ Loss of voice
__ Thirst
__ Excessive phlegm
__ TMJ
__ Facial pain
__ Gum problems
__ Dry mouth

Skin
__ Hives
__ Rashes
__ Eczema/ psoriasis
__ Night sweating
__ Excess sweating
__ Dry skin
__ Easy bruising
__ Changes in moles, lumps
__ Itching

Respiratory
__ Difficulty breathing
__ Difficulty breathing when reclining
__ Wheezing
__ Asthma
__ Chronic cough
__ Wet cough
__ Dry cough
__ Coughing up phlegm
__ Coughing up blood
__ Shortness of breath
__ Tight chest
__ Pneumonia

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Chest pain or tightness
__ Palpitation
__ Rapid heart beat
__ Irregular heart beat
__ Poor circulation
__ Swollen ankles
__ Phlebitis
__ Anemia
__ History of heart attack

Gastrointestinal
__ Nausea
__ Indigestion
__ Stomach pain
__ Diarrhea
__ Constipation
__ Poor appetite
__ Excessive hunger
__ Vomiting
__ Gas
__ Hiccups
__ Acid regurgitation
__ Bloating
__ Bad breath
__ Laxative use
__ Bloody stool
__ Mucus in stool
__ Hemorrhoids
__ Gall Bladder disorder

Musculoskeletal
__ Joint pain/disorder
__ Sore muscles
__ Weak muscles
__ Difficulty walking
__ Neck/shoulder pain
__ Upper back pain
__ Lower back pain
__ Rib pain
__ Limited range of motion
__ Other (describe)

Neurological
__ Seizures
__ Tremors
__ Numbness or tingling
__ Pain
__ Paralysis
__ Poor coordination
__ Other (describe)

Genito-urinary
__ Pain on urination
__ Frequent urination
__ Urgent urination
__ Blood in urine
__ Unable to hold urine
__ Incomplete urination
__ Bedwetting
__ Wake to urinate
__ Increased libido
__ Decreased libido
__ Kidney stones
__ Impotence
__ Premature ejaculation
__ Nocturnal emission
__ Pain/itching of genitalia
__ Lumps in testicles

Infection Screening
__ HIV risks: self or partner
__ TB: self or household
__ Hepatitis risk: self or partner
__ History of sexually transmitted disease: self or partner
__ Gonorrhea
__ Chlamydia
__ Syphilis
__ Genital warts
__ Herpes: oral/ genital

Other

_____

_____

GYNECOLOGY:

Age of first menses: _____ Date of last menstrual period:_____ Duration of flow _____

Blood clots: yes/no/when: _____ Length of cycle _____

Color of menstrual blood: pale_____ bright red_____ dark red_____ brown_____ other _____

Texture of menstrual blood: thick_____ thin_____ watery_____ normal_____

Pain: yesnowhen: _____

Irregular periods (describe): _____

PMS (please describe): _____

Current method of contraception: _____ Past method of contraception: _____

Are you currently pregnant? yes/no

Number of pregnancies:_____

Number of live births:_____

Number of miscarriages:_____

Number of abortions:_____

Any premature births:_____

Breast (lumps, cysts, tenderness, etc.): _____

Urinary tract infections: _____ How frequent? _____

Vaginal infections/ discharges (describe color): _____

Pain/itching of genitalia: _____

Pap smear: normal/abnormal Date of last Pap smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

_____

Any bleeding since? _____

Are you currently on Hormone Replacement Therapy (HRT)? Yes/no Dose: _____

How long have you been on HRT? _____ Any side effects? _____

Other: _____

_____

_____

_____