



Acupuncture New Patient Intake Form

Please take the time to fill out this questionnaire. The information you provide will assist us in formulating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Today's Date: _____

(/ /)
Name Date of Birth Current Age Height Weight

Street Address Unit City State Zip

Cell Phone Carrier (for appt reminder texts) Home Phone Email (for appt reminders and billing communication)
If you prefer not to receive text message appointment reminders, please check here: Opt-out of Text Message Reminders

Employer & Occupation: _____ Relationship Status: _____

Emergency contact: _____ Phone: _____

Who can we thank for referring you to us? _____

Have you ever seen an Acupuncturist before? Yes No If yes, when? _____

If yes, who did you see? _____ What for? _____

Have you ever seen a Chiropractor? Yes No Have you ever seen a Nutritionist? Yes No

Primary Care Physician

Name: _____ Hospital or Group Associated w/: _____

Address: _____ Phone: _____

Did your primary care physician refer you to us? Yes No

Please list any other providers you have seen for your condition: _____

May we communicate with your other physicians about your case and treatment? Yes No

HEALTH INFORMATION

Main complaint: _____

Other complaints: _____

How long have you had this problem? _____

What makes your symptoms improve? _____

What makes your symptoms worse? _____

Have you received a medical diagnosis? ____ Y ____ N If yes, please list: _____

MEDICAL HISTORY

Please check any of the following that have ever affected you.

Addiction	Candida	Gallstones	Hypotension	Rheumatism
AIDS/HIV	Chronic fatigue	Glaucoma	Kidney stones	Seizures
Alcoholism	Colitis/bowel disease	Goiter	Malaria	Stroke
Anemia	Diabetes	Gout	Meningitis	STD
Arteriosclerosis	Digestive disorders	Heart disease	Mononucleosis	Thyroid problems
Arthritis	Eating disorder	Hernia	Multiple sclerosis	Tonsillitis
Asthma	Emotional imbalance	Hepatitis	Nephritis	Tuberculosis
Breast lumps	Emphysema	Herpes	Neuralgia	Ulcers
Bursitis	Epilepsy	High cholesterol	Paralysis	Urinary problems
Cancer	Fibromyalgia	Hypertension	Prostate problems	Whooping Cough

Other: _____

Surgeries, Hospitalizations, and Significant traumas (car accidents, loss of loved ones, etc.):

Date	Event

Medications taken in the last 3 months, including over-the counter medications:

Medication	Dosage	Reason	How long

Please list any vitamins, supplements, or herbal medicines you are currently taking (with dosage):

Please list any allergies or adverse reactions, especially to food or drugs:

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following diseases or conditions? Check all that apply.

<input type="checkbox"/>	Addiction	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Mental health
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Obesity
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Stroke

Other: _____

PERSONAL & SOCIAL HISTORY

How many hours per night do you sleep? ____ When do you usually go to bed? ____ Wake rested? ____ Y ____ N

Do you exercise regularly? ____ Y ____ N What kind and how much? _____

What are your hobbies/things you enjoy doing in your free time? _____

Energy level: ____ up and down ____ low ____ normal ____ excess ____ low after eating

Mental/Emotional: ____ happy ____ easily irritable ____ difficulty making decisions ____ angry ____ cry easily
____ stressed ____ hurry to do things ____ depression ____ anxiety ____ restlessness

Please indicate use and frequency of the following:

Cigarettes: ____ Y ____ N How many per day? ____ Since when? _____

Alcohol: ___ Y ___ N Type and amount per week? _____

Recreational drugs: ___ Y ___ N Type and amount per week? _____ Since when? _____

Coffee: ___ Y ___ N Amount _____ Soda: ___ Y ___ N Amount _____

Water: ___ Y ___ N Amount _____

How do you feel about the following areas of you life?

	GREAT	GOOD	FAIR	POOR	BAD	COMMENTS
Significant other						
Family						
Diet						
Sex						
Self						
Work						
Spirituality						

SYMPTOM SURVEY

Please check any of the following that apply to you now or in the past.

GENERAL

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
		Shortness of breath			Poor appetite			Allergies
		Poor coordination			Excess appetite			Fever
		Vertigo/dizziness			Strong thirst			Chills
		Bleed/bruise easily			Fatigue			Heavy body
		Hot/cold intolerance			Poor sleeping			Weight loss
		Nervousness/irritability			Night sweats			Weight gain
		Sudden energy drop			Sweat easily			Tremors
		Localized weakness			Swollen glands			Mood changes
		Frequent infection			Cold hands/feet			Cravings

Other general: _____

PSYCHOLOGICAL

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
		Loss of control			Irritability			Depression
		Anxiety			Bad temper			Panic attacks
		Suicidal thoughts			Suicidal attempt			Easily stressed
		Seeing a therapist			Extreme fear			Extreme grief

Other psychological: _____

SKIN AND HAIR

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
		Rashes			Dry skin			Itching
		Eczema			Acne			Psoriasis
		Hives			Moles			Dandruff
		Tumors/lumps			Ulceration			Slow wound healing

Other skin/hair: _____

HEAD, EYES, EARS, NOSE, AND THROAT

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
		Dizziness			Color blindness			Corrective lenses
		Headache			Vision changes			Poor hearing
		Migraine			Cataracts			Ear pain
		Concussion			Glaucoma			Sinus problems
		Facial pain			Spots in vision			Runny nose
		Sore throat			Night blindness			Sneezing
		Sores on lips/tongue			Blurry vision			Congestion
		Grinding teeth			Eye pain			Loss of smell
		Jaw clicks			Dry eyes			Nosebleeds
		Gum problems			Red eyes			Peculiar smells
		Excessive saliva			Itchy eyes			Peculiar tastes

Other head/eyes/ears/nose/throat: _____

CARDIOVASCULAR

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
		High blood pressure			Swelling of hands			Fainting
		Low blood pressure			Swelling of ankles			Blood clots
		Irregular heartbeat			Cold hands/feet			Palpitations
		High cholesterol			Heart murmur			Chest pain
		Poor circulation			Heart valve issues			Heart attack
		Varicose veins			Stroke			Clotting disorder

Other cardiovascular: _____

RESPIRATORY

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
		Shortness of breath			Shallow breathing			Sleep apnea
		Pain in deep breathing			Bronchitis			Asthma
		Tightness of chest			Emphysema			Wheezing
		Difficulty breathing			Frequent colds/flu			Pneumonia
		Excessive phlegm			Coughing blood			Cough

Other respiratory: _____

GASTROINTESTINAL

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
		Burning of anus			Constipation			Hemorrhoids
		Chronic laxative use			Diarrhea			Gas/bloating
		Pain with defecation			Blood in stool			Indigestion
		Incomplete defecation			Food in stool			Belching
		Light colored stools			Black stool			Nausea
		Foul smelling stools			Rectal pain			Vomiting
		Abdominal pain			Bad breath			Hiccups
		Hiatal hernia			Lack of appetite			Acid reflux

Other GI: _____

GENITO-URINARY

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
		Pain on urination			Kidney stones			Herpes
		Urgency to urinate			Increased libido			Bedwetting
		Unable to hold urine			Decreased libido			STDs
		Decreased urine flow			Frequent UTIs			Genital itching
		Incomplete urination			Sores on genitals			Blood in urine
		Nighttime urination			Malodorous urine			Cloudy urine

Other genito-urinary: _____

MALE REPRODUCTIVE (Men only)

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
		Prostate problems			Penile discharge			Impotence
		Sexual dysfunction			Testicular lumps			Testicular pain

Other male reproductive: _____

Have you had a prostate exam? ___ Y ___ N If yes, when? _____ results? _____

GYNECOLOGICAL (Women only, if you have gone through menopause, please describe your past menstruation)

Is there a possibility you're pregnant? ___ Y ___ N

Date of last pap smear? _____

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
		Painful periods			Irregular periods			Mastitis
		Vaginal discharge			Uterine bleeding			Fibroids
		Infertility			Breast lumps			Endometriosis
		Yeast infection			Vaginitis			Endometriosis
					PMS			PID

Age of first period: _____ Number of days between periods: _____ Number of days of flow: _____

Menstruation: Flow: ___ Heavy ___ Light ___ Clots ___ Painful ___ Spotting between periods

Color of flow: _____ Start date of last cycle: _____

PMS Symptoms: _____

Menopause: Age of menopause: _____ Menopausal symptoms: _____

Pregnancy: # of pregnancies: ___ # of births: ___ # of miscarriages: ___ # of abortions: ___

of premature births ___

MUSCULOSKELETAL/NEUROLOGICAL

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
		Neck tightness/pain			Knee pain			Hernia
		Shoulder pain			Muscle weakness			Seizures
		Hand/wrist pain			Muscle pain			Tremors
		Back pain			Joint sprain			Numbness
		Hip pain			Joint disorders			Tingling
		Sciatica			Scoliosis			Paralysis

Other musculoskeletal / neurological: _____

Please feel free to list/describe any other issues you would like to discuss.

The information on this form is correct and accurate to the best of my knowledge.

Signature: _____ Date: _____

Authorizations and Releases

By initialing and signing below, you agree to the following:

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here:
<http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf>.

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations. Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
5. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the practitioner. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial _____

Missed Appointments & Late Cancellation Charges

Patient will be charged a \$50 fee for missed appointments or appointments that are canceled less than 24 hours in advance of the scheduled start time.

Initial _____

Agreed and accepted:

Signature: _____ **Date:** _____

Name (print): _____