New Patient Intake Form

Name:____ Gender: M F
Date:_____________ Home Address:____
City:_________________________________ State:______________ Zip:________________
Email:____
Birth date:_______________________ Age:______
If under 18, person responsible for your account:_____________________________
Home phone:_____________________ Cell phone: ______________________
I would like a reminder via (circle please): *E-mail* *Phone call* *Text*
Emergency Contact- Name:__________________________________ Contact phone:_____________________
Marital Status: ______single ______married ______divorced ______widowed ______with a significant other
Occupation:______________________________________ Number of years in this type of work:__________
Primary care physician: Name:_____________________________ Phone:_____________________

How did you hear about us? *(please circle)* *Internet* *Facebook* *Newspaper* *Signage* *TV* *brochure*
VA referral *Vet Center* *Another patient or friend referral:* _____________________________________
Dr referral: ____________________________ *Other:* _____________________________________

Have you had acupuncture before? Yes No When___________ For what condition?______________________

Please indicate if any of the following pertain to you:
____hepatitis ____HIV ____high blood pressure ____seizures ____pacemaker
____blood-thinning meds ___pregnancy ____surgically implanted joint/bone replacement or stabilizers.

Current Health Concerns
Please list your health concerns in order of priority:
1.____
2.____
3.____
4.____
5.____
6.____

Please list all past medical conditions for which you were hospitalized and/or received surgery (include dates)
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Habits and Lifestyle

Do you smoke? Yes No How much per day?_____________ Since when?______ Do you drink alcohol? Yes No
How much?_________________ Do you exercise regularly? Yes No What type? _______________________

Emotional stress scale

Please circle:

1	2	3	4	5	6	7	8	9	10
No Stress				Moderate					Extremely stressed

Nutrition

Do you drink coffee? Yes No Do you drink soda? Yes No Skip meals? Yes No

Family History

Please describe your family's health, including current age or age at death, and major illness history (diabetes, heart disease, osteoporosis, cancer, allergies, mental illness, etc.)

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WOMEN ONLY *please circle response as appropriate*

Are you currently experiencing any gynecological symptoms or problems? Yes No

If yes please list: ____

Do you have any history of cervical, ovarian, or breast cancer? Yes No

Currently on birth control? Yes No

If you are of menstruating age: date of last period___________________

If you are menopausal or peri-menopausual: Are you taking hormone replacement therapy? Yes No

Number of pregnancies ____________ Number of live births:_____________________

Are you currently trying to conceive? Yes No

MEN ONLY *please circle response as appropriate*

Have you ever had a diagnosis of prostate enlargement or cancer? Yes No

Do you ever experience trouble with urination (frequency, hesitancy, pain, dribbling)? Yes No

Do you ever experience trouble with sexual function/libido? Yes No

Medications/Supplements

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them.

(If you have a typed list ask us to make a copy)

Medications (with starting date and dose):	*Reason:*
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Supplements (with start date and dose):	*Reason:*
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Please describe any other health concerns not previously covered in this form.

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Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes.

Signature____

(Patient or guardian if patient is a minor)

Date___________________________