New Patient Intake Form

Today's Date ______/______/_______

Name | Marital Status: _______________ | Birthdate / / | Age _______

Address _________________________________ ☐ Male ☐ Female

_________________________________ Ht ________ Wt ________

Email | Occupation

Home Phone | Work | Cell

Referred by

Reason for visit today | Have you had acupuncture before? | Chinese herbal medicine?

How long have you had this condition?

Is it getting worse? | Does it bother your ☐sleep ☐work ☐other (specify)?

What seemed to be the initial cause?

What seems to make it better?

What seems to make it worse?

Are you under the care of a physician now? ☐ Yes ☐ No if yes, for what?

Physician's name: | Physician's phone:

Other concurrent therapies:

Family Medical History:

☐ Allergies (list)	☐ Arteriosclerosis	☐ Cancer (type)	☐ Diabetes (Type:)	☐ Seizures
________________	☐ Asthma	________________	☐ Heart Disease	☐ Stroke
________________	☐ Alcoholism	☐ Depression	☐ High Blood Pressure	

Your Past Medical History:

☐ AIDs/HIV	☐ Emphysema	☐ Mumps	☐ Cancer type:	☐ Tuberculosis
☐ Alcoholism	☐ Epilepsy	☐ Pacemaker (Date:)	treatment: ________________	☐ Typhoid fever
☐ Allergies	☐ Goiter	☐ Pleurisy	________________	☐ Ulcers
☐ Appendicitis	☐ Gout	☐ Pneumonia	________________	☐ Venereal disease
☐ Arteriosclerosis	☐ Heart Disease	☐ Polio	☐ Surgery (list) ________	☐ Whooping cough
☐ Asthma	☐ Hepatitis (Type:)	☐ Rheumatic fever	________________	☐ Other
☐ Birth Trauma	☐ Herpes (Type:)	☐ Scarlet fever	________________	
(your own birth)	☐ High Blood Pressure	☐ Seizures	☐ Major trauma (car,fall, pls list) ________	
☐ Chicken Pox	☐ Measles	☐ Stroke	________________	
☐ Diabetes (Type:)	☐ Multiple Sclerosis	☐ Thyroid disorders	________________	

Your Diet:

Appetite	☐ Low	☐ Coffee/Tea	☐ Artificial	☐ Sugar	Protein Intake	☐ Low	Thirst for water:
	☐ High	☐ Soft Drinks/ Fruit Juices	Sweeteners	☐ Salty foods		☐ High	# glasses per day:

Pharmaceuticals (name and dosage): | *Vitamins/Supplements (name and dosage):*