Center for Acupuncture and Complementary Medicine, Inc.
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New Patient Intake Form

Today's Date: _____
Last Name: _____ First Name: _____ Middle Initial: _____ Sex: _____
Marital Status: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____
Address: _____
(Street address, incl. apt. #) City State Zip Code
Home Phone Number: (_____)_____ Business Phone Number: _____
Occupation:_____Employer:_____
Emergency Contact: Name and Phone Number _____Relationship:_____
Referred by: _____
Reason for visit today:_____
How long have you had this condition? _____ Is it getting worse? Yes ☐ No ☐
What seemed to be the initial cause? _____
What is your treatment goal(s)? _____

Are you under the care of a physician now? Yes ☐ No ☐ If yes, for what?_____
Physician's Name: _____ Phone Number_____
Other Concurrent Therapies_____
Pharmaceuticals taken in last 2 months (list all): 1_____ 2_____ 3_____
4_____5 _____6_____7_____8_____
Vitamins/supplements/homeopathics taken in last 2 months:_____
Have you had acupuncture before? Yes ☐ No ☐ Chinese herbal medicine? Yes ☐ No ☐

FEMALES ONLY: When was your last period? _____ Are you pregnant? Yes ☐ No ☐

FAMILY MEDICAL HISTORY

☐ Allergies	☐ Arteriosclerosis	☐ Cancer	☐ Diabetes	☐ Seizures
_____	☐ Asthma	_____	☐ Heart Disease	☐ Stroke
_____	☐ Alcoholism	_____	☐ High Blood Pressure	☐ Other
_____		_____		

YOUR PAST MEDICAL HISTORY (and DATES)

(Check any of the following conditions you currently have, or have had in the past. Please check if you feel any of the following are a significant part of your medical history)

	☐ Diabetes	☐ Multiple Sclerosis	☐ Stroke	☐ Vaccinations
☐ Alcoholism	☐ Emphysema	☐ Mumps	☐ Surgeries (List all)	_____
☐ Allergies	☐ Epilepsy	☐ Osteoporosis	_____	_____
☐ Appendicitis	☐ Goiter	☐ Pacemaker	_____	_____
☐ Arteriosclerosis	☐ Heart Disease	☐ Pleurisy	☐ Thyroid Disorders	
☐ Asthma	☐ Hepatitis	☐ Pneumonia	☐ Tuberculosis	
☐ Birth Trauma (your own birth)	☐ Herpes	☐ Polio	☐ Ulcers	
☐ Cancer	☐ High Blood Pressure	☐ Rheumatic Fever	☐ Venereal Disease	
☐ Chicken Pox	☐ Measles	☐ Seizures	☐ Whooping Cough	

☐ Other Significant Illnesses (Specify) _____
☐ Accidents/Significant Trauma (Car, fall, etc, -list)_____
☐ Medications _____

LIFESTYLE & DIET

☐ Alcohol Amount/How often____	☐ Soft Drinks	☐ Exercise: (list) Type_____	Frequency_____
☐ Drugs	☐ Artificial Sweetener	☐ Stress	
☐ Marijuana	☐ Sugar	☐ Occupational Hazards	
☐ Coffee	☐ Salty Food	☐ Cigarette: amt/freq..._____ Cigar: amt/freq. _____	

CURRENT GENERAL HEALTH INDICATIONS

☐ Appetite-Poor	☐ Localized weakness	☐ Cold feet	☐ Fever	☐ Heavy Sleep
☐ Appetite-Heavy	☐ Strong thirst	☐ Cold feet	☐ Warm/Hot body	☐ Dizziness
☐ Appetite-Changes in	☐ Little thirst	☐ Cold abdomen	☐ Sweating easily	☐ Poor balance
☐ Cravings	☐ Localized weakness	☐ Cold body	☐ Night sweats	☐ Poor coordination
☐ Weight gain/loss	☐ Low back pain	☐ Cold back	☐ Poor/disturbed sleep	☐ Tremors
☐ Fatigue	☐ Knee pain	☐ Chills	☐ Insomnia	☐Sensitive to tastes/smells
☐ Sudden energy drop (when?) _____		☐ Other unusual/abnormal conditions_____		

SKIN AND HAIR

☐ Rashes	☐ Ulcerations	☐ Hives	☐ Itching	☐ Eczema
☐ Pimples	☐ Dandruff	☐ Hair loss	☐ Recent moles	☐ Purpura
☐ Changes in hair or skin texture		☐ Any other hair or skin problems _____		

HEAD, EYES, EARS, NOSE, THROAT

☐ Dizziness ☐ Cataracts ☐ Poor hearing ☐ Dry mouth ☐ Jaw clicks
☐ Concussions ☐ Floaters ☐ Earaches ☐ Copious saliva ☐ Grinding of teeth
☐ Migraines ☐ Eye pain ☐ Ringing in ears ☐ Mucus ☐ Teeth Problems
☐ Headaches ((where/when?) _____ ☐ Nose bleeds ☐ Gum problems ☐ Facial Pain
☐ Poor vision ☐ Glasses ☐ Sinus problems ☐ Sores on lips/tongue ☐ Facial Ticks
☐ Eye strain ☐ Night blindness ☐ Dry throat ☐ TMJ ☐
☐ Blurry vision ☐ Color blindness ☐ Recurrent sore throat ☐ Other head or neck problems _____

CARDIOVASCULAR

☐ Hypertension ☐ Low blood pressure ☐ Chest pain ☐ Irregular heartbeat ☐ Fainting
☐ Cold hands or feet ☐ Swelling of hands ☐ Swelling of feet ☐ Blood clots ☐ Difficulty Breathing
☐ Phlebitis ☐ Any other heart/blood vessel problems _____

RESPIRATORY

☐ Cough ☐ Coughing up blood ☐ Chronic bronchitis ☐ Asthma ☐ Pain on inhaling
☐ Pneumonia ☐ Diff. breathing (when? what position?) _____ ☐ Prod. of phlegm (color?) _____
☐ Any other lung problems _____

GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas
☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bloating
☐ Abdominal pain/cramps ☐ Chronic laxative use ☐ Sensitive abdomen
Any other GI problems _____

GENITOURINARY

☐ Pain on urination ☐ Frequent urination ☐ Urgency to urinate ☐ Unable to hold urine ☐ Blood in urine
☐ Kidney stones ☐ Decrease in flow ☐ Diff. initiating flow ☐ Impotence ☐ Genital sores
☐ Wake at night to urinate (how often? what time?)_____ ☐ Color of urine_____

Any other problems with genitourinary function _____

REPRODUCTIVE AND GYNECOLOGICAL

Age of first menstrual period_____ Age at menopause_____ Number of pregnancies_____
Number of live births_____ Premature births_____ Miscarriages/abortions_____
☐ Vaginal discharge ☐ PMS ☐ Length of menstrual cycle _____
☐ Vaginal odor ☐ Painful menses ☐ Duration of menses_____ Color_____ ☐ Menstrual clots
☐ Breast lumps ☐ Irregular menses ☐ Strong odor
☐ Breast swelling
Birth control method (since)_____ Other problems_____

MUSCULOSKELETAL

☐ Neck pain ☐ Muscle pains ☐ Knee pain ☐ Back pain ☐ Muscle weakness
☐ Foot/ankle pain ☐ Hip pain ☐ Shoulder pain ☐ Hand/wrist pain
Any other joint or bone problems_____

The preceding information is true and correct to the best of my knowledge.

SIGNED _____ DATE_____

(OFFICE USE ONLY)
Meds ,Herb Suppl, Homeop.,

1._____

2._____

3._____

4._____

5._____