New Patient Intake Form

Name:______________________________ Date: _______________

Date of Birth:__________Age:________Email: ______________________

Street Address:____________________________City, State, Zip______________________________________

Home Phone #:_______________________Work:_______________________Cell: ______________________

Occupation:__________________________________Height:_________________Weight: ________________

Marital Status: ☐ M ☐ S ☐ W ☐ D ☐ Civil Union ☐ Other ☐ Prefer Not to Say

Gender: ☐ M ☐ F ☐ MTF ☐ FTM ☐ Transitioning ☐ Other ☐ Prefer Not to Say

Emergency Contact Name:_____________________Phone:________________Relationship: _______________

Physician Name:____________________________________Phone # _______________________

How did you hear about TLC Acupuncture? ____

In the event I have an intern in the clinic can they observe your treatment? ☐ Yes ☐ No

General Questions

Have you had acupuncture before? ☐ Yes ☐ No

Chief Complaint: ____

How long have you had this condition? __________________________________

Is it getting worse? ☐ Yes ☐ No

Does it bother your ☐ Sleep ☐ Work ☐ Other ________________

What seemed to be the initial cause? ____

What makes it better? ____

What makes it worse? ____

Are you experiencing any pain right now? ☐ Yes ☐ No

Describe your pain: ☐ Dull ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Wandering ☐ Other _______________

What makes your pain better? ☐ Heat ☐ Pressure ☐ Movement ☐ Cold ☐ Massage ☐ Rest ☐ Other __________

Family Medical History

Please check if your family has (past or present) any of the below conditions:

☐ Allergies ☐ Alcoholism ☐ Asthma ☐ Addictions
☐ Arteriosclerosis ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure
☐ Seizures ☐ Mental Disorders ☐ Stroke ☐ Cancer

Other: ____

Are you currently taking any medications? ☐ No ☐ Yes Please List: ______________________________

Do you take any vitamins/ supplements? ☐ No ☐ Yes Please List: ______________________________

Lifestyle

Have you gained or lost weight recently? ☐ Yes ☐ No

☐ Alcohol ☐ Migraines ☐ Stress ☐ Tobacco ☐ Drugs

Occupational Hazards: ____________________

Type of Exercise and Frequency: ____________________

Diet

☐ Coffee ☐ Soft Drinks ☐ Artificial Sweeteners ☐ Sugar ☐ Salty Foods Other: ____________

Appetite Level: ☐ Normal ☐ High ☐ Low

Thirst Level: ☐ Normal ☐ High ☐ Low

Drink Temperature Preference: ☐ Hot ☐ Cold ☐ Room Temperature

Your average daily food menu includes:

Breakfast: ____________ Lunch: ____________

Dinner: ____________ Snacks: ____________

Patient Medical History

List any allergies ____________________

Please check if you currently have or had in the past:

☐ HIV/AIDS	☐ Alcoholism	☐ Appendicitis	☐ Arteriosclerosis
☐ Asthma	☐ Cancer	☐ Chicken Pox	☐ Diabetes
☐ Emphysema	☐ Epilepsy	☐ Heart Disease	☐ Goiter
☐ Herpes	☐ Hepatitis	☐ Measles	☐ Mumps
☐ Pacemaker	☐ Tuberculosis	☐ Stroke	☐ Polio
☐ Birth Trauma	☐ Pleurisy	☐ Pneumonia	☐ Scarlet Fever
☐ STD	☐ Seizures	☐ Ulcers	
☐ Thyroid Issues	☐ Hypertension	☐ Rheumatic Fever	

Other ____________________

List surgeries with dates: ____________________

List major traumas (car accidents, falls, etc.) ____________________

Head, Eyes, Ears, Throat, Nose

☐ Headaches	☐ Migraines	☐ Concussion	☐ Glasses
☐ Eye Strain	☐ Eye Pain	☐ Red Eyes	☐ Itchy Eyes
☐ Night Blindness	☐ Poor Vision	☐ Blurred Vision	☐ Spots
☐ Glaucoma	☐ Cataracts	☐ Teeth Problems	☐ Facial Pain
☐ Grinding Teeth	☐ TMJ Pain	☐ Earaches	☐ Dry Mouth
☐ Mouth Sores	☐ Sore Throats	☐ Swollen Glands	☐ Nose Bleeds
☐ Gum Problems	☐ Sinus Problems	☐ Enlarged Thyroid	☐ Lumps in Throat
☐ Poor Hearing	☐ Ears Ringing		

☐ Phlegm: Color: ____________ Thick or Thin: ____________ Difficult to Expectorate ☐ Y ☐ N

Other Related Problems: ____________________

Respiratory

☐ Difficulty Breathing When Lying Down	☐ Shortness of Breath	☐ Tight Chest
☐ Asthma/Wheezing	☐ Coughing Blood	☐ Pneumonia
☐ Emphysema	☐ COPD	

Mouth ☐ Wet ☐ Dry Phlegm ☐ Thick ☐ Thin Color of Phlegm: ____________

Other: ____________________

Cardiovascular

☐ High Blood Pressure ☐ Blood Clots ☐ Low Blood Pressure ☐ Pacemaker

☐ Chest Pain ☐ Palpitations ☐ Difficulty Breathing ☐ Phlebitis
☐ Irregular Heartbeat

Other: ____________________

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Acid Reflux ☐ Bloating ☐ Diarrhea
☐ Constipation ☐ Gas ☐ Belching ☐ Intestinal Pain/Cramping
☐ Hemorrhoids ☐ Chronic Laxative Use

Bowel Movements: Frequency:__________Color:__________Texture/Form:__________Odor: ☐ Y ☐ N

Other GI Issues: ____________________

Neurophysiological

☐ Depression ☐ Irritability ☐ Anxiety ☐ Bad Temper
☐ Panic Attacks ☐ Bipolar ☐ Seizures ☐ Dizziness
☐ Vertigo ☐ Lack of Balance ☐ Lack of Coordination ☐ Restlessness
☐ Thoughts of Suicide ☐ Abusive Behavior ☐ Eating Disorder ☐ Currently in Therapy

Other: ____________________

Genito-Urinary

☐ Painful Urination ☐ Frequent Urination ☐ Urgent Urination ☐ Incontinence
☐ Wake to Urinate ☐ Decrease in Urine Flow ☐ Kidney Stones ☐ Blood in Urine

For Men Only

☐ Erectile Issues ☐ Testicular Pain/Swelling ☐ Premature Ejaculation
☐ Penis Discharge ☐ Decreased Sex Drive ☐ Increased Sex Drive
☐ Breast Swelling ☐ Sores on Genitals ☐ STD
☐ Enlarged Prostate

Other: ____________________

For Women Only

Are you pregnant ☐ Y ☐ N ☐ Maybe

Are you trying to get pregnant? ☐ Y ☐ N

Method of Birth Control ____________________

Are you currently breastfeeding? ☐ Y ☐ N

Length of Cycle:__________Duration of Flow:__________Discharge Color: __________

☐ Irregular Menses ☐ Painful Periods ☐ PMS ☐ Vaginal Sores ☐ Vaginal Odor ☐ Clots

Pregnancies:________# Live Births:________# Premature Births:________# Miscarriages: ________

☐ Breast Lumps ☐ Endometriosis ☐ Fibroids ☐ Ovarian Cysts ☐ Breast Lumps/Swelling ☐ UTI's

Age Menses Began:__________Age at Menopause:__Date of Last PAP: __

Date of Last Period:__________Other: ____________________

Please detail any other conditions or issues that may not have been noted above:

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SIGNATURE

The information on this form is correct and to the best of my knowledge. I understand that my information will be kept confidential.

Signature:____________________Date: ____________________