Acupuncture New Patient Intake

Today's Date: __________

Name: ___________________________Age: ______ Birth Date: ______ Weight: __

E-mail: _________________________ Okay to communicate through email? Y/N

Cell #: __________________________ Okay to leave a message here? Y/N

Phone #: ________________________ Okay to leave a message here? Y/N

Business #: ______________________ Okay to leave a message here? Y/N

Occupation: _____________________ Okay to sign you up for newsletter? Y/N

GENERAL PHYSICIAN: NAME: ___________________________TELEPHONE: _____________

City/State: ______________ LAST EXAM DATE: _______

EMERGENCY CONTACT INFO: NAME: _____________________TELEPHONE: _______________

ADDRESS: ____RELATIONSHIP: ______________

List 3 Main Health Concerns: 1.) ____

2.) ___________________________________3.) ____________________________

Past Surgeries & Hospitalizations:

Current Medications Indicate Yes or No:

COUMADIN? Y /N IBUPROFEN? Y /N ASPIRIN /PAIN RELIEVERS? L IST___________________

WARFARIN? Y/ N CORTISONE? Y/ N ANTIBIOTICS? Y /N ANTIHISTAMINES? Y /N

METFORMIN/GLUCOPHAGE/INSULIN? Y ? N(specify) _________________________

OTHER MEDICATIONS, INCLUDING SUPPLEMENTS OR VITAMINS? ________________________________

____

List Unusual Childhood Illnesses:

Family Medical History-- Circle diseases that have affected your family:

high blood pressure, heart disease, diabetes, cancer, asthma, bronchitis, digestive disorders, obesity, migraines, depression, mental illness, other:

____

____Married ____ Unmarried ____ Widow/er

Have you had acupuncture before? __________________ If so, for how long and for what purpose?

____

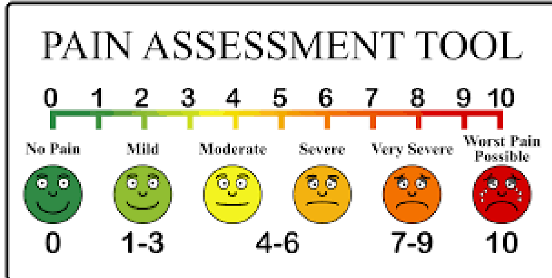
Please describe briefly what you hope to achieve from your treatments here:

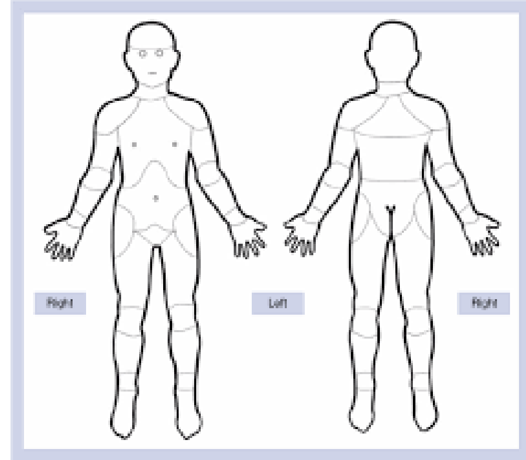
____

What other therapies or activities are you using to help achieve these goals?____

Are You willing to use herbal therapies to achieve these goals? Yes/ No Apply acupressure? Yes/ No

Pain Conditions:





Structural/Spine Issues:

Rate Sleep 1-10 (1 is Good) (10 is Bad)
Quality of sleep (1-10):
Wake feeling rested (1-10):
Trouble falling asleep? Yes No
Trouble staying asleep? Yes No

Stress Level 1-10 (1 is Good) (10 is Bad):

Mental & Emotional Issues:

Autoimmune Issues:

Digestive Issues:

Other Health Concerns Not Listed:

Smoking Habits:

Drinking/Drug Habits:

Respiratory Issues:

Circulatory & Cardiovascular Issues:

(Office Use Only)
TCM DX:

TCM TX (circled):
LV3, 4, 9---LI4, 10, 11, 20---ST3, 36, 37, 38, 40
GB14, 34, 40, 41---TB5---LU 1, 6, 7, 9, 10
KI3, 6, 7---BL2, 40, 60, 62---SI3, 4, 5---HT5, 7, 8
SP3, 4, 6, 9, 10 PER6, 7, 8---DU 20
Yintang, Taiyin, Bitang
Tung:
Ear: Shen Men, Brain, Apex, Smoking
____
Herbal Therapy:

Home Aroma Acupressure:

Patient Signature: ____ **Date:** _______________

L.Ac. Signature: ____