New Patient Information

Name: _____ Date: _____

Age: _____ M / F Date of birth: _____ Birthplace: _____

Address: _____

_____

Phone # (home)_____ (work) _____ (mobile) _____
(Please circle the best phone number to reach you)

Email address: _____ SSN: _____

Occupation: _____ Hours per week: _____

Marital status: _____ Number of Children: _____

Emergency contact: _____ Phone #: _____

Primary Care Physician: _____

Name of Health Insurance: _____

Referred by: _____

Have you been treated by an acupuncturist before? _____

If so, name of acupuncturist and conditions treated: _____

Primary health concern:

if you are coming in for an autoimmune disease, cancer, or other chronic-degenerative disease, please provide a detailed history of your health all the way back to childhood - this should include any significant illnesses as well as any major physical or emotional traumas. This may require a separate sheet of paper.

_____

_____

_____

Other concerns (list as many as you like, in order of importance to you):

_____

_____

_____

List any significant illnesses, hospitalizations, or surgeries:

_____

_____

List any major diseases or health problems in your family (indicate relationship):

_____

_____

List any allergies and/or food sensitivities:

_____

_____

Current Medications with dosages and reason for taking:
(please list all prescription, non-prescription, herbal and dietary supplements)

_____

_____

_____

_____

Smoking? Yes _____ No _____ How much: _____

Drink Alcohol? Yes _____ No _____ How much: _____

Recreational Drugs? Yes _____ No _____ How much: _____

Drink Coffee? Yes _____ No _____ How much: _____

Please list what activities you do for exercise: _____

How often: _____

Typical Diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Cravings (sweet, salty, sour, bitter, spicy, other) _____

Name _____ Date _____

Please check any symptoms that apply to you now or were significant health concerns in the past.

HEAD & NECK
❒ Dizziness
❒ Fainting
❒ Neck Stiffness
❒ Enlarged lymph glands
❒ Headaches
Other _____

EARS
❒Infection
❒Pain
❒Ringing
❒Decreased hearing
❒Congestion
Other _____

EYES
❒Blurred vision
❒Visual changes
❒Spots
❒Eye inflammation
Other _____

NOSE, THROAT & MOUTH
❒Bleeding
❒Sinus infection
❒Hay fever or allergies
❒Sore throat
❒Hoarseness
❒Difficulty swallowing
❒Changes in taste
❒Changes in smell
❒Oral ulcers
Other _____

SKIN
❒Hives
❒Rashes
❒*Eczema*
❒Itching
❒Night sweating
❒Excess sweating
❒Dryness
❒Bruise easily
❒Changes in moles or lumps
Other _____

RESPIRATORY
❒Chronic cough
❒Coughing up blood
❒Coughing up phlegm
❒Difficulty breathing
❒Wheezing/asthma
❒Frequent Colds
Other _____

CARDIO-VASCULAR
❒Palpitations
❒Chest pain or tightness
❒Rapid heart beat
❒Irregular heart beat
❒Poor circulation
❒Swelling of ankles
❒Phlebitis
Other _____

GASTROINTESTINAL
❒Indigestion
❒Bloating
❒Stomach Pain
❒Diarrhea
❒Constipation
❒Poor appetite
❒Excessive hunger
❒Nausea
❒Vomiting
❒Vomiting blood
❒Blood in stool or black stools
❒Hemorrhoids
❒Gall bladder disorder
❒Recent change in weight
❒Food cravings
Other _____

NEUROLOGICAL
❒Seizures
❒Tremors
❒Numbness or tingling of limbs
❒Pain
❒Paralysis
Other _____

MUSCLE & JOINT
❒Joint disorder
❒*Sore or painful muscles*
❒Weak muscles
❒Difficulty walking
❒Spinal curvature
❒Backache or pain
Other _____

UROGENITAL
❒Pain/ itching of genitalia
❒Genital lesions/ discharge
❒Painful urination
❒Frequent urination
❒Excessive or scanty urination
❒*Blood in urine*
❒Diminished bladder control
Other _____

FEMALE
❒Frequent urinary tract infections
❒Frequent vaginal infection
❒Pelvic inflammatory disease
❒Abnormal Pap smear
❒Uterine fibroids
❒Irregular periods
❒Painful menstrual periods
❒Abnormal bleeding
❒Menopausal symptoms
❒Premenstrual symptoms
❒Breast Pain or lumps
❒Ovarian Cysts
❒Miscarriages
Other _____

Date of last menstrual period:
_____
Date of last Pap smear:
_____
Were Pap results normal?
❒Yes ❒No
Date of Last mammogram:
_____
Are you pregnant?_____
Are you nursing? _____
Do you use birth control?
❒Yes ❒No Type:_____

MALE
❒Lumps in testicles
❒Prostate problem
❒Weak urinary stream
❒Impotence
Other _____

GENERAL
❒Insomnia
❒*Vivid dreams / nightmares*
❒Anxiety
❒Irritability
❒Forgetfulness
❒Depression
❒Fatigue
❒Feel hot or cold
❒Aversion to heat or cold
❒Fever and/or chills
❒Thirst
❒Psychiatric treatment
Other _____
Do you exercise? ❒ Yes ❒No
If so, what and how often?
_____