NEW PATIENT INTAKE FORM

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How To Prepare for your First Acupuncture Appointment

- It is best to eat food within 4 hours of receiving your treatment. If you have not recently eaten a light snack is recommended.
- Please refrain from caffeine and alcohol before your treatment.
- Loose fitting clothing is recommended. If you forget or are coming from work, don't worry, we have towels you can use!
- Please provide any recent lab results that pertain to your condition.
- Please provide a list of any medications you are currently taking.
- Please complete the following New Patient Intake form and bring it with you to your first appointment.
- Questions before your appointment? Email Liz: lizkelchak@gmail.com

NEW PATIENT INTAKE FORM

PLEASE READ: Fill out this intake completely and include as much detail as possible. Some questions may seem irrelevant to your main complaint, however this information is significant in helping us make an accurate diagnosis and formulate the most appropriate treatment for you.

All information is confidential.

PATIENT INFORMATION:

Patient Name (Mr., Mrs., Ms.): _____ Date:_____

DOB: _____ Age:_____ Gender: F ____ M____ Height:_____' _____" Weight:_____lbs

Street Address: _____ City: _____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address: _____ Legal Guardian (if Under 18):_____

Emergency Contact: _____ Phone: _____

Employer: _____ Occupation: _____

Primary Physician: _____Phone: _____

How did you find out about us? _____

MAJOR COMPLAINTS	WHEN DID THE CONDITION START?
1.	
2.	
3.	
4.	
5.	

How do these conditions affect your daily activity? _____

_____

PATIENT MEDICAL HISTORY (Circle any of the following that you had/ or have)

Allergies
Anemia
Arthritis
Asthma
Blood transfusion
Cancer-
Type_____
Chicken Pox
Diabetes
Epilepsy/Seizures
Glaucoma
Gonorrhea/Herpes
Gout
Heart Attack
Hepatitis
High Blood Pressure
High Cholesterol
HIV/Aids
Jaundice
Kidney Stones
Liver Illness
Low Blood Pressure
Measles
Migraines
Mononucleosis
Multiple Sclerosis
Mumps
Obesity
Pacemaker
Parasites
Parkinson's
Pneumonia
Polio
Syphilis
Thyroid Disease
Tuberculosis

Other:

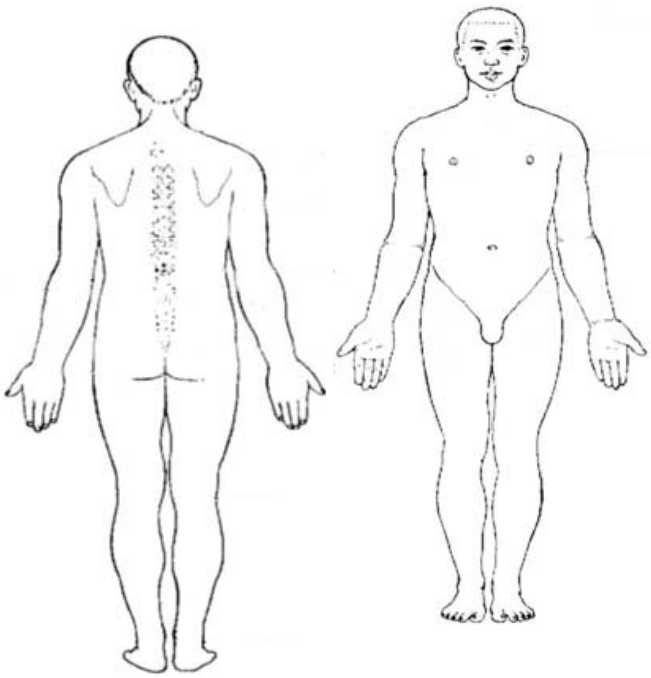
_____

Hospital
Stays/Surgeries:_____

Recent Tests: (include type of test, test results, and date):

_____

Please mark areas of pain:



PAIN QUALITY

____Sharp ____Achy ____Burning

____Numb ____Tingling ____Throbbing

____Other:_____

WHAT MAKES THE PAIN BETTER?

____Heat ____Cold ____Pressure

____Stretching ____Rest ____Movement

____Other:
_____

WHAT MAKES THE PAIN WORSE?

____Heat ____Cold ____Pressure

____Stretching ___Rest ____Movement

____Other: _____

Please check the following that currently pertain to you:

OVERALL:

___Hot body temperature
___Cold body temperature
___Afternoon flushes
___Night sweats
___Heat in Hands, feet, chest
___Hot flashes any time of day
___Thirsty
___Perspire easy
___Lack of perspiration
___Low energy
___Dizziness
___Catch colds easily
___Shortness of breath
___Difficult keep eyes open during day
___Floaters in vision

HEART:

___Anxiety
___Palpitations
___Sores on tip of tongue
___Mental Confusion
___Frequent Dreams
___Tightness in chest
___Trouble Falling Asleep
___Trouble Staying Asleep

LUNG:

___Allergies—To what_____
___Asthma
___Sinus Congestion/Pressure
___Cough
___Headache—Location_____
Frequency_____
___Dry Throat
___Dry Nose
___Dry Mouth
___Alternate chills & fever
___Smoke cigarettes--#/day_____
___Sadness
___Sore throat
___Stiff Neck
___Stiff Shoulders
___Difficulty breathing
___Snoring
___Chest Congestion

SPLEEN, STOMACH, INTESTINES:

___Low Appetite
___Large Appetite
___Abdominal Bloating
___Abrupt weight loss
___Abrupt weight gain
___Abdominal gas
___Bad breath
___Gurgling in the stomach
___Fatigue after eating
___Bruise easily
___Hemorrhoids
___Worry
___Over-thinking
___Prolapsed organs—Which_____
___Loose stool
___Constipation
___Diarrhea
___Incomplete
___Blood in stool
___Mucous in stool
___Undigested food in stool
___Burning sensation after eating
___Heartburn
___Acid Reflux/Regurgitation
___Ulcer
___Belching
___Hiccups
___Bleeding, swollen gums
___Stomach pain
___Vomiting

DAMPNESS IN THE BODY:

___Mental Heaviness
___Mental Fogginess
___Mental Sluggishness
___Sensation of heaviness in body
___Swollen Hands
___Swollen Feet
___Swollen Joints
___Nausea

Please check the following that currently pertain to you:

LIVER, GALLBLADDER:

___Alternating diarrhea & Constipation
___Tightness in chest
___Bitter taste in mouth
___Headache top of head
___Depression
___Frustration
___Anger Easily
___Irritability
___Numbness
___Muscle Twitching
___Muscle Spasms
___Muscle Cramping
___Tingling Sensation
___Seizures
___Lump in Throat
___Neck tension
___Shoulder tension
___Drink Alcohol
___Skin Rash
___High-Pitched ringing in ears
___Limited Range-of-Motion—Neck
___Limited Range of Motion---Shoulder
___Adapt to Stress Poorly
___Recreational drug use—
Which?_____
How often per week?_____

EYES :

___Itchy
___Bloodshot
___Hot sensation
___Dry
___Watery
___Gritty
___Blurry Vision
___Decrease night vision
___Near-sighted
___Far-sighted

KIDNEY, URINARY BLADDER:

___Easily broken bones
___Sore knees
___Weakness of knees
___Cold sensation in knees
___Frequent Cavities
___Low Back pain
___Memory Problems
___Excessive hair loss
___Low-pitch ringing in ears
___Kidney stones
___Bladder infection
___Lack of Bladder control
___Wake during night to urinate
# of times/night_____
___Startle easy
___Fear

URINATION:

___Normal Color
___Dark Yellow
___Cloudy
___Scanty
___Profuse
___Strong Odor
___Burning
___Painful
___Difficult
___Urgent
___Frequent
___Weak Stream

LIBIDO (Sex Drive):

___Normal
___High
___Low

MEN ONLY:

___Swollen Testes
___Testicular Pain
___Impotence
___Premature ejaculation
___Coldness or Numbness in external genitalia
___Enlarged Prostate
___Prostate Cancer

WOMEN ONLY:

Are you Pregnant? YES / NO Number of Children _____ # of Pregnancies _____

Age of first menstruation _____ Regular Menstrual Cycles? YES / NO

Avg # of days of cycle _____ Avg # of days bleeding _____ Bleeding between periods—YES / NO

Age of Menopause _____ Hysterectomy YES / NO

PMS SYMPTOMS:

___Breast Swelling ___Breast Tenderness ___Water Retention ___Migraines
___Headaches ___Anxiety ___Depression ___Irritability
___Nausea ___Vomiting ___Food Craving

___Cramping/Pain—When?_____ ___Spotting—When?_____

Please use the following choices to describe your menses flow every day during your period in the table below:

Color: black / brown / purple / dark red / bright red / pink / pale

Amount: heavy / medium / light / spotting

Clots: many / few / none

Clot size: dime-size / nickel-size / quarter-size / larger

Consistency: thick / thin / watery / dilute

	Color	Amount	Clots	Clot size	Consistency
Day 1					
Day 2					
Day 3					
Day 4					
Day 5					
Day 6					
Day 7					

MEDICATION LOG

(Please include ALL prescriptions, OTC meds, Vitamins, & supplements)

Any known Allergies? _____

Medication/Vit/Supplement	Reason taking	Dosage	Frequency	Date Started

Diet

Breakfast	
Lunch	
Dinner	
Snacks	
Other	

Water intake per day?_____
Coffee per day? 0 1-2 3-4 5+
Soda/Pop per day? 0 1-2 3-4 5+ Diet or Regular
Energy Drinks? _____
Do you drink Milk? Daily 3-5x/wk 1-2x/wk Never
Alcohol? _____
Do you eat Organic food? Never Sometimes Always
Do you use Artificial Sweeteners? Yes / No which one? _____