

New Patient Intake Form

Name: _____ Date: _____ Social Security #: _____
Date of Birth: _____ Age: _____ Email: _____
Address: _____ City, State, Zip _____
Home Phone #: _____ Work: _____ Cell: _____
Occupation: _____ Please check here if we can email you updates and a newsletter. _____
Marital Status: M S W D Height: _____ Weight: _____ Allergies: _____
Emergency Contact Name: _____ Phone: _____ Relationship: _____
Physician: (Name) _____ (Phone) _____

General Questions:

PLEASE MARK YOUR AREA OF PAIN

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? _____

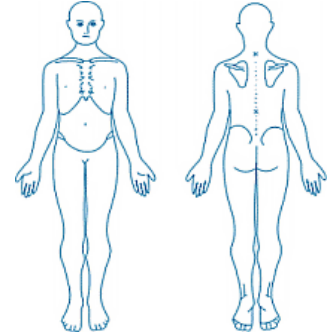
What seems to make it better? _____

What seems to make it worse? _____

Are you experiencing pain right now? Yes No

Describe your pain: Dull Sharp Stabbing Shooting Burning Other _____

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



Family Medical History:

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

Are you currently on any medications? No Yes If Yes, Please List: _____

Do you take any vitamins/supplements? No Yes If Yes, Please List: _____

Lifestyle:

Alcohol # per day _____ Stress Marijuana Regular Exercise:
Type _____ Frequency _____
Type _____ Frequency _____
 Tobacco # per day _____ Drugs Occupational Hazards

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

<input type="checkbox"/> AIDs/HIV	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Measles	<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Major Trauma: _____
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Allergies	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Fever	_____
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers	_____
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Gout	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Birth Trauma (your own birth)	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Surgery (Please List All)	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Seizures	_____	_____
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke	_____	_____

General Symptoms: (Please check all that apply)

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Craves cold drinks | <input type="checkbox"/> Craves hot drinks | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sweat easily(describe):
_____ |
| <input type="checkbox"/> Dream-Disturbed Sleep | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Heavy Sleep | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Vertigo or dizziness | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Depression | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Easily Stressed |
| <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Headaches | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Tight Chest | <input type="checkbox"/> Hives | <input type="checkbox"/> Change in hair/skin texture |
| <input type="checkbox"/> Cough: If yes, is it
<input type="checkbox"/> Wet OR <input type="checkbox"/> Dry
<input type="checkbox"/> Thick OR <input type="checkbox"/> Thin | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Migraines | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Intestinal Pain | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Bloody Stools | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Considered/attempted Suicide | <input type="checkbox"/> Lymph Nodes Removed | <input type="checkbox"/> Infectious Diseases: _____ | <input type="checkbox"/> Impotence | <input type="checkbox"/> Bowel Movements: Frequency per day
_____ |

Musculoskeletal: (Please check all that apply)

- | | | | | |
|---|--|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Limited Range of Motion | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Rib Pain | <input type="checkbox"/> Muscle Spasm | _____ |

Woman Only: Gynecology

- | | | | | |
|---|--|--|--|---------------------------------|
| Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | Duration of flow
_____ | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> PMS |
| Vaginal Discharge (Color)
_____ | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> Vaginal Odor | <input type="checkbox"/> Clots | Date Last Period began
_____ |
| Length of cycle (Day 1 to Day 1)
_____ | # Pregnancies
_____ | # Live Births
_____ | Premature Births
_____ | Age at Menopause
_____ |

Please List Any Other Pertinent Information:

I have read and agree to the Financial Policies of Shore Acupuncture, LLC.

Signature of Patient _____ **Date** _____