New Patient Intake Form

Thank you for taking the time to thoroughly complete this CONFIDENTIAL evaluation form. The information you provide here will be carefully reviewed in order to provide you with the most comprehensive health care we can offer. **Please include any amount of detail you feel is necessary to communicate your personal health care needs.**

Legal/Given Name: _____ Preferred Name: _____

Date: _____ Home Address: _____ City: _____

State & zip: _____ Home phone: _____ Work phone:_____

Cell Phone: _____Email:_____ May we add you to our mailing list? _____

Occupation:_____Person responsible for your account:_____

Who may we thank for referring you?_____

DOB: _____ Age: _____ Number of children: _____ Sex assigned at birth: Male Female Intersex

Gender identity: _____ Preferred gender pronouns: _____

Relationship status: Married/Engaged Domestic Partner Committed Relationship Single Divorced Widowed

Emergency Contact Name *and* Phone _____Relationship_____

Have you received acupuncture before? Yes No With Whom? _____

Please indicate (X) any significant illnesses you or a blood relative (parent, grandparent, sibling) have had:

	You	Relative	Approx. Date		You	Relative	Approx. Date
Cancer	____	_____	_____	Diabetes	____	_____	_____
Hepatitis	____	_____	_____	Heart Disease	____	_____	_____
High BP	____	_____	_____	Seizures	____	_____	_____
Rheumatic Fever	____	_____	_____	Depression	_____	_____	_____
Infectious Dz.	____	_____	_____	Tuberculosis	____	_____	_____

Please list any medications and supplements you are currently taking: (Please continue on the back of this page or attach a list if necessary.)

Medication	Dosage	Reason	How long	Prescribed by	Date of last checkup
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please indicate the use and frequency of the following habits:

	Yes	No	How much	How Frequently
Coffee/black tea	_____	____	_____	_____
Alcohol	_____	_____	_____	_____
Soda pop	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____

What is (are) the main health issue(s) for which you are seeking treatment?

What other forms of treatment have you sought and how long ago?

Please list any other health concerns you currently have:

Please list any allergies or food sensitivities you have:

Please list any previous accidents, surgeries, major illnesses, or hospitalizations including dates:

Do you have lab results? (Please include copies if available.)

What are your goals for treatment (please be specific)?

Please answer any of the following that apply to you.

Gynecological Health

Age of menarche (first period) _____ Are you pregnant? Yes No Number of pregnancies _____

Age of menopause (last period) _____ Number of live births _____ Number of abortions _____

Number of days between periods _____ Number of miscarriages _____ Date of Last Period _____

Number of days of flow _____ Date of last: Mammogram _____ Pap smear _____

Color of flow _____ Bone density scan _____ Remarkable results? _____

Clots? Yes No Color _____ _____

Have you been diagnosed with: Fibroids ____ Fibrocystic breasts ____ Endometriosis ____ Ovarian cysts ____ PID ___

If you experience pain before, during or after menses, please indicate the quality of the pain, indicating whether it is before, during, or after the flow begins.

Cramping _____ Stabbing _____ Burning _____ Aching _____ Dull _____

Bloating _____ Consistent _____ Intermittent _____ Bearing down sensation _____

Other symptoms related to menses: Please circle any that apply.

Nausea	Vaginal dryness	Decreased libido	Night sweats	Ravenous appetite	Other_____
Swollen breasts	Constipation	Headache	Insomnia	Mood swings	
Poor appetite	Mood swings	Diarrhea	Hot flashes	Increased libido	

Prostate/Urological Health

Do you get out of bed to urinate at night? Yes_____ No_____ If yes, how many times? _____

Please check any that apply:

Decreased force of urine flow _____ Testicle pain, swelling, or lumps _____ Difficulty with erection _____

Difficulty completely emptying bladder _____ History of kidney, bladder or prostate infections _____

Date of last prostate and rectal exam _____ Remarkable results? _____