Center for Acupuncture and Complementary Medicine, Inc.
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New Patient Intake Form

Today's Date: ____________
Last Name: ________________________ First Name: ___________________ Middle Initial: _____ Sex: _____
Marital Status: _____ Date of Birth: ________ Age: ______ Height: _________ Weight: ______
Address: ____
(Street address, incl. apt. #) City State Zip Code
Home Phone Number: (_____)_______________ Business Phone Number: ___________________
Occupation:_________________Employer:____
Emergency Contact: Name and Phone Number _______________________Relationship:________
Referred by: _________________________
Reason for visit today:____
How long have you had this condition? ___________ Is it getting worse? Yes ☐ No ☐
What seemed to be the initial cause? ____
What is your treatment goal(s)? ____

Are you under the care of a physician now? Yes ☐ No ☐ If yes, for what?_____________________
Physician's Name: ______________________ Phone Number______________________
Other Concurrent Therapies____
Pharmaceuticals taken in last 2 months (list all): 1_______________ 2_______________ 3______________
4_________________5 ________________6_______________7_______________8_________________
Vitamins/supplements/homeopathics taken in last 2 months:_______________________________________
Have you had acupuncture before? Yes ☐ No ☐ Chinese herbal medicine? Yes ☐ No ☐

FEMALES ONLY: When was your last period? __________________ Are you pregnant? Yes ☐ No ☐

FAMILY MEDICAL HISTORY

☐ Allergies
____
____
____
☐ Arteriosclerosis
☐ Asthma
☐ Alcoholism
☐ Cancer
____
____
____
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Seizures
☐ Stroke
☐ Other

YOUR PAST MEDICAL HISTORY (and DATES)

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

☐ Alcoholism
☐ Allergies
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Birth Trauma (your own birth)
☐ Cancer
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Measles
☐ Multiple Sclerosis
☐ Mumps
☐ Osteoporosis
☐ Pacemaker
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Seizures
☐ Stroke
☐ Surgeries (List all)
____
____
☐ Thyroid Disorders
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ Whooping Cough
☐ Vaccinations
____
____
____

☐ Other Significant Illnesses (Specify) ____
☐ Accidents/Significant Trauma (Car, fall, etc, -list)____
☐ Medications ____

LIFESTYLE & DIET

☐ Alcohol Amount/How often____
☐ Drugs
☐ Marijuana
☐ Coffee
☐ Soft Drinks
☐ Artificial Sweetener
☐ Sugar
☐ Salty Food
☐ Exercise: (list) Type______________ Frequency__________
☐ Stress
☐ Occupational Hazards
☐ Cigarette: amt/freq..______ Cigar: amt/freq. _____

CURRENT GENERAL HEALTH INDICATIONS

☐ Appetite-Poor
☐ Appetite-Heavy
☐ Appetite-Changes in
☐ Cravings
☐ Weight gain/loss
☐ Fatigue
☐ Sudden energy drop (when?) _________
☐ Localized weakness
☐ Strong thirst
☐ Little thirst
☐ Localized weakness
☐ Low back pain
☐ Knee pain
☐ Cold feet
☐ Cold feet
☐ Cold abdomen
☐ Cold body
☐ Cold back
☐ Chills
☐ Other unusual/abnormal conditions__________________________________
☐ Fever
☐ Warm/Hot body
☐ Sweating easily
☐ Night sweats
☐ Poor/disturbed sleep
☐ Insomnia
☐ Heavy Sleep
☐ Dizziness
☐ Poor balance
☐ Poor coordination
☐ Tremors
☐ Sensitive to tastes/smells

SKIN AND HAIR

☐ Rashes
☐ Pimples
☐ Changes in hair or skin texture
☐ Ulcerations
☐ Dandruff
☐ Hives
☐ Hair loss
☐ Any other hair or skin problems _____________________________
☐ Itching
☐ Recent moles
☐ Eczema
☐ Purpura

HEAD, EYES, EARS, NOSE, THROAT

☐ Dizziness ☐ Cataracts ☐ Poor hearing ☐ Dry mouth ☐ Jaw clicks
☐ Concussions ☐ Floaters ☐ Earaches ☐ Copious saliva ☐ Grinding of teeth
☐ Migraines ☐ Eye pain ☐ Ringing in ears ☐ Mucus ☐ Teeth Problems
☐ Headaches ((where/when?) ____________ ☐ Nose bleeds ☐ Gum problems ☐ Facial Pain
☐ Poor vision ☐ Glasses ☐ Sinus problems ☐ Sores on lips/tongue ☐ Facial Ticks
☐ Eye strain ☐ Night blindness ☐ Dry throat ☐ TMJ ☐
☐ Blurry vision ☐ Color blindness ☐ Recurrent sore throat ☐ Other head or neck problems ________________

CARDIOVASCULAR

☐ Hypertension ☐ Low blood pressure ☐ Chest pain ☐ Irregular heartbeat ☐ Fainting
☐ Cold hands or feet ☐ Swelling of hands ☐ Swelling of feet ☐ Blood clots ☐ Difficulty Breathing
☐ Phlebitis ☐ Any other heart/blood vessel problems ____

RESPIRATORY

☐ Cough ☐ Coughing up blood ☐ Chronic bronchitis ☐ Asthma ☐ Pain on inhaling
☐ Pneumonia ☐ Diff. breathing (when? what position?) _______ ☐ Prod. of phlegm (color?) ____________________
☐ Any other lung problems ____

GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas
☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bloating
☐ Abdominal pain/cramps ☐ Chronic laxative use ☐ Sensitive abdomen
Any other GI problems ____

GENITOURINARY

☐ Pain on urination ☐ Frequent urination ☐ Urgency to urinate ☐ Unable to hold urine ☐ Blood in urine
☐ Kidney stones ☐ Decrease in flow ☐ Diff. initiating flow ☐ Impotence ☐ Genital sores
☐ Wake at night to urinate (how often? what time?)________________ ☐ Color of urine_____________________

Any other problems with genitourinary function ____

REPRODUCTIVE AND GYNECOLOGICAL

Age of first menstrual period__________ Age at menopause__________ Number of pregnancies__________
Number of live births_______ Premature births____________ Miscarriages/abortions___________
☐ Vaginal discharge ☐ PMS ☐ Length of menstrual cycle _______
☐ Vaginal odor ☐ Painful menses ☐ Duration of menses________ Color________ ☐ Menstrual clots
☐ Breast lumps ☐ Irregular menses ☐ Strong odor
☐ Breast swelling
Birth control method (since)__________________ Other problems____

MUSCULOSKELETAL

☐ Neck pain ☐ Muscle pains ☐ Knee pain ☐ Back pain ☐ Muscle weakness
☐ Foot/ankle pain ☐ Hip pain ☐ Shoulder pain ☐ Hand/wrist pain
Any other joint or bone problems____

The preceding information is true and correct to the best of my knowledge.

SIGNED ___________________________________ DATE____________________________

(OFFICE USE ONLY)
Meds ,Herb Suppl, Homeop.,

1.____________________________

2.____________________________

3.____________________________

4.____________________________

5.____________________________