

New Patient Intake      date:

**Personal Information**

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Weight/Height \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Home Ph # \_\_\_\_\_ Other Ph # \_\_\_\_\_  
Email \_\_\_\_\_ DOB \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Occupation \_\_\_\_\_  
Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ #of Children \_\_\_\_\_  
Have you received Acupuncture Before? Yes \_\_\_ No \_\_\_ Date last treated: \_\_\_\_\_

Primary physician name and phone \_\_\_\_\_

- What are the main health problems or complaints for which you are seeking acupuncture?
- List any other health problems you now have.
  
- What other therapies have you tried for your current health concerns? Do they help?
  
- Have you noticed what makes your symptoms better and what makes them worse? (For example; better or worse with rest, exercise, specific movements, specific changes in weather, eating, applications of hot or cold, emotions or stress etc.)
  
- List any surgeries, hospitalizations or accidents in last 18 months? (Include dates)
  
- Are there any conditions for which you are taking medication?

List medications below:

\_\_\_\_\_

How often do you have alcoholic drinks? # Of drinks per day /week

Do you eat regular meals?

How often do you exercise?

How many cups of Coffee or caffinated drinks do you have daily? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many cigarettes daily? \_\_\_\_\_

How much Water do you drink daily? \_\_\_\_\_

Please list any supplements or herbs you are taking.

## Symptom Survey

The following is a list of signs and symptoms. Please indicate as follows: **Check mark(V)**= sometimes experience, **Plus sign (+)**=frequently experience. Leave the space blank if you never experience the symptom.

### wood

- Eye problems
- Jaundice
- Difficulty digesting oily foods
- Symptoms aggravated by stress & emotions
- Irritability/Depression
- Soft or brittle nails
- Abdominal or breast distention
- Easily angered or agitated
- Difficulty in making plans or decisions
- Spasms or twitching of muscles
- Feeling of a lump in the throat
- Pain in the ribs
- Migraines
- Belching/Gas
- Crave sour foods

### fire

- Insomnia, difficulty sleeping
- Heart palpitations
- Nightmares
- Mentally restless Laughing with no reason
- Chest pain
- Hyperactivity
- Anxiety
- Manic behavior
- Urinary tract infections
- Mouth sores
- Love burnt foods

### metal

- Wheezing& Cough
- Intolerance to weather change or sensitive to Santa Anna winds
- Tendency to catch colds easily
- Shortness of breath
- Decreased sense of smell
- Allergies
- Nasal problems
- Skin problems
- Colitis/diverticulitis
- Constipation
- Hemorrhoids
- History of Bronchitis
- Feelings of grief and loss
- Bleeding of lower gums
- Crave Spicy foods

### water

- Hearing impairment
- Ears ringing
- Decreased sex drive
- Hair loss
- Urinary incontinence, frequency or urgency
- Edema
- Fearfulness
- Feel cold all the time

- Chronic sore throat
- Knee pain
- Lumbar pain
- Symptoms worse in cold
- Loose teeth/dental problems
- Arthritis
- Poor memory
- Crave salty foods

### earth

- Lack of appetite
- Excessive appetite
- Loose stool or diarrhea
- Digestive problems
- Irregular diet
- Vomiting
- Always phlegmy
- Feeling of retention of food in the stomach
- Bleeding of upper gums
- Constant worrying
- Tendency to become obsessive in work, relationships, personal habits or studying
- Bleeding problems
- Easily bruised
- Fatigue
- Cold hands and feet
- Damp weather makes symptoms worse
- Sweet cravings

## For Women

Age when period started (menarche) \_\_\_\_\_ Age of Menopause \_\_\_\_\_

Last Menstrual Cycle started on... \_\_\_\_\_

# of Days between periods \_\_\_\_\_ # of Days of flow \_\_\_\_\_

Any Clotting? Yes \_\_\_\_\_ no \_\_\_\_\_ Color of menstrual blood \_\_\_\_\_

Any Emotional changes with your cycle (PMS) \_\_\_\_\_

Other signs and symptoms related to your menstrual cycle:

\_\_\_ Headache \_\_\_ Nausea \_\_\_ constipation \_\_\_ Diarrhea \_\_\_ loose stools

\_\_\_ Breast swelling \_\_\_ ravenous appetite \_\_\_ decreased appetite \_\_\_ fluid retention

\_\_\_ Poor appetite \_\_\_ hot flashes \_\_\_ Night sweats \_\_\_ Increased libido

\_\_\_ decreased libido \_\_\_ Insomnia

Any Pain with your cycle? \_\_\_\_\_ Any pain at ovulation? \_\_\_\_\_

Location of pain \_\_\_\_\_

Nature of pain- please indicate if before during or after menstruation

Cramping \_\_\_\_\_ Stabbing/sharp \_\_\_\_\_ Dull ache \_\_\_\_\_

Bloating \_\_\_\_\_ Constant \_\_\_\_\_ Intermittent \_\_\_\_\_

What kind of birth control are you using if any? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Total Number of Pregnancies \_\_\_\_\_