New Patient Intake Form

Today`s Date: ________________________

Name: _________________________________ Cell Phone: ____________________

Date of Birth: ______/______/______ Age:______ Home Phone: __________________

Work Phone: __________________

Marital Status: __S __M __D __W __Partnership

Mailing Address

Street/PO Box: _____________________________ City: __________________ State & Zip: ________

Occupation: ___________________________ Referred By: _______________________

Ht: __________ Wt: ____________ Email Address: ______________________________

Emergency Contact Name / Phone:

____

Have you had acupuncture before? ___ Y ___N Chinese Herbal Medicine? ___Y ___N

Reason for visit today: ____

How long have you had this condition? ____

Is it getting worse? ____

Does it bother your: ___Sleep ___Work ___ Other: ____

What seemed to be the initial cause? ____

What makes it better? ______________________ What makes it worse: ______________________

Are you under the care of a physician now? ___ Y ___N

If yes, for what? ____

Physicians's Name: ______________________________ Physician's Phone: _____________________

Other current therapies:

____

Chinese Medicine questions:

what season do you prefer __________________________ what climate do you prefer ____________

how is your energy level __________________________ how is your appetite ___________________

how is your sleep ______________________ bedtime: _______________ #of hours _____________

difficulty falling asleep / wake frequently # of times _____ at which times _______________________

how is your digestion ____

# of daily bowel movements ___ stool color & consistency: (circle) normal, loose, hard, light-colored, dark, watery, mucus blood

How often do you urinate daily ____________ at night _____________ are you thirsty _____________

___ Headaches ___Migraines ___Concussion ___ Other head/neck problems:

____

How do you plan to pay for treatments?: _____ Cash _____ Check

Insurance Company Name: _____________________________ ID#: ____________________________

I ascertain that all information gives above is true and correct to the best of my knowledge

Please discuss my case with my primary care physician: ___________________________

Signature: _______________________________________ Date: ____________________________