

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

## New Patient Intake

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

### General Information

Address	City	State
Home Phone	Occupation	Zip
Work Phone	SS#	Date of Birth
Mobile Phone	E-mail	Receive email communications? <input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Contact	Relationship	Phone
Have you had Acupuncture or Oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Family Physician	Phone
What was your experience? <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> No change	<input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single	
Are you presently under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who and what for? _____	
Are there any other therapies which you are involved in? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who and what for? _____	

### Insurance Information

Insurance Company	Phone	Date Called
ID #	Co-Pay \$	Covered %
Visit #	Deductible Amount	
Contact Name	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Focus

What is the primary reason for seeking care at our office?  
\_\_\_\_\_

What was the initial cause?  
\_\_\_\_\_

When did it begin?  
\_\_\_\_\_

What makes it worse?  
\_\_\_\_\_

What makes it better?  
\_\_\_\_\_

How does this problem interfere with your daily activities?  Work  Standing  Sexually  Other  
 Sleep  Emotional  Recreation  
 Walking  Relationships  Bending  
 Sitting  Social Life  Stretching

What have you done about this?  
\_\_\_\_\_

Are you interested in:  Pain Relief  Holistic Health  Stress Relief  Other  
 Preventative Care  Stretching/Yoga  Herbal Therapy  
 Oriental Nutrition  Maintenance Care

What are your health goals?  
\_\_\_\_\_

List any past or future surgeries:  
\_\_\_\_\_

List any significant trauma & when it occurred  
(e.g. auto accident, falls, emotional, sexual, etc.):  
\_\_\_\_\_

List exercise and sport activities you  
have been or are currently involved in:  
\_\_\_\_\_

## Medical History

Do you have any allergies?  Yes  No If so, to what? \_\_\_\_\_

Do you take medication?  Yes  No If so, what types and how often? \_\_\_\_\_

Do you take supplements?  Yes  No If so, what types and how often? \_\_\_\_\_

Please indicate if you or any family members have or had any of the following conditions:

- |                                       |  |   |  |   |
|---------------------------------------|--|---|--|---|
| <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Drug reaction     | <input type="checkbox"/> Mental breakdown | <input type="checkbox"/> Gonorrhea/Herpes        | <input type="checkbox"/> Mental illness     |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart attack      | <input type="checkbox"/> Jaundice         | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Hypo/hyper thyroid |
| <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Parasites        | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Premature graying  |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Measles          | <input type="checkbox"/> Heart disease           | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Epilepsy     | <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Obesity           | <input type="checkbox"/> Syphilis         | <input type="checkbox"/> Cancer                  |   |

Do you sleep well?  Yes  No

Do you dream?  Yes  No

Do you have a high point during the day?  Yes  No When? \_\_\_\_\_ Do you have a low point during the day?  Yes  No When? \_\_\_\_\_

What are your indulgences? \_\_\_\_\_

What are your hobbies/pleasures? \_\_\_\_\_

## Female Concerns

Date of last menstruation \_\_\_\_\_ Is your cycle regular?  Yes  No Is your cycle painful?  Yes  No

Have you ever been pregnant?  Yes  No Birth control?  Yes  No How long? \_\_\_\_\_

PMS  Clotting  Vaginal sores  Vaginal pain  Discharge

Other \_\_\_\_\_

## Male Concerns

Testicle pain  Penis pain  Penis sores  Discharge  Premature ejaculation  Nocturnal emission  Impotence

Other \_\_\_\_\_

## Signs/Symptoms

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> Abdominal pain/distention | <input type="checkbox"/> Coughing blood          | <input type="checkbox"/> Hemorrhoids             | <input type="checkbox"/> Muscle cramps/pain  | <input type="checkbox"/> Sinus pressure        |
| <input type="checkbox"/> Abuse survivor            | <input type="checkbox"/> Dark stools             | <input type="checkbox"/> Heart palpitations      | <input type="checkbox"/> Nasal congestion    | <input type="checkbox"/> Skin fungal infection |
| <input type="checkbox"/> Acid regurgitation        | <input type="checkbox"/> Decreased libido        | <input type="checkbox"/> Hiccup                  | <input type="checkbox"/> Neck/shoulder pain  | <input type="checkbox"/> Spots in eyes         |
| <input type="checkbox"/> Acne                      | <input type="checkbox"/> Depression              | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Night sweat         | <input type="checkbox"/> Sweat easily          |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Dizziness/vertigo       | <input type="checkbox"/> Increased libido        | <input type="checkbox"/> Nose bleeds         | <input type="checkbox"/> Sore throat           |
| <input type="checkbox"/> Bad breath                | <input type="checkbox"/> Dry throat/mouth        | <input type="checkbox"/> Indigestion             | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Sudden energy drop    |
| <input type="checkbox"/> Blood in stools           | <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Intestinal pain/cramps  | <input type="checkbox"/> Odorous stools      | <input type="checkbox"/> Swollen glands        |
| <input type="checkbox"/> Blood in urine            | <input type="checkbox"/> Ear aches               | <input type="checkbox"/> Irritable               | <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Teeth/gum problems    |
| <input type="checkbox"/> Blurry vision             | <input type="checkbox"/> Enlarged thyroid        | <input type="checkbox"/> Itchy eyes              | <input type="checkbox"/> Peculiar tastes     | <input type="checkbox"/> Ulcerations           |
| <input type="checkbox"/> Breast lump/pain          | <input type="checkbox"/> Eye pain/strain/tension | <input type="checkbox"/> Itchy skin              | <input type="checkbox"/> Poor appetite       | <input type="checkbox"/> Upper back pain       |
| <input type="checkbox"/> Bruise easily             | <input type="checkbox"/> Excessive phlegm        | <input type="checkbox"/> Joint pain              | <input type="checkbox"/> Poor circulation    | <input type="checkbox"/> Urgent urination      |
| <input type="checkbox"/> Chest pains               | Color of _____                                   | <input type="checkbox"/> Kidney stones           | <input type="checkbox"/> Poor memory         | <input type="checkbox"/> Vomiting              |
| <input type="checkbox"/> Chills                    | <input type="checkbox"/> Excessive saliva        | <input type="checkbox"/> Laxative use            | <input type="checkbox"/> Poor sleep          | <input type="checkbox"/> Wake to urinate       |
| <input type="checkbox"/> Cold hands/feet           | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Weight loss/gain      |
| <input type="checkbox"/> Concussion                | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Loss of hair            | <input type="checkbox"/> Rash                | <input type="checkbox"/> Wheezing              |
| <input type="checkbox"/> Confusion                 | <input type="checkbox"/> Frequent urination      | <input type="checkbox"/> Low back pain           | <input type="checkbox"/> Redness of eyes     | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Constipation              | <input type="checkbox"/> Gas/belching            | <input type="checkbox"/> Migraine                | <input type="checkbox"/> Seizures            | _____  |
| <input type="checkbox"/> Cough                     | <input type="checkbox"/> Grinding teeth          | <input type="checkbox"/> Mouth sores             | <input type="checkbox"/> Short temper        | _____  |
|  | <input type="checkbox"/> Headache                | <input type="checkbox"/> Mucus in stools         | <input type="checkbox"/> Shortness of breath | _____  |

## Pain

Use the diagram and pain key to the right to indicate areas and type of pain. Use the chart below to indicate pain intensity and limitations.

### Pain intensity levels

No Pain       Moderate pain       Severe pain       Terrible pain

### Sleeping

No problem       Disturbed       Very disturbed       Cannot sleep

### Work - Can do:

Usual work       50% of work       25% of work       No work

### Frequency of pain

25% of time       50% of time       75% of time       100% of time

### Travel

No problem       Moderate pain on trips       Severe pain

### Recreation - Can do:

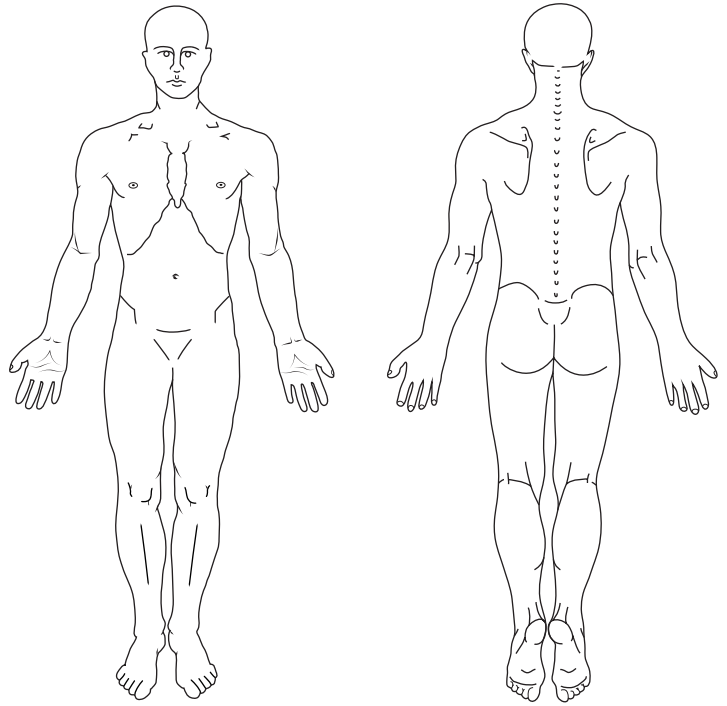
All activities       Some activities       No activities

### Walking

Can walk fine       Pain after 1/2 mile       Cannot walk

### Sitting

No pain sitting       Some pain while sitting       Cannot sit



### Pain Key

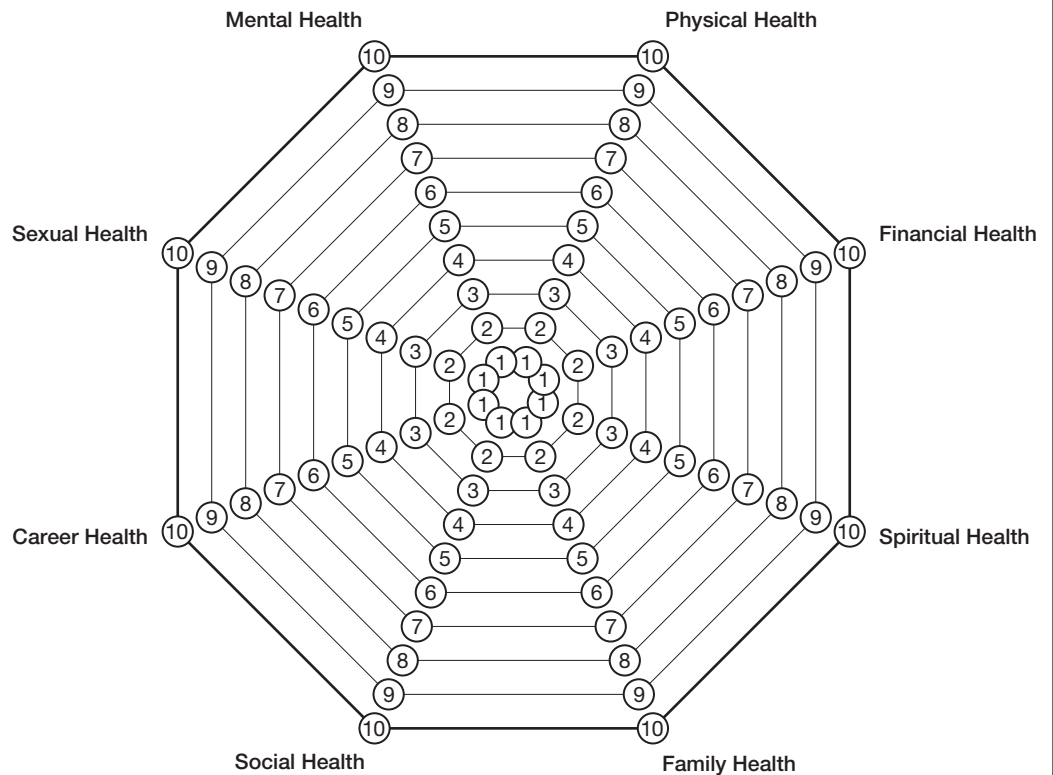
Ache	Numbness	Pins & Needles	Burning	Stabbing
^ ^ ^ ^	= = = =	0 0 0 0	X X X X	/ / / /

## Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied  
5 = Neutral  
10 = Extremely satisfied



## Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed    1   2   3   4   5   6   7   8   9   10    very committed