New Patient Intake Form

Today's Date _____/_____/_____

Name | Marital Status: _____ | Birthdate / / Age _____

Address _____ ☐ Male ☐ Female

_____ Ht _____ Wt _____

Email | Occupation

Home Phone | Work | Cell

Referred by

Reason for visit today | Have you had acupuncture before? Chinese herbal medicine?

How long have you had this condition?

Is it getting worse? Does it bother your ☐sleep ☐work ☐other (specify)?

What seemed to be the initial cause?

What seems to make it better?

What seems to make it worse?

Are you under the care of a physician now? ☐ Yes ☐ No if yes, for what?

Physician's name: | Physician's phone:

Other concurrent therapies:

Family Medical History:

☐ Allergies (list)	☐ Arteriosclerosis	☐ Cancer (type)	☐ Diabetes (Type:)	☐ Seizures
	☐ Asthma		☐ Heart Disease	☐ Stroke
	☐ Alcoholism	☐ Depression	☐ High Blood Pressure	

Your Past Medical History:

☐ AIDs/HIV	☐ Emphysema	☐ Mumps	☐ Cancer type:	☐ Tuberculosis
☐ Alcoholism	☐ Epilepsy	☐ Pacemaker (Date:)	treatment:	☐ Typhoid fever
☐ Allergies	☐ Goiter	☐ Pleurisy		☐ Ulcers
☐ Appendicitis	☐ Gout	☐ Pneumonia		☐ Venereal disease
☐ Arteriosclerosis	☐ Heart Disease	☐ Polio	☐ Surgery (list)	☐ Whooping cough
☐ Asthma	☐ Hepatitis (Type:)	☐ Rheumatic fever		☐ Other
☐ Birth Trauma	☐ Herpes (Type:)	☐ Scarlet fever		
(your own birth)	☐ High Blood Pressure	☐ Seizures	☐ Major trauma (car,fall, pls list)	
☐ Chicken Pox	☐ Measles	☐ Stroke		
☐ Diabetes (Type:)	☐ Multiple Sclerosis	☐ Thyroid disorders		

Your Diet:

Appetite ☐ Low ☐ High

☐ Coffee/Tea ☐ Soft Drinks/ Fruit Juices

☐ Artificial Sweeteners ☐ Sugar ☐ Salty foods

Protein Intake ☐ Low ☐ High

Thirst for water: # glasses per day:

Pharmaceuticals (name and dosage):

Vitamins/Supplements (name and dosage):