

NEW PATIENT HEALTH HISTORY INTAKE

General Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Married Single Partner Divorced Widowed Date of Birth _____

Work Phone _____ Home Phone _____ Mobile Phone _____

Email _____ Occupation _____

Emergency Contact _____ Referred By _____

Family Physician _____ Contact # _____

Have you had Acupuncture or Oriental medicine before? Yes No

Are you presently under a doctor's care? Yes No Who and for what? _____

Are there any other therapies which you are involved in? Who and for what? _____

Focus

What is your 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?
- | | | | |
|----------------------------------|--|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Work | <input type="checkbox"/> Standing | <input type="checkbox"/> Sexually | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Emotional | <input type="checkbox"/> Recreation | _____ |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Relationships | <input type="checkbox"/> Bending | _____ |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Social Life | <input type="checkbox"/> Stretching | _____ |

What have you done about this? _____

- Are you interested in:
- | | | | |
|---|---|---|--------------------------------|
| <input type="checkbox"/> Pain Relief | <input type="checkbox"/> Performance Care | <input type="checkbox"/> Maintenance Care | <input type="checkbox"/> Other |
| <input type="checkbox"/> Preventative Care | <input type="checkbox"/> Holistic Health | <input type="checkbox"/> Stress Relief | _____ |
| <input type="checkbox"/> Oriental Nutrition | <input type="checkbox"/> Meridian Yoga | <input type="checkbox"/> Herbal Therapy | _____ |

What are your health goals? _____

List any past or future surgeries. _____

List any significant trauma. When did it occur? (auto accident, falls, emotional, sexual, etc...) _____

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

Signs/Symptoms

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

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

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

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? _____

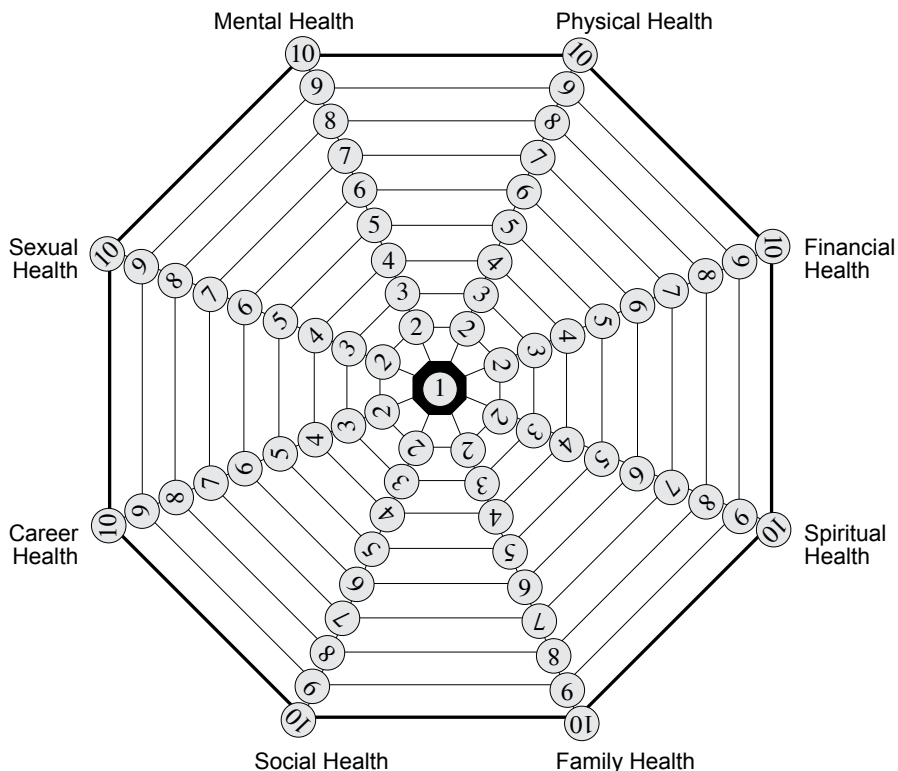
Web of Wellness

Health and wellness is 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 below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

- 1 = Not happy
- 10 = Extremely satisfied



Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain Moderate pain Severe pain Terrible pain

Sleeping

No problem Mildly disturbed Greatly disturbed Cannot sleep

Work - Can do:

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

Frequency of pain

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

Travel

No problem on long trips Moderate pain on trips Severe pain

Recreation - Can do:

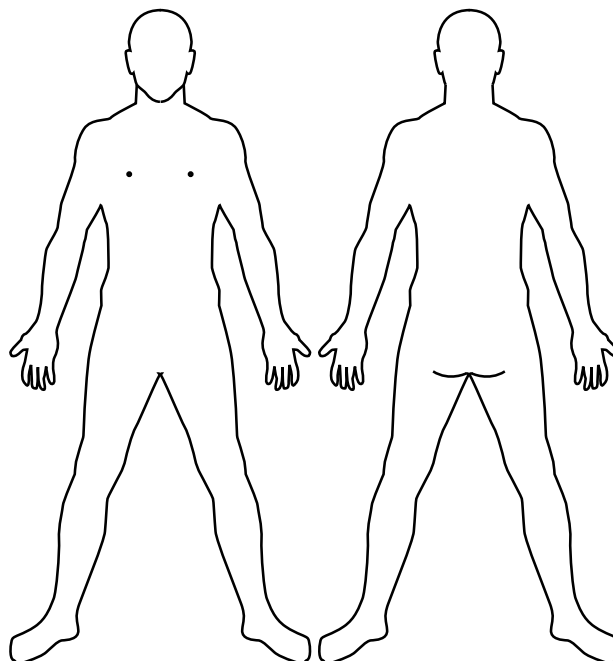
All activities Some activities No activities

Walking

Can walk any distance Pain after 1/2 mile Cannot walk

Sitting

No pain sitting Some pain while sitting Cannot sit



Types of Care

According to your signs and symptoms please indicate where your current state of health falls along this Types of Care time line.



Acute Care
 (OBVIOUS SYMPTOMS AND SIGNS)
 Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Maintenance Care
 (SYMPTOM AND SIGNS DISAPPEAR)
 Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

Wellness & Preventative Care
 (YOU FEEL GREAT)
 Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive medical system to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

(Signature) _____ (date) _____