NEW PATIENT INTAKE FORM

Name _____ Today's Date _____/_____/_____

Address _____ Preferred phone _____

City/State/Zip _____ Other Phone _____

Email _____ _____

Emergency contact and phone number _____

What is your gender? _____ How did you hear about us? _____

Have you had acupuncture before? _____YES _____NO Have you had massage before? _____YES _____NO

Primary Concerns

What are your primary concerns for seeking care?	How long have you been experiencing?	What is severity from 1-10 (10 being most severe)?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

What goals would you like to achieve in our work together? _____

Health History

Please list major health events, such as diagnoses, injuries, surgeries, pregnancies, and births, etc. Include month/year.

Please list any significant/relevant family medical history.

Please list any food, drug, seasonal, and environmental allergies you have, the reaction you experience, and severity.

Please list current medications, supplements and herbs you take regularly and include dosage.

Check if any of these pertain to you now or in the past:

- ○ Currently Pregnant
- ○ Currently breastfeeding
- ○ SeizuresConcussions, head injuries
- ○ Cancer, Radiation or chemotherapy
- ○ Hepatitis
- ○ HIV
- ○ Diabetes
- ○ Disordered eating
- ○ Significant weight change
- ○ Abuse or trauma
- ○ PTSD
- ○ Substance abuse/ addiction
- ○ Nicotine use

More on reverse side

Ripple Effect Wellness

Check symptoms you have or had in the last year:

HEAD/FACE
- ○ Headache, migraine
- ○ Dizziness, vertigo
- ○ Pronounced hairloss
- ○ Sinus problems
- ○ Frequent colds
- ○ Seasonal allergies
- ○ Painful or bleeding gums
- ○ Tooth pain
- ○ Frequent cavities
- ○ Jaw tension/pain
- ○ TMJ problems
- ○ Enlarged glands/tonsils

VISION/HEARING
- ○ Eye pain
- ○ Itchy eyes
- ○ Watering eyes
- ○ Blurry vision/floaters
- ○ Worsening vision
- ○ Earache
- ○ Tinnitus/ear ringing
- ○ Loss of hearing

SKIN
- ○ Acne
- ○ Boils
- ○ Cysts or lipoma
- ○ Rosacea
- ○ Eczema
- ○ Bruise easily
- ○ Dry skin
- ○ Itching
- ○ Rash
- ○ Sensitive skin
- ○ Sore throat that won't heal
- ○ Profuse sweating
- ○ Sweaty hands/feet
- ○ Mole removal
- ○ Skin cancer

MUSCLES/JOINTS/BONES
- ○ Tremors or cramps
- ○ Swollen joints
- ○ Neck/back pain
- ○ Arm/hand pain
- ○ Leg/Foot pain
- ○ Weakness
- ○ Tingling or numbness

CHEST/RESPIRATORY/ CARDIOVASCULAR
- ○ Hoarseness
- ○ Asthma/wheezing
- ○ High or low blood pressure
- ○ Chest pain
- ○ Chest tightness
- ○ Pain over heart
- ○ Difficulty breathing
- ○ Persistent cough
- ○ Heart palpitation
- ○ Rapid or irregular heartbeat
- ○ Hardening of arteries
- ○ Chest congestion/phlegm
- ○ Poor circulation
- ○ Previous heart attack
- ○ Previous stroke or TIA
- ○ Swelling of ankles

ABDOMEN/DIGESTION/BM
- ○ Belching
- ○ Heartburn
- ○ Nausea
- ○ Vomiting
- ○ Difficulty swallowing
- ○ Constipation
- ○ Diarrhea
- ○ Urgency with bowels
- ○ Pain over stomach area
- ○ Pain in lower abdomen
- ○ Distention of abdomen
- ○ Hemorrhoids

THIRST/APPETITE
- ○ Excessive thirst
- ○ Disinterest in fluids
- ○ Nausea after drinking
- ○ Low appetite
- ○ Hungry all the time
- ○ Craving specific tastes/flavors
- ○ Do you have any dietary restrictions or follow any dietary philosophies? Pease explain: _____

GENITOURINARY
- ○ Frequent urination
- ○ Wake up to urinate
- ○ Urinary urgency
- ○ Inability to control urine
- ○ Blood/pus in urine
- ○ Urinary tract infection
- ○ Kidney infection or stone
- ○ Painful or burning urination
- ○ Prostate troubles
- ○ Penile discharge

SEXUAL/REPRODUCTIVE HEALTH
- ○ Currently sexually active
- ○ STD/STI
- ○ Decrease libido
- ○ Increase libido
- ○ Erection difficulties
- ○ Infertility

OBGYN
- ○ Bleeding between periods
- ○ Clots in menstrual blood
- ○ Heavy menstrual flow
- ○ Light menstrual flow
- ○ Cramps with period
- ○ Low back pain with period
- ○ Digestive changes with period
- ○ PMS
- ○ Irregular cycle
- ○ Menopausal symptoms
- ○ Pregnancy
- ○ Previous miscarriage(s)
- ○ Previous abortion(s)
- ○ Vaginal pain
- ○ Itching of vulva
- ○ Polycystic breasts
- ○ Endometriosis
- ○ Fibroids
- ○ Polycystic Ovarian Syndrome
- ○ Pelvic Inflammatory Disorder

SLEEP/ENERGY
- ○ Difficulty falling asleep
- ○ Difficultly staying asleep
- ○ Interrupted sleep
- ○ Nightmares
- ○ Vivid dreams
- ○ Wake up feeling tired
- ○ Fatigue/tiredness
- ○ Rate your energy level on 1-10 scale (10 being highest):

  1 2 3 4 5 6 7 8 9 10

MENTAL/EMOTIONAL WELLBEING
- ○ Depression
- ○ Anxiety
- ○ Mania
- ○ Difficulty focusing
- ○ Poor memory
- ○ Easily startled
- ○ Major grief or loss
- ○ Frequent worry
- ○ Frequent anger
- ○ Frequent fear
- ○ Nervousness
- ○ Irritable
- ○ Overwhelmed by life
- ○ Rate your stress level on 1-10 scale (10 being highest):

  1 2 3 4 5 6 7 8 9 10

PATIENT SIGNATURE _____ **Date** _____/_____/_____