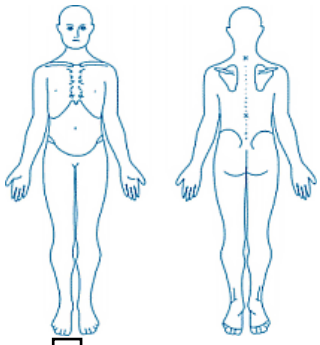
Balanced Body ACUPUNCTURE

New Patient Intake Form

Name: _____ **Date:**_____
Date of Birth:_____ **Age:**_____ **Email:** _____
Address:_____ **City, State, Zip** _____
Home Phone #: _____ **Work:** _____ **Cell:** _____
Occupation: _____ ☐ **Please check here if we can email you updates and a newsletter.**
☐ **Please check if you would like to receive SMS and/or email appointment reminders (standard text messaging rates may apply as provided in your wireless plan - contact your carrier for pricing plans and details).**
Marital Status: ☐ **M** ☐ **S** ☐ **W** ☐ **D** **Height:** _____ **Weight:** _____ **Allergies:** _____
Emergency Contact Name:_____ **Phone:**_____ **Relationship:**_____
Physician: (Name) _____ **(Phone)** _____

General Questions:

PLEASE MARK YOUR AREA OF PAIN



Have you had acupuncture before? ☐ Yes ☐ No
Chief Complaint: _____
How long have you had this condition?_____
Is it getting worse? ☐ Yes ☐ No **Does it bother your:** ☐ Sleep ☐ Work ☐ Other _____
What seemed to be the initial cause? _____
What seems to make it better? _____
What seems to make it worse? _____
Are you experiencing pain right now? ☐ Yes ☐ No
Describe your pain: ☐ Dull ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Other_____
What makes your pain better? ☐ Heat ☐ Pressure ☐ Movement ☐ Cold ☐ Massage ☐ Rest

Family Medical History:

☐ Arteriosclerosis ☐ Cancer ☐ Diabetes ☐ Seizures ☐ Asthma ☐ Heart Disease ☐ Stroke
☐ Alcoholism ☐ High Blood Pressure ☐ Other: _____

Are you currently on any medications? ☐ No ☐ Yes If Yes, Please List: _____
Do you take any vitamins/supplements? ☐ No ☐ Yes If Yes, Please List: _____

Lifestyle:

☐ Alcohol # per day_____ ☐ Stress ☐ Marijuana ☐ Regular Exercise:
Type _____ Frequency_____
Type _____ Frequency_____
☐ Tobacco # per day_____ ☐ Drugs ☐ Occupational Hazards

Your Past Medical History: (Check any of the following conditions you currently have, or have had in the past. Please also circle if you feel any of the following are a significant part of your medical history)

☐ AIDs/HIV ☐ Diabetes ☐ Measles ☐ Thyroid Disorders ☐ Major Trauma:
☐ Alcoholism ☐ Emphysema ☐ Mumps ☐ Tuberculosis _____
☐ Allergies ☐ Epilepsy ☐ Pacemaker _____
☐ Appendicitis ☐ Goiter ☐ Pneumonia ☐ Ulcers _____
☐ Arteriosclerosis ☐ Gout ☐ Polio ☐ Venereal Disease _____
☐ Asthma ☐ Heart Disease ☐ Rheumatic Fever ☐ Whooping Cough ☐ Other:
☐ Birth Trauma (your own birth) ☐ High Blood Pressure ☐ Scarlet Fever ☐ Surgery (Please List All) _____
☐ Cancer ☐ Herpes ☐ Seizures _____
☐ Chicken Pox ☐ Hepatitis ☐ Stroke _____

General Symptoms: (Please check all that apply)

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Craves cold drinks
- ☐ Craves hot drinks
- ☐ Bleed or bruise easily
- ☐ Chills
- ☐ Cold hands or feet
- ☐ Poor circulation
- ☐ Night sweats
- ☐ Sweat easily(describe): _____
- ☐ Dream-Disturbed Sleep
- ☐ Insomnia
- ☐ Heavy Sleep
- ☐ Anxiety
- ☐ Depression
- ☐ Facial pain
- ☐ Poor Memory
- ☐ Fatigue
- ☐ Vertigo or dizziness
- ☐ Blurred vision
- ☐ Recent weight loss/gain
- ☐ Easily Stressed
- ☐ Fever
- ☐ Glaucoma
- ☐ Sinus problems
- ☐ Eczema
- ☐ Hives
- ☐ Hair Loss
- ☐ Asthma/wheezing
- ☐ Nose bleeds
- ☐ Headaches
- ☐ Migraines
- ☐ Change in hair/skin
- ☐ Difficulty breathing when lying down
- ☐ Shortness of breath
- ☐ Tight Chest
- ☐ Numbness
- ☐ Chest Pain
- ☐ Low blood pressure
- ☐ Cough: If yes, is it
  - ☐ Wet OR ☐ Dry
  - ☐ Thick OR ☐ Thin
- ☐ Coughing Blood
- ☐ Tachycardia
- ☐ Fainting
- ☐ Constipation
- ☐ Acid regurgitation
- ☐ Blood in urine
- ☐ Lymph Nodes Removed
- ☐ Pneumonia
- ☐ Blood clots
- ☐ Seizures
- ☐ Intestinal Pain
- ☐ Vomiting
- ☐ Frequent urination
- ☐ Infectious Diseases: _____
- ☐ High blood pressure
- ☐ Irregular Heartbeat
- ☐ Bloody Stools
- ☐ Impotence
- ☐ Heart Palpitations
- ☐ Difficulty Breathing
- ☐ Bowel Movements: **Frequency, etc. =** _____
- ☐ Diarrhea
- ☐ Nausea
- ☐ Pain on urination

Musculoskeletal: (Please check all that apply)

- ☐ Neck/shoulder pain
- ☐ Muscle pain
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Joint Pain
- ☐ Rib Pain
- ☐ Limited Range of Motion
- ☐ Muscle Spasm
- ☐ Other: _____

Woman Only: Gynecology

Are you pregnant? ☐ Yes ☐ No

Duration of flow _____

☐ Irregular Periods ☐ Painful Periods ☐ PMS

Vaginal Discharge (Color) _____

☐ Vaginal Sores ☐ Vaginal Odor ☐ Clots

Date Last Period began _____

Length of cycle (Day 1 to Day 1) _____

Pregnancies _____

Live Births _____

Premature Births _____

Age at Menopause _____

Please List Any Other Pertinent Information:

_____

_____

_____

_____

☐ **I agree that the information I provided on this intake is true. It is my responsibility to inform the Acupuncturist at any point of my course of treatments if any information has changed.**

Signature of Patient_____ **Date**_____