BODY & SOUL

ACUPUNCTURE
bodysoulacupuncture.com
860-881-7449

New Patient Intake Form

Please help me provide you with a complete evaluation
By taking the time to fill out this questionnaire carefully.
All answers are confidential. Please print clearly in ink.

5419 Deale Churchton Rd.
Suite 104
Churchton, MD 20733
(410) 867-8600

IDENTIFICATION Practitioner _____ Date _____

Name _____ Sex ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

DOB _____ Age _____ Email _____

☐ Single ☐ Married ☐ Partnered
☐ Widowed ☐ Separated ☐ Divorced

Height _____ Weight _____ Occupation _____

Education _____

Emergency Contact _____ Relation _____

Emergency Contact Telephone Home _____ Cell _____

Physician* Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Counselor/Psychologist* Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Gynecologist* Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

* No contact will be made without your permission

Your signature _____

Symptoms

FAMILY HISTORY Please complete for each family member, as best as you can, indicating any illness that they have ever had. Please check the box for those who are appropriate.

Adopted	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Good Health	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Cancer or Tumors	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Diabetes	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Thyroid Disorders	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Kidney Disorders	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
High Blood Pressure	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Blood Disorders	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Seizures	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Allergies	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Alcohol or Drug Use	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Stoke/Heart Disease	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child

Depression/ Mental Illness	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Hepatitis/ Liver Disorders	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Musculo-Skeletal Disorder	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
HIV/AIDS	☐ Self	☐ Mother	☐ Father
	☐ Sibling	☐ Spouse/Partner	☐ Child
Deceased	☐ Mother	☐ Father	☐ Sibling
	☐ Spouse/Partner	☐ Child	

PERSONAL LIFESTYLE HABITS For each item, please indicate how much, how many, or how often. Please note if this is current of the date that you quit.

Cigarettes (pack per day)		Coffee/ Tea (cups per day)	
Alcohol (drinks per week)		Soda (regular or diet)	
Drug Use recreational		Exercise How often, if applicable	
		What kind of exercise?	

MEDICAL If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do no include normal pregnancies)

YEAR OPERATION/ILLNESS HOSPITAL OR TREATMENT LOCATION

MEDICINES Please list all medications, vitamins and/or food supplements you are currently taking:

Medications | Dosage | For what condition?

Vitamins | Dosage | For what condition?

Food Supplements | For What condition?

CURRENT AND PAST CONDITIONS/SYMPTOMS/TRAUMAS

If you are currently experiencing any of the following, please check select "C" from the drop down. If you have experienced any of the following in the past, please select "P" from the drop down. If you have experience the condition in the pass and currently, please select "P-C" from the drop down.

General

Insomnia

Dreams/Nightmares

Fatigue

Poor Memory

Strongly like cold drinks

Strongly like hot drinks

Bad breath

Recent weight loss/gain

Cold hands & feet

Chills

Fever

Bad breath

Other (describe)

Nose, Throat & Mouth

Sinus Infection

Hay Fever / Allergies

Frequent sore throat

Difficulty swallowing

Mouth & tongue ulcers

Frequent colds

Nosebleed

Dry Nose

Nasal congestion

Loss of voice

Thirst

Excessive Phlegm

TMJ

Facial pain

Gum problems

Dry Mouth

Other (describe)

Dental problems?

Cardiovascular

High Blood Pressure

Low Blood Pressure

Chest pain or tightness

Palpitation

Rapid heart beat

Irregular heart beat

Poor circulation

Swollen ankles

Phlebitis

Anemia

History of heart disease

Heart murmur

Night sweats

Tendency to be cold

Tendency to be warm

Other (describe)

Head & Neck

Headaches

Migraines

Stiff neck

Dizziness

Fainting

Swollen glands

Other (describe)

Ears

Ringing

Hearing loss

Hearing aids

Infection

Earache

Vertigo

Other (describe)

Skin

Hives

Rashes

Eczema / psoriasis

Night sweating

Excess sweating

Dry skin

Easily bruised

Changes in moles, lumps

Itching

Other (describe)

Gastrointestinal

Nausea

Indigestion

Stomach pain

Diarrhea

Constipation

Poor appetite

Excessive hunger

Vomiting

Gas

Hiccups

Acid regurgitation

Bloating

Laxative use

Bloody stool

Other (describe)

Eyes

Glasses/contact lenses

Blurred vision

Poor night vision

Spots or floaters

Eye inflammation

Double vision

Glaucoma

Cataracts

"Lazy" eye

Other (describe)

How often checked?

Respiratory

Difficulty breathing

Difficulty breathing(reclined)

Wheezing

Asthma

Chronic cough

Wet cough

Dry cough

Coughing up phlegm

Coughing up blood

Shortness of breath

Pneumonia

Other (describe)

Musculoskeletal

Joint pain/swelling

Sore muscles

Weak muscles

Difficulty walking

Pain (describe)

Limited range of motion

Other (describe)

Neurological

Seizure

Tremors

Numbness or tingling

Pain (describe)

Paralysis

Poor coordination

Other (describe)

Mental/Emotional

Depression

Mood swings

Irritability

Difficulty relaxing

Loneliness

Sensitive

Shyness

Frequent crying

Worries frequently

Compulsive behaviors

Difficulty focusing

Hopeless outlook

Suicidal thoughts

Lose temper

Frustration

Other (describe)

Urinary

Vaginal pain/itching

Pain on urination

Uterine fibroids

Frequent urination

Urgent urination

Blood in urine

Incontinence

Incomplete urination

Bed wetting

Wake to urinate

History of UTI

Kidney (specify)

Other (describe)

Male Genital (Men Only)

Impotence

Premature ejaculation

Nocturnal emission

Pain/itching of genitalia

Lumps in testicles

Increased libido

Decreased libido

Other (describe)

Gynecology (Women Only)

Currently pregnant

# of Pregnancies

# of Live births

# of Miscarriages

# of Abortions

Menopause

Irregular periods

Menstrual periods

Excessive blood flow

Menstrual blood clots

Breast tenderness

Breast checked

Abnormal pap smear

Vaginal infections

Endometriosis

Breast, lumps, cysts

Increased libido

Decreased libido

Other (describe)

Infection Screening (select: self, partner or both)

HIV risks

TB

Hepatitis risks

History of STD

Other (describe)

Trauma (list)

Other Information

Patient Signature

Date