Wildwood  Acupuncture

New Patient Intake

Date_____

Name _____ Date of Birth _____ Age _____

Address_____

City_____ State _____Zip_____

Home Phone _____Work Phone _____Cell_____

Email address_____ □M □ F Other_____ Marital Status_____

Emergency Contact (Name & Number)_____

Employer_____Occupation_____Hours/wk_____

Work Address_____

Discovered how or Referred by?_____

Primary Care Physician_____Phone_____

Are you under a physician's care now? □YES □NO Reason_____

_____

Is this visit related to a work or motor vehicle injury? □YES □NO

Injury Date_____

Have you received Oriental medicine treatment before? If so, what type?_____

_____

Name_____Date_____

Medical History Form

Reason for visit today?_____

_____

_____

_____

How long have you had this condition?_____

Is it getting any better or worse?_____

Does it bother your: ☐Sleep ☐Work ☐Other_____

What was the initial cause?_____

What makes it better?_____

What makes it worse?_____

Family Medical History: (Please indicate family member)

□Allergies □Arteriosclerosis □Asthma □Alcoholism

□Cancer □Diabetes □Heart Disease □Hepatitis

□High Blood Pressure □Mental/Emotional issues □Neurological Disease

□Seizures □Stroke □Substance Abuse □Thyroid

Is there anything else about your family history I should know_____

_____

_____

Name_____Date_____

Patient Health Information

Ht._____ Wt._____ **Blood Pressure_____**

Do you have any reason to believe you are pregnant? ☐Yes ☐No

Do you have any chronic infectious diseases? ☐Yes ☐No type_____

What prescription or over the counter medications do you take CURRENTLY?

What vitamins/herbs/supplements do you take CURRENTLY?

Do you have food or drug allergies or sensitivities? ☐Yes ☐No

(Please List)_____

Name_____**Date**_____

<u>Your Medical History:</u> (check if you had or currently have any of these conditions)

☐AIDS/HIV	☐Alcoholism	☐Allergies
☐Appendicitis	☐Anemia	☐Arteriosclerosis
☐Asthma	☐Birth Trauma	☐Cancer
☐Chicken Pox	☐Diabetes (type)_____	☐Emotional Disorder
☐Emphysema	☐Epilepsy	☐Major Trauma
☐Major Hospitalization	☐Goiter	☐Gout
☐Heart Disease	☐Hepatitis (type)_____	☐Herpes
☐High Blood Pressure	☐Low Blood Pressure	☐Measles
☐Multiple Sclerosis	☐Mumps	☐Neurological
☐Pacemaker	☐Pneumonia	☐Polio
☐Rheumatic Fever	☐Scarlet Fever	☐Seizures
☐STD (type)_____	☐Stroke	☐Surgery
☐Tuberculosis	☐Typhoid Fever	☐Ulcers
☐Venereal Disease	☐Whooping Couch	☐Other

Please describe:_____

_____

_____

_____

_____

_____

Name_____Date_____

Diet & Lifestyle:

Appetite? ☐Low ☐Normal ☐High

Foods Cravings? ☐Sweet ☐Salty ☐ Rich ☐ Other _____

Thirst for water? ☐Low ☐High Strongly prefer water? ☐Cold ☐Hot ☐Tepid

Do you usually feel? ☐Hot ☐Cold ☐Varies ☐Cold Hands and Feet ☐Just Right

Please describe your typical diet, including any particular foods that you *do* or *do not eat:*

_____

_____

_____

_____

_____

Do you feel this is a good diet for you? ☐Yes ☐No

What would you change about your diet?_____

Do you use tobacco (what form/how much)?_____

Do you drink alcohol (what form/how much)?_____

Do you use caffeine (what form/how much)?_____

Do you use recreational drugs (what form/how much)?_____

Exercise (what form/how much)?_____

Daily H20 intake? _____

Sleep Habits? _____

Bowel Movements per day? _____

Are you sexually active? ☐Yes ☐No Method of contraception_____

What are the major stressors in your life?_____

_____

What do you enjoy in life?_____

_____

Hobbies/Interests?_____

_____

Do you have a spiritual or faith practice (please explain) ?_____

_____

_____

What emotions and feelings are currently predominant in your life?

_____

_____

_____

Have you experienced any major traumas (please explain)_____

_____

_____

<u>Emotional / Mental Self Report: Circle the number that best describes you today.</u>

How do you feel about: (Great <5…4…3…2…1.> Not So Great)

Your life 5 4 3 2 1

Your profession 5 4 3 2 1

Your relationships 5 4 3 2 1

Your family 5 4 3 2 1

Your spirituality 5 4 3 2 1

Is there anything else I should know about you?_____

_____

_____

_____

_____

_____

_____

Body System Review – Please check any areas of concern, whether current, past, or occasional.

	Current	Past	Occasional
GENERAL:			
Fatigue			
Low energy			
Anemia			
Slow wound healing			
Chronic infections			
Allergies			
Difficulty sleeping			
Unexplained fever			
Headaches			
Frequent colds			
Alcohol or substance abuse			
MUSCULO-SKELETAL:			
Lower back pain			
Upper back pain			
Neck pain			
Shoulder pain			
Arm/wrist/hand pain			
Leg/foot pain			
Joint pain/stiffness			
Arthritis			
Muscle spasms/cramps			
NERVOUS SYSTEM;			
Numbness/tingling			

	Current	Past	Occasional
Feeling hot or cold			
Cold hands or feet			
CARDIOVASCULAR:			
Heart disease			
Stroke			
Chest pain			
High blood pressure			
Low blood pressure			
Heart palpitations			
Irregular heartbeat			
Heart murmur			
Rheumatic fever			
Varicose veins			
Ankle swelling			
Water retention/edema			
RESPIRATORY:			
Shortness of breath			
Difficulty breathing			
Lung congestion			
Persistent cough			
Asthma/wheezing			
Chronic bronchitis			
Influenza			
Pneumonia			

Paralysis/atrophy			
Dizziness/Vertigo			
Fainting			
Seizures/Epilepsy			
Tics			
Forgetfulness/Poor memory			
Depression			
Irritability			
Easily stress			
Anxiety/Nervousness			
Mood swings			
Abuse survivor			
Considered/attempted suicide			
Seeing a therapist			
ENDOCRINE:			
Hypo/hyper thyroid			
Low blood sugar			
Diabetes I or II			
Unusual day sweats			
Night sweats			

Pleurisy			
Emphysema			
Tuberculosis			
GASTROINTESTIONAL:			
Poor appetite			
Excessive appetite			
Changes in appetite			
Weight gain or loss			
Excessive thirst			
Belching			
Gas/bloating			
Indigestion			
Acid regurgitation/ heartburn			
Nausea/vomiting			
Abdominal cramps/pain			
Hemorrhoids			
Hiccups			
Bad breath			
Peculiar tastes			
Diarrhea			

Frequent stools			
Constipation			
Slow/infrequent stools			
Laxative use			
Undigested food in stool			
Mucous in stool			

Eczema			
Psoriasis			
Herpes			
Hives			
Shingles			
Ulcerations			

Black or bloody stool			
Itchy or burning anus			
Colitis/Irritable bowel			
Intestinal pain or cramping			
Rectal pain			
Appendicitis			
Gall bladder problems			
Liver trouble			
EENT:			
Vision problems/changes			
Eye pain or strain			
Red, itchy eyes			
Floaters (spots) in vision			
Poor night vision			
Glaucoma			
Tearing/dryness			
Glasses/contacts			
Hearing problems			
Earaches/discharge			
Ear ringing/tinnitus			
Sinus problems			
Phlegm			
Nose bleeds			
Frequent sore throats			

Fungal infections			
Hair loss			
GENITO-URINARY:			
Frequent urinary tract infections			
Painful urination			
Excessive urination			
Changes in stream			
Leakage of urine			
Bed wetting			
Blood in urine			
Sexually transmitted disease			
Kidney stones			
Kidney disease			
MEN'S HEALTH:			
Sexual difficulties			
Prostate problems			
Testicular pain/swelling			
Discharge from penis			
Changes in sexual desire or function			
Fertility issues			
WOMEN'S HEALTH:			
PMS			
Menstrual irregularity			
Menstrual cramping			

Enlarged thyroid				Changes in menstrual cycle			
Hay fever				Bleeding between cycles			
Teeth grinding				Vaginal pain/infections			
Jaw pain/clicking				Vaginal discharge			
Dental problems				Frequent yeast infections			
Headaches				Pain with intercourse			
Migraines				Breast pain/lumps			
Concussion				Nipple discharge			
SKIN & HAIR:				Menopause symptoms			
Frequent bruising				Hot flashes			
Itching				Menopause			
Dryness				Changes in sexual desire or function			
Rashes				Sexual difficulties			
Acne				Fertility issues			

Please elaborate as needed on these conditions:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PAIN

Describe the location: _____ Mark on the figures the areas of pain.

Quality of pain: (circle)
Dull, sharp, stabbing, sore, cramping, throbbing, burning, constant, radiating, fixed, moves about

Rate the intensity of the pain. (circle)
(1 = An annoyance) (10 = Kidney stones or giving birth)
1 2 3 4 5 6 7 8 9 10

What relieves the pain? _____

What aggravates it? _____

Is there any stiffness? Where? _____

Are there any movements that aggravate the pain? _____

What does the pain prevent you from doing? _____

Do any medications help your pain? _____

What other treatments have you had for the pain? _____