Integrated Acupuncture Matters
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NEW PATIENT INTAKE FORM

Please take the time to fill out this questionnaire. The information you provide will assist us in formulating a complete health profile for you. All of your answers are absolutely confidential.
If you have any questions, please ask.

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____ City: _____ State: _____

Zip: _____

Primary phone: _____ Secondary phone: _____

Email: _____

Preferred method of contact: _____ phone _____ email

Date of birth: _____ Current age: _____ Height: _____Weight: _____

Relationship status: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____

Emergence contact: _____ Phone: _____

How did you hear about us? _____Have you had acupuncture before? _____

If yes, when?_____ By whom? _____

What for? _____

HEALTH INFORMATION

Main complaint: _____

Other complaints: _____

How long have you had this problem? _____

What makes your symptoms improve? _____

What makes your symptoms worse? _____

Have you received a medical diagnosis? _____ Y_____ N

If yes, Please list: _____

MEDICAL HISTORY

Please check any of the following that have ever affected you.

_____ Addiction
_____ Aids
_____ Alcoholism
_____ Anemia
_____ Arteriosclerosis
_____ Arthritis
_____ Asthma
_____ Breast lumps
_____ Bursitis
_____ Cancer
_____ Candida
_____ Chronic fatigue
_____ Colitis/bowel disease
_____ Diabetes
_____ Digestive disorders
_____ Eating disorder
_____ Emotional imbalance
_____ Emphysema
_____ Epilepsy
_____ Fibromyalgia
_____ Gallstones
_____ Glaucoma
_____ Goiter
_____ Gout
_____ Heart disease
_____ Hepatitis
_____ Hernia
_____ Herpes
_____ High cholesterol
_____ Hypertension
_____ Hypotension
_____ Kidney stones
_____ Malaria
_____ Meningitis
_____ Mononucleosis
_____ Multiple sclerosis
_____ Nephritis
_____ Neuralgia
_____ Paralysis
_____ Prostate problems
_____ Rheumatism
_____ STD
_____ Seizures
_____ Stroke
_____ Tonsillitis
_____ Tuberculosis
_____ Ulcers
_____ Urinary problems
_____ Whopping cough

Other: _____

Surgeries, Hospitalizations, and Significant traumas (car accidents, loss of loved ones, etc.):

Date	Event

Medications taken in the last 3 months, including over-the counter medications:

Medication	Dosage	Reason	How long

Please list any vitamins, supplements, or herbal medicines you are currently taking (with dosage):

_____

_____

_____

Please list any allergies or adverse reactions, especially to food or drugs:

_____

_____

_____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following diseases or conditions? Check all that apply.

_____ Arthritis
_____ Addiction
_____ Allergies
_____ Anemia
_____ Asthma
_____ Heart disease
_____ Mental health
_____ Hypertension
_____ Obesity
_____ Cancer
_____ Kidney disease
_____ Seizures
_____ Arteriosclerosis
_____ Diabetes
_____ Liver disease
_____ Stroke

Other: _____

PERSONAL & SOCIAL HISTORY

How many hours per night do you sleep? _____ When do you usually go to bed? ___

Wake rested? _____

Do you exercise regularly? _____

What kind and how much? _____

What are your hobbies/things you enjoy doing in your free time?

_____

Energy level:

_____ up and down _____ normal _____ low after eating

_____ low _____ excess

Mental/Emotional:

_____ happy _____ angry _____ hurry to do things

_____ easily irritable _____ cry easily _____ depression anxiety

_____ difficulty making decisions _____ stressed _____ restlessness

Please indicate use (yes/no) and frequency of the following:

- Cigarettes: _____ How many per day? _____ When did you start : _____
- Alcohol: _____ Type and amount per week? _____
- Recreational drugs: _____ Type and amount per week? _____ Since when? _____
- Coffee: _____ Amount _____
- Soda: _____ Amount _____
- Water: _____ Amount _____

Please describe your daily diet:

Morning:_____

Afternoon:_____

Evening:_____

Do you crave any particular foods or flavours :_____

How do you feel about the following areas of your life?

	GREAT	GOOD	FAIR	POOR	BAD	Comments
Partner						
Family						
Diet						
Sex						
Self						
Work						
Spirituality						

SYMPTOM SURVEY

Please check any of the following that apply to you now or in the past.

CONDITION	PAST	NOW	CONDITION	PAST	NOW	CONDITION	PAST	NOW
Shortness of breath			Poor appetite			Allergies		
Poor coordination			Excess appetite			Fever		
Vertigo/dizziness			Strong thirst			Chills		
Bleed/bruise easily			Fatigue			Heavy body		
Hot/cold intolerance			Poor sleeping			Weight loss		
Nervousness/irritability			Night sweats			Weight gain		
Sudden energy drop			Sweat easily			Tremors		
Localized weakness			Swollen glands			Mood changes		
Frequent infect			Cold hands/feet			Cravings		

Other:_____

PSYCHOLOGICAL

CONDITION	PAST	NOW	CONDITION	PAST	NOW	CONDITION	PAST	NOW
Loss of control			Irritability			Depression		
Anxiety			Bad temper			Panic attacks		
Suicidal thoughts			Suicidal attempt			Easily stressed		
Seeing a therapist			Extreme fear			Extreme grief		

Other:_____

SKIN AND HAIR

CONDITION	PAST	NOW	CONDITION	PAST	NOW	CONDITION	PAST	NOW
Rashes			Dry skin			Itching		
Eczema			Acne			Psoriasis		
Hives			Moles			Dandruff		
Tumors/lumps			Ulceration			Slow wound healing		

Other:_____

HEAD, EYES, EARS, NOSE AND THROAT

CONDITION	PAST	NOW	CONDITION	PAST	NOW	CONDITION	PAST	NOW
Dizziness			Color blindness			Corrective lenses		
Headache			Vision changes			Poor hearing		
Migraine			Cataracts			Ear pain		
Concussion			Glaucoma			Sinus problems		
Facial Pain			Spots in vision			Runny nose		
Sore throat			Night blindness			Sneezing		
Sores on lips/tongue			Blurry vision			Congestion		
Grinding teeth			Eye pain			Loss of smell		
Jaw clicks			Dry eyes			Nosebleeds		
Gum problems			Red eyes			Peculiar smells		
Excessive salive			Itchy eyes			Peculiar tastes		

Other:_____

CARDIOVASCULAR

CONDITION	PAST	NOW	CONDITION	PAST	NOW	CONDITION	PAST	NOW
High blood pressure			Swelling of hands			Fainting		
Low blood pressure			Swelling of ankles			Blood clots		
Irregular heartbeat			Cold hands/feet			Palpitations		
High cholesterol			Heart murmur			Chest pain		
Poor circulation			Heart valve issues			Heart attack		
Varicose veins			Stroke			Clotting disorder		

Other:_____

RESPIRATORY

CONDITION	PAST	NOW	CONDITION	PAST	NOW	CONDITION	PAST	NOW
Shortness of breath			Shallow breathing			Sleep apnea		
Pain in deep breathing			Bronchitis			Asthma		
Tightness of chest			Emphysema			Wheezing		
Difficulty breathing			Frequent colds/flu			Pneumonia		
Excessive phlegm			Coughing blood			Cough		

Other:_____

GASTROINTESTINAL

CONDITION	PAST	NOW	CONDITION	PAST	NOW	CONDITION	PAST	NOW
Burning of anus			Constipation			Haemorrhoids		
Chronic laxative use			Diarrhea			Gas/bloating		
Pain with defecation			Blood in stool			Indigestion		
Incomplete defecation			Food in stool			Belching		
Light colored stools			Black stool			Nausea		
Foul smelling stools			Rectal pain			Vomiting		
Abdominal pain			Bad breath			Hiccups		
Hiatal hernia			Lack of appetite			Acid reflux		

Other:_____

GENITO_URINARY

CONDITION	PAST	NOW	CONDITION	PAST	NOW	CONDITION	PAST	NOW
Pain on urination			Kidney stones			Herpes		
Urgency to urinate			Increased libido			Bedwetting		
Unable to hold urine			Decreased libido			STD’s		
Decreased urine flow			Frequent UTIs			Genital itching		
Incomplete urination			Sores on genitals			Blood in urine		
Night-time urination			Malodorous urine			Cloudy urine		

Other:_____

MALE REPRODUCTIVE (Men only)

CONDITION	PAST	NOW	CONDITION	PAST	NOW	CONDITION	PAST	NOW
Prostate problems			Penile discharge			Impotence		
Sexual dysfunction			Testicular lumps			Testicular pain		

Other:_____

Have you had a prostate exam? _____ Y _____ N If yes, when? _____
Results? _____

GYNECOLOGICAL (Women only)

If you have gone through menopause, please describe past menstruation.
Is there a possibility you're pregnant? _____ Y _____ N

CONDITION	PAST	NOW	CONDITION	PAST	NOW	CONDITION	PAST	NOW
Painful periods			Irregular periods			Mastitis		
Vaginal discharge			Uterine bleeding			Fibroids		
Infertility			Breast lumps			PCOS		
Yeast infection			Vaginitis			Endometriosis		
Ovarian Cysts			PMS			PID		

Date of last pap smear? _____

Age of first period: _____ Number of days between periods: _____
Number of days of flow: _____

Menstruation:
Flow:
_____ Heavy
_____ Light
_____ Clots
_____ Painful
_____ Spotting between periods

Color of flow: _____ Start date of last cycle: _____

PMS Symptoms:_____

Menopause: Age of menopause: _____
Menopausal symptoms:_____

Pregnancy: # of pregnancies: _____ # of births: _____ # of miscarriages: _____
# of abortions: _____ # of premature births _____

Other:_____

MUSCULOSKELETAL/NEUROLOGICAL

CONDITION	PAST	NOW	CONDITION	PAST	NOW	CONDITION	PAST	NOW
Neck tightness/pain			Knee pain			Hernia		
Shoulder pain			Muscle weakness			Seizures		
Hand/wrist pain			Muscle pain			Tremors		
Back pain			Joint sprain			Numbness		
Hip pain			Joint disorders			Tingling		
Sciatica			Scoliosis			Paralysis		

Other:_____

Please feel free to list/describe any other issues you would like to

discuss:_____

_____

_____

The information on this form is correct and accurate to the best of my knowledge.

Signature: _____

Date: _____

Please save this document and return it to me via e-mail (info@IAM-Acupuncture.com) before your first appointment. This way I will have the opportunity to get an idea of your current and past conditions and general state of health before we meet.

Thank you, I look forward to working with you in the near future.