southpoint community
ACUPUNCTURE

New Patient Intake

Name: ______________________________________ Phone: ____________________

Address: ____

Email: _______________________________ Date of Birth: ______________________

Occupation: _________________________ Have you had acupuncture before? ______

How did you hear of our clinic? ____

Emergency contact information: ____

When was your last complete medical exam? __________________________________

Are you currently under a doctors care? _______________________________________

Known allergies (please list): ____

Medications currently taking: ____

Supplements/vitamins/herbs/other: ____

Does your health history include major illnesses/surgeries/accidents/etc? If yes, please list:

____

____

What main concern(s) would you like addressed today? __________________________

____

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What would you like to get out of your acupuncture treatment? ____________________

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Check conditions you have or have had in the past:

O AIDS	O Cancer	
O Anemia	O Diabetes	O Seizure disorder
O Arthritis	O Fibromyalgia	O Stroke
O Bleeding disorders	O Hepatitis	O Thyroid disease
O Breast lump(s)	O Persistent fatigue	O Unexplained weight gain/loss

Muscles/Joints/Bones:

Check symptoms you have or have had in the past year:

O Muscle cramps	O Swollen joints	O Tremors

O Other: ____

Pain, weakness, or numbness in:

O Arms	O Hips	O Shoulder
O Back	O Legs	O Other
O Feet	O Knees	
O Hands	O Neck	

Are you experiencing pain at this moment? ______________________________

How (aching, burning, shooting, stabbing, etc.) would you describe it?

____

On a scale of 1-10 (1=mild, 10=severe), how would you rate it at this moment? ____________

Does anything make it better (heat, cold, pressure, rest, etc)? _______________

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Does anything make it worse? ____

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Ear/Eyes/Nose/Throat:

O Asthma/wheezing	O Frequent colds	O Red/itchy eyes
O Blurry vision	O Hay fever/allergies	O Ringing in ears
O Chronic cough	O Headache	O Sinus problems
O Difficulty breathing	O Hoarseness	O Teeth grinding
O Dizziness	O Gum trouble	O Shortness of breath
O Earache	O Mouth sores	O Swollen glands
O Enlarged glands	O Nose bleeds	O Other:
O Eye pain	O Loss of hearing	________________

Skin:

O Boils	O Itching	O Sore that won't heal
O Bruise easily	O Rash	O Unusual sweats
O Dry skin	O Sensitive skin	O Other: ___________

Genito-urinary:

O Blood/pus in urine	O Incontinence	O Other: ___________
O Dribbling urine	O Kidney stones	
O Frequent urination	O Lowered libido	

Sleep:

How many hours of sleep do you get per night? _______ Is this enough? _______

How would you describe the quality of your sleep? __________________________

Do you wake to urinate? ________ If yes, how many times? _________________

Do you wake feeling rested? ____________________

Do you have enough energy throughout the day? ___________________________

Gastrointestinal:

O Belching
O Colon trouble
O Constipation
O Diarrhea
O Difficulty swallowing
O Excessive hunger
O Gall bladder trouble
O Gas/bloating
O Heartburn
O Hemorrhoids
O IBS
O Morning sickness
O Nausea
O Poor appetite
O Stomach pain
O Ulcer
O Vomiting
O Other: ________________

How would you describe your diet? ____

____

How often do you have a bowel movement? _____________________________________

Any problems/concerns? _________ If yes, please describe: _______________________

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Cardiovascular:

O Chest pain
O High blood pressure
O Low blood pressure
O Palpitations
O Poor circulation
O Previous heart attack
O Rapid/irregular heart beat
O Swelling of ankes
O Other: _______________

Emotional:

Which emotions dominate your experience?

O Anger
O Anxiety
O Depression
O Fear
O Grief
O Indecision
O Irritability
O Joy
O Overthinking
O Sadness
O Timid/shy
O Worry
O Other: ___________

For men only:

O Erection difficulties
O Penis discharge/pain
O Prostate trouble
O Other: _______________

For women only:

O Breast tenderness	O Spotting between periods	O PMS
O Clots in menses	O Hot flushes	O Scanty menstrual flow
O Excessive menstrual flow	O Irregular cycle	O Other: _____________
O Severe menstrual pain	O Night sweats	

Number of pregnancies: _______________ Number of live births: _______________

Could you be pregnant? _______________Age at first menses: __________________

Length of full monthly cycle in days: ________________

Length of menses (How many days do you bleed for?): __________________

Are you using hormonal birth control? _________ For how long? ________________

Age at last menses (if applicable): __________________

Are you using hormone replacement therapy (HRT) ? _________

For how long? ______________

Is there anything else related to your physical, emotional, or spiritual health history that you think is important for your practitioner to know? _____________________

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This information is true to the best of my knowledge.

____ ______________________

Signature Date