Wind Point Acupuncture

New Patient Intake Form

Today's Date ________ /_________ /_________

Name **Date of Birth**

Address

Phone **Work Phone**

Occupation

Emergency Contact-Name & Phone

Physician Name & Phone

Have you had acupuncture before? ☐ **Yes** ☐ **No** **Referred by**

Reason for visit

How long have you had this condition?

What makes it better? **What makes it worse?**

Family Medical History (Mother, Father, Siblings, Children)

☐ Allergies :	☐ Diabetes	☐ Seizures
☐ Asthma	☐ Heart Disease	☐ Stroke
☐ Cancer (type):	☐ High Blood Pressure	

Your Medical History

(Check any of the following conditions that you currently have, or have had in the past.)

☐ AIDS/HIV	☐ Heart Disease	☐ Stroke	☐ Tuberculosis
☐ Alcoholism	☐ Hepatitis	☐ Surgery (please list)	☐ Ulcers
☐ Allergies	☐ High Blood Pressure		☐ Whooping Cough
☐ Appendicitis	☐ Measles		☐ Other (specify):
☐ Asthma	☐ Multiple Sclerosis		
☐ Cancer	☐ Pacemaker	☐ Thyroid Problems	
☐ Diabetes	☐ Pneumonia	☐ Trauma/Accidents (list)	
☐ Emphysema	☐ Polio		
☐ Epilepsy	☐ Rheumatic Fever		
☐ Gout	☐ Seizures		

Your Diet

Appetite: ☐ **Low** ☐ **High** **Thirst:** ☐ **Low** ☐ **High**

Cravings/Preferences: ☐ **Salty** ☐ **Sweets** ☐ **Spicy** ☐ **Sour** ☐ **Other:**

Beverages: ☐ **Coffee (cups per day):** ☐ **Soft Drinks (# per day):** ☐ **Water (cups per day):** ☐ **Other:**

Allergies to Foods or Medications:

Medications / Supplements

(List medications and supplements you are currently taking, or any you have taken in the past 2 months)

Lifestyle

- ☐ Alcohol ☐ Marijuana ☐ Stress ☐ Regular Exercise (type & frequency):
- ☐ Tobacco ☐ Drugs ☐ Occupational Hazards

General Symptoms

- ☐ Recent weight loss ☐ Poor sleep ☐ Cold hands or feet ☐ Fever ☐ Sweat easily
- ☐ Recent weight gain ☐ Heavy sleep ☐ Poor circulation ☐ Chills ☐ Dizziness/Vertigo
- ☐ Fatigue ☐ Dream-disturbed sleep ☐ Shortness of breath ☐ Night sweats ☐ Peculiar taste (describe):
- ☐ Lack of strength

Head, Ears, Eyes, Nose, Throat

- ☐ Headaches ☐ Red eyes ☐ Sinus problems ☐ TMJ ☐ Ringing in ears
- ☐ Migraines ☐ Itchy eyes ☐ Dry mouth ☐ Sores on lips or tongue ☐ Poor hearing
- ☐ Concussions ☐ Dry eyes ☐ Excess saliva ☐ Sore throat ☐ Ear pain
- ☐ Facial Pain ☐ Glaucoma ☐ Excessive phlegm ☐ Swollen glands ☐ Other:
- ☐ Blurred vision ☐ Cataracts ☐ Teeth problems ☐ Lump in throat
- ☐ Eye pain ☐ Nosebleeds ☐ Gum problems ☐ Enlarged thyroid

Respiratory

- ☐ Difficulty breathing when lying down ☐ Tight chest ☐ Dry cough ☐ Cough with phlegm ☐ Coughing blood

Cardiovascular

- ☐ Chest pains ☐ Blood clots ☐ Low blood pressure ☐ Palpitations ☐ Irregular heartbeat ☐ Other:

Gastrointestinal

- ☐ Nausea ☐ Gas ☐ Bad breath ☐ Laxative use ☐ Mucous in stools ☐ Other:
- ☐ Vomiting ☐ Hiccups ☐ Diarrhea ☐ Black stools ☐ Intestinal pain/cramps
- ☐ Acid reflux ☐ Bloating ☐ Constipation ☐ Bloody stools ☐ Hemorrhoids

Musculoskeletal

- ☐ Neck/Shoulder pain ☐ Muscle pain (where?) ☐ Joint pain (where?) ☐ Other (specify):
- ☐ Upper back pain
- ☐ Lower back pain

Skin and Hair

- ☐ Acne ☐ Eczema ☐ Fungal infections ☐ Dandruff ☐ Change in hair/skin texture
- ☐ Hives ☐ Psoriasis ☐ Itching ☐ Hair loss ☐ Other (specify):

Neuropsychological

- ☐ Numbness ☐ Anxiety ☐ Poor memory ☐ Easily stressed ☐ Other (specify):
- ☐ Tic/twitching ☐ Depression ☐ Irritability ☐ Abuse survivor

Genito-urinary

- ☐ Pain on urination ☐ Incomplete urination ☐ Bedwetting ☐ Increased libido ☐ Other (specify):
- ☐ Frequent urination ☐ Blood in urine ☐ Wake to urinate ☐ Decreased libido
- ☐ Urgent urination ☐ Unable to hold urine ☐ Kidney stones ☐ Impotence

Gynecology

- ☐ Irregular periods ☐ PMS # Pregnancies: Age menses began: Date of last PAP:
- ☐ Painful periods ☐ Vaginal discharge # Live births: Age at menopause:
- ☐ Clots ☐ Breast lumps Date last period began:

Other

(Please list any other problems or conditions not covered above.)