

New Patient Intake Form

Today's Date:

Name (Last, First, M.I.):					<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	
Address:			City:		State: TX	Zip:	
Email:		Home Number:		Work Number:			
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed							
Emergency Contact:			Emergency Phone:			Cell Number:	
Age:	Weight:		Height:		Reason for visit?		
Use Chinese Herbal Medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you ever had acupuncture before? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Referred by:		Occupation:					
How long have you had condition? N/A		Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does it bother your:			
What seemed to be the initial cause?				What seems to make it better?			
Are you under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N If yes, for what?							
Who is your physician?		Physician Phone?		Other Current Therapies:			
Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio							
Immunizations and dates:		<input type="checkbox"/> Tetanus <input type="checkbox"/> Hepatitis		<input type="checkbox"/> Pneumonia <input type="checkbox"/> Chickenpox		<input type="checkbox"/> Influenza <input type="checkbox"/> MMR Measles, Mumps, Rubella	
YOUR PAST MEDICAL HISTORY: (CHECK ANY OF THE FOLLOWING CONDITIONS YOU CURRENTLY HAVE, OR HAVE HAD IN THE PAST. PLEASE ALSO CHECK IF YOU FEEL ANY OF THE FOLLOWING ARE A SIGNIFICANT PART OF YOUR MEDICAL HISTORY.)							
<input type="checkbox"/> AIDS/ HIV	<input type="checkbox"/> Birth Trauma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Measles	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Polio	<input type="checkbox"/> Typhoid Fever		
<input type="checkbox"/> Allergies	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ulcers		
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Venereal Diseases		
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Seizures			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke				
MUSCULOSKELATON:							
<input type="checkbox"/> Neck/ shoulder	<input type="checkbox"/> Upper back	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Limited range of motion	<input type="checkbox"/> Other			
<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Lower back	<input type="checkbox"/> Rib pain	<input type="checkbox"/> Limited use				
SKIN AND HAIR:							
<input type="checkbox"/> Rashes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Changes in hair/ skin texture				
<input type="checkbox"/> Hives	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Itching	<input type="checkbox"/> Fungal infections				
<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Acne	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Other				
NEUROPSYCHOLOGICAL:							
<input type="checkbox"/> Seizures	<input type="checkbox"/> Tics	<input type="checkbox"/> Depression	<input type="checkbox"/> Easily Stressed	<input type="checkbox"/> Abuse survivor			
<input type="checkbox"/> Numbness	<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Irritability	<input type="checkbox"/> Consider/Attempted Suicide			
<input type="checkbox"/> Seeing a Therapist	<input type="checkbox"/> Other Specify:						
GENITO-URINARY:							
<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Impotence			
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Premature ejaculation			
<input type="checkbox"/> Urgent urination	<input type="checkbox"/> Incomplete urination	<input type="checkbox"/> Wake to urination	<input type="checkbox"/> Kidney stone	<input type="checkbox"/> Nocturnal emission			
GYNECOLOGY:							
Duration of flow:	<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Breast lumps	<input type="checkbox"/> Painful periods	<input type="checkbox"/> PMS			
<input type="checkbox"/> Vaginal sores	<input type="checkbox"/> Vaginal odor	<input type="checkbox"/> Vaginal discharge	Color:	# of Pregnancies:			
Age menses began:		Length of cycle (day 1 to day 1):		Date of last period:			
# Live births:		Premature births:		Age at Menopause:			
Any hot flashes or sweating at night? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Allergies to medications							
Name the Drug		Reaction You Had					

Hospitalizations		
Year	Reason	Hospital delete
Have you ever had a blood transfusion?		Yes <input type="checkbox"/> No <input type="checkbox"/>
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
HEALTH HABITS AND PERSONAL SAFETY		

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Sex	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you live alone?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?		<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
			Grandmother <i>Maternal</i>		
			Grandfather <i>Maternal</i>		
			Grandmother <i>Paternal</i>		
			Grandfather <i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

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