Acupuncture and Holistic Care

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New Patient Intake Form

Patient Information	**Contact Information**
Today's Date: Name: Date of birth: Occupation: Primary care provider: Have you had acupuncture before? Yes ☐ No ☐	Address: Phone: Email: Emergency contact Name: Cell phone:

Health History

Primary reasons for coming in for treatment:
1.
2.

Intensity of complaint (0 to 10):

How long have you had this condition(s)?

Is it getting worse?

What makes it better? (heat, cold, damp, exercise/activity, rest, sleep, etc.)

What makes it worse? (heat, cold, damp, exercise/activity, rest, sleep, etc.)

Other current therapies

How is your sleep?

How is your digestion?

How often do you move your bowels? With Ease?

Significant/chronic illnesses, accidents or surgeries.

When was your last menstrual cycle?

Are you pregnant?

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

- ☐ Depression
- ☐ Anxiety
- ☐ Difficulty focusing
- ☐ Dizziness
- ☐ Easily startled
- ☐ Excessive worry and/or fear
- ☐ Excessive anger
- ☐ Fatigue/tiredness
- ☐ Loss of sleep/poor sleep
- ☐ Nervousness/irritability
- ☐ Overwhelmed by life

Check any other areas of concern you have other than your primary reasons for coming:

- ☐ Muscle/joint/bone
- ☐ Eyes/ears/nose/throat/respiratory
- ☐ Skin related issues
- ☐ Genito/urinary
- ☐ Cardiovascular
- ☐ Gastrointestinal
- ☐ Menstrual related issues
- ☐ Sexual/reproductive

List medications or food supplements:

Anything else you would like us to know about you?

The information in this form is correct to the best of my knowledge.

Signature: **Date:**