NEW PATIENT INTAKE FORM

(Please note that all INFORMATION will be kept STRICTLY CONFIDENTIAL)

First Name: ________________________________ Middle Initial:____ Last:___________________________

Address (street): ____

City / State / Zip: ____

Home phone:___________________________________ Cell phone: ________________________________

Work phone: ___________________________________ E-mail Address:___________________________

Date of Birth:__________/_______/__________________ Age: ___________________________________

Marital Status: ___ Single ___ Married ___ Life partner ___ Separated ___ Divorced ___ Widowed

Occupation: ______________________________________ Height: _____________ Weight: ___________

Emergency contact :

Name: ____

Relationship:____ Phone:____________________________

How were you referred? ____

Have you ever had a massage treatment before? If yes, where and when:

____

____

Have you ever had an acupuncture treatment before? If yes, where and when:

____

____

REASON FOR TODAY'S VISIT:

____

ARE YOU SEEKING / HAVE SEEKED OTHER HEALTH CARE PROFESSIONAL'S HELP FOR YOUR CURRENT CONDITION? IF YES, PLEASE LIST.

Specialty	Date

Signature: ____ Date: ____________________

PLEASE FILL IN AS MUCH INFORMATION AS YOU CAN PROVIDE.

PAST MEDICAL HISTORY:

HOSPITALIZATIONS:

REASON	DATE

SIGNIFICANT TRAUMA (auto accident, fall, injuries, scars, etc.):

TRAUMA	DATE

ALLERGIES (drugs, chemicals, pets, foods, etc.)

____

____

MEDICATIONS / SUPPLEMENTS: (Include prescription, over the counter drugs, vitamins, food supplements, etc. taking or have taken in the last 3 months).

NAME	DOSAGE / DAY	REASON	PRESCRIBED? Y/N

Please indicate if you have any of the following:

__ Pacemaker __ Bleeding disorder __ Fainting disorder __ Sensitive skin __ Glasses/Contacts

__ Surgical implants: If so, what kind? ____

PERSONAL HISTORY / LIFESTYLE:

Emotional stress scale (please circle): 1 (no stress) 2 3 (moderate) 4 5 (extremely stressed)

What type of exercise do you perform?: ___ None ___ Light ___ Moderate ___ Strenous

Please indicate the use and frequency of the following:

Coffee/Black Tea: yes ____ no ____ how much __________

Tobacco: yes ____ no ____ how much __________

Alcohol: yes ____ no ____ how much __________

Approximately how much water do you drink per day? ______________________________

Signature: ____ Date: ____________________

MEDICAL HISTORY:

Please indicate any significant illnesses you or a blood relative have:

	You	Mother	Father	Brother	Sister	Children	DATE
Allergies							
Diabetes							
High Blood Pressure							
Stroke							
Heart Disease							
Cancer							
Seizure							
Hepatitis							
Rheumatic Fever							
Kidney Disorder							
Thyroid Disorder							
Emotional Disorder							
Systemic Lupus							

FOR EACH CONDITION LISTED BELOW, PLACE A CHECK IN THE PAST COLUMN IF YOU HAVE HAD THE CONDITION IN THE PAST. IF YOU PRESENTLY HAVE A CONDITION LISTED BELOW, PLACE A CHECK IN THE PRESENT COLUMN.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
___	___	Headaches	___	___	Knee pain	___	___	Hip pain
___	___	Neck pain	___	___	Wrist/Hand pain	___	___	Muscle weakness
___	___	Low back pain	___	___	Shoulder pain	___	___	Muscle spasms/cramps
___	___	Upper back pain	___	___	Elbow pain	___	___	Jaw pain
___	___	Mid back pain	___	___	Ankle/Foot pain	___	___	Sciatica
___	___	Arthritis	___	___	Rheumatoid Arthritis	___	___	Joint swelling/stiffness
___	___	Anxiety	___	___	Depression	___	___	Insomnia
___	___	Mood swings	___	___	Nervousness	___	___	Mental tension
___	___	Poor memory	___	___	Lightheadedness	___	___	Dizziness
___	___	General Fatigue	___	___	Visual disturbances	___	___	Difficult concentration
___	___	High Blood pressure	___	___	Low Blood pressure	___	___	Heart Attack
___	___	Chest pains	___	___	Angina	___	___	Tachycardia
___	___	Palpitations	___	___	Irregular heartbeats	___	___	Varicose veins
___	___	Kidney stones	___	___	Kidney disorders	___	___	Frequent UTI
___	___	Painful urination	___	___	Incontinence	___	___	Frequent urination
___	___	Abnormal weight gain	___	___	Abnormal weight loss	___	___	Loss appetite
___	___	Abdominal pain	___	___	Belching	___	___	Heartburn
___	___	Acid Reflux	___	___	Bloating	___	___	Ulcer
___	___	Nausea	___	___	Vomiting	___	___	Liver/Gallbladder disorder
___	___	Persistent cough	___	___	Bronchitis	___	___	Pneumonia
___	___	Difficult breathing	___	___	Frequent common colds	___	___	Chest tightness
___	___	Rashes	___	___	Hives	___	___	Eczema
___	___	Psoriasis	___	___	Bruise easily	___	___	Excess sweating

Signature: ______________________________ Date: ____________________

For Women

PAST	PRESENT		PAST	PRESENT	
___	___	Birth control pills	___	___	Hormone Replacement Therapy

Are you pregnant? _____ yes ______ no

Age menses: _______ Age of last period (menopause): _______

Duration flow: ______________ Number of days between periods: __________

# of Pregnancies: _____ # Births: _____ # of Miscarriages: _____ # of Abortions: ____

Date of last Pap Smear: ________ Mammogram: ________ Bone Density Scan: ________

Results: ____

Have you ever been diagnosed with: ___ Fibroids ___ Endometriosis ___ Ovarian Cysts ___PID

Do you suffer from PMS? _____ yes _____ no If yes, what are your symptoms: _______________________

____

____

Do you suffer from menopausal symptoms? _____ yes _____ no If yes, what are your symptoms: ______

____

____

For Men

Date of last prostate check up _____________ PSA results_________________

Manual prostate exam results____

Signature: ____ Date: ____________________

THANK YOU