Dragonwell Clinic
Acupuncture + Cupping + Herbs

# Acupuncture New Patient Intake Form

Please take the time to fill out this questionnaire. The information you provide will assist us in forumalating a complete health profile for you. All of your answers are absolutely condiential. If you have any questions, please ask.

**Today's Date:** _____

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Name: _____ Sex: ____ Date of Birth: ____ /____ /____

Current age: _____ Height: _____ Weight: _____ Race/Ethnicity: _____

Street address: _____ City: _____ State: ____ Zip: _____

Cell Phone: _____ Home Phone:_____ Email: _____

Employer & Occupation: _____ Relationship Status: _____

Emergency contact: _____ Phone: _____

Who can we thank for referring you to us?_____

Have you ever seen an acupuncturist before? ☐ Yes ☐ No If yes, when?_____

If yes, who did you see? _____ What for? _____

**Primary care physician**

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Name: _____ Hospital or Group Associated w/: _____

Address: _____ Phone: _____

Did your primary care physisician refer you to us? ☐ Yes ☐ No

Please list any other providers you have sen for your condition: _____

May we communicate with your other physicians about your care and treatment? ☐ Yes ☐ No

## Health Information

Main complaint: _____

Other compleints: _____

How long have you had this problem? _____

What makes your symptoms improve? _____

What makes your symptoms worse? _____

Have you received a medical diagnosis? ☐ Yes ☐ No If yes, Please list: _____

Are you currently taking any medication for this problem? ☐ Yes ☐ No

## Medical History

**Please check any of the following that have ever affected you.**

| | | | | |
|---|---|---|---|---|
| ☐Addiction | ☐Candida | ☐Gallstones | ☐Hypotension | ☐Rheumatism |
| ☐AIDS/HIV | ☐Chronic fatigue | ☐Glaucoma | ☐Kidney stones | ☐Seizures |
| ☐Alcoholism | ☐Colitis/bowel disease | ☐Goiter | ☐Malaria | ☐Stroke |
| ☐Anemia | ☐Diabetes | ☐Gout | ☐Meningitis | ☐STD |
| ☐Arteriosclerosis | ☐Digestive disorders | ☐Heart disease | ☐Mononucleosis | ☐Thyroid problems |
| ☐Arthritis | ☐Eating disorder | ☐Hernia | ☐Multiple sclerosis | ☐Tonsillitis |
| ☐Asthma | ☐Emotional imbalance | ☐Hepatitis | ☐Nephritis | ☐Tuberculosis |
| ☐Breast lumps | ☐Emphysema | ☐Herpes | ☐Neuralgia | ☐Ulcers |
| ☐Bursitis | ☐Epilepsy | ☐High cholesterol | ☐Paralysis | ☐Urinary problems |
| ☐Cancer | ☐Fibromyalgia | ☐Hypertension | ☐Prostate problems | ☐Whopping cough |

Other: _____

Surgeries, hospitalizations, and significant traumas (car accients, loss of loved ones, etc.):

| Date | Event |
|---|---|
| | |
| | |
| | |
| | |

Medications taken in the last 3 months, including over-the counter medications:

| Medication | Dosage | Reason | How long |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please list any vitamins, supplements, or herbal medicines you are currently taking (with dosage):

| Vitamins/Herbs/Supplements/Herbs | Dosage | Reason | How long |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please list any allergies or adverse reactions, especially to food or drugs:

_____

_____

_____

**Family Medical History**

Do you have a family history of any of the following diseases or conditions? Check all that apply.

| | | | |
|---|---|---|---|
| ☐Addiction | ☐Arthritis | ☐Heart disease | ☐Mental health |
| ☐Allergies | ☐Asthma | ☐Hypertension | ☐Obesity |
| ☐Anemia | ☐Cancer | ☐Kidney disease | ☐Seizures |
| ☐Arteriosclerosis | ☐Diabetes | ☐Liver disease | ☐Stroke |

Other: _____

Is your biological mother still alive? ☐ Yes ☐ No ☐N/A If so, what is her age? _____

Is your biological father still alive? ☐ Yes ☐ No ☐N/A If so, what is his age? _____

**Personal & Social History**

How many hours per night do you sleep? _____ When do you usually go to bed? _____

When do you usually wake up? ____ Wake rested? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No If yes, what kind and how much?_____

What are your hobbies/things you enjoy doing in your free time? _____

_____

Energy level:☐ up and down ☐ low ☐ normal ☐ excess ☐ low after eating

Mental/Emotional: ☐ happy ☐ easily irritable ☐ difficulty making decisions ☐ angry ☐ cry easily

☐ stressed ☐ hurry to do things ☐ depression ☐ anxiety ☐ restlessness ☐ Forgetful

Please indicate use and frequency of the following:

Cigarettes:☐ Yes ☐ No If yes, how many per day? _____ Since when? _____

Alcohol: ☐ Yes ☐ No Type and amount per week? _____

Recreational drugs: ☐ Yes ☐ No Type and amount per week? _____ Since when? _____

Coffee: ☐ Yes ☐ No Amount _____

Soda: ☐ Yes ☐ No  If yes, amount _____

Water: ☐ Yes ☐ No If yes, amount _____

Please describe your daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you crave any particular foods or flavors?

_____

How do you feel about the following areas of your life?

| | GREAT | GOOD | FAIR | POOR | BAD | Comments |
|---|---|---|---|---|---|---|
| Significant Other | | | | | | |
| Family | | | | | | |
| Diet | | | | | | |
| Sex | | | | | | |
| Self | | | | | | |
| Work | | | | | | |
| Spituality | | | | | | |

**Symptom Survey**

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Please check any of the following that apply to you currently (C) or in the past (P).

**General**

| C | P | Condition | C | P | Condition | C | P | Condition |
|---|---|---|---|---|---|---|---|---|
| | | Shortness of breath | | | Poor appetite | | | Allergies |
| | | Poor coordination | | | Excess appetite | | | Fever |
| | | Vertigo/dizziness | | | Strong thirst | | | Chills |
| | | Bleed/bruise easily | | | Fatigue | | | Heavy body |
| | | Hot/cold intolerance | | | Poor sleeping | | | Weight loss |
| | | Nervousness/irritability | | | Night sweats | | | Weight gain |
| | | Sudden energy drop | | | Sweat easily | | | Tremors |
| | | Localized weakness | | | Swollen glands | | | Mood changes |
| | | Frequent infection | | | Cold hands/feet | | | Cravings |

Other General: _____

**Phychological**

| C | P | Condition | C | P | Condition | C | P | Condition |
|---|---|---|---|---|---|---|---|---|
| | | Loss of control | | | Irritability | | | Depression |
| | | Anxiety | | | Bad temper | | | Panic attacks |
| | | Suicidal thoughts | | | Suicidal attempt | | | Easily stressed |
| | | Seeing a therapist | | | Extreme fear | | | Extreme grief |

Other phschological: _____

**Skin and Hair**

| C | P | Condition | C | P | Condition | C | P | Condition |
|---|---|---|---|---|---|---|---|---|
| | | Rashes | | | Dry skin | | | Itching |
| | | Eczema | | | Acne | | | Psoriasis |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Hives | | | Moles | | | Dandruff |
| | | Tumors/lumps | | | Ulceration | | | Slow wound healing |

Other Skin/Hair: _____

**Head, Eyes, Ears, Nose and Throat**

| C | P | Condition | C | P | Condition | C | P | Condition |
|---|---|---|---|---|---|---|---|---|
| | | Dizziness | | | Color blindness | | | Corrective lenses |
| | | Headache | | | Vision changes | | | Poor hearing |
| | | Migraine | | | Cataracts | | | Ear pain |
| | | Concussion | | | Glaucoma | | | Sinus problems |
| | | Facial pain | | | Spots in vision | | | Runny nose |
| | | Sore throat | | | Night blindness | | | Sneezing |
| | | Sores on lips/tongue | | | Blurry vision | | | Congestion |
| | | Grinding teeth | | | Eye pain | | | Loss of smell |
| | | Jaw clicks | | | Dry eyes | | | Nosebleeds |
| | | Gum problems | | | Red eyes | | | Peculiar smells |
| | | Excessive saliva | | | Itchy eyes | | | Peculiar tastes |

Other Head, Eyes, Ears, Nose and Throat: _____

**Cardiovascular**

| C | P | Condition | C | P | Condition | C | P | Condition |
|---|---|---|---|---|---|---|---|---|
| | | High blood pressure | | | Swelling of hands | | | Fainting |
| | | Low blood pressure | | | Swelling of ankles | | | Blood clots |
| | | Irregular heartbeat | | | Cold hands/feet | | | Palpitations |
| | | High cholesterol | | | Heart murmur | | | Chest pain |
| | | Poor circulation | | | Heart valve issues | | | Heart attack |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Varicose veins | | | Stroke | | | Clotting disorder |

Other cardiovascular:_____

**Respiratory**

| C | P | Condition | C | P | Condition | C | P | Condition |
|---|---|---|---|---|---|---|---|---|
| | | Shortness of breath | | | Shallow breathing | | | Sleep apnea |
| | | Pain in deep breathing | | | Bronchitis | | | Asthma |
| | | Tightness of chest | | | Emphysema | | | Wheezing |
| | | Difficulty breathing | | | Frequent colds/flu | | | Pneumonia |
| | | Excessive phlegm | | | Coughing blood | | | Cough |

Other respiratory: _____

**Gastrointestinal**

| C | P | Condition | C | P | Condition | C | P | Condition |
|---|---|---|---|---|---|---|---|---|
| | | Burning of anus | | | Constipation | | | Hemorrhoids |
| | | Chronic laxative use | | | Diarrhea | | | Gas/bloating |
| | | Pain with defecation | | | Blood in stool | | | Indigestion |
| | | Incomplete defecation | | | Food in stool | | | Belching |
| | | Light colored stools | | | Black stool | | | Nausea |
| | | Foul smelling stools | | | Rectal pain | | | Vomiting |
| | | Abdominal pain | | | Bad breath | | | Hiccups |
| | | Hiatal hernia | | | Lack of appetite | | | Acid reflux |

Other GI: _____

**Genito-Urinary**

| C | P | Condition | C | P | Condition | C | P | Condition |
|---|---|---|---|---|---|---|---|---|

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Pain on urination | | | Kidney stones | | | Herpes |
| | | Urgency to urinate | | | Increased libido | | | Bedwetting |
| | | Unable to hold urine | | | Decreased libido | | | STDs |
| | | Decreased urine flow | | | Frequent UTIs | | | Genital itching |
| | | Incomplete urination | | | Sores on genitals | | | Blood in urine |
| | | Nighttime urination | | | Malodorous urine | | | Cloudy urine |

Other genito-urinary:_____

**Male reproductive (Men only)**

| C | P | Condition | C | P | Condition | C | P | Condition |
|---|---|---|---|---|---|---|---|---|
| | | Prostate problems | | | Penile discharge | | | Impotence |
| | | Sexual dysfunction | | | Testicular lumps | | | Testicular pain |

Other male reproductive:
_____

Have you had a prostate exam? ☐ Yes ☐ No If yes, when? _____ results? _____

**Gynecological (Women only, if you have gone through menopause or currently on birth control, please describe your past menstruation)**

Is there a possibility you're pregnant? ☐ Yes ☐ No Date of last pap smear? _____ /_____ /_____

| C | P | Condition | C | P | Condition | C | P | Condition |
|---|---|---|---|---|---|---|---|---|
| | | Painful periods | | | Irregular periods | | | Mastitis |
| | | Vaginal discharge | | | Uterine bleeding | | | Fibroids |
| | | Infertility | | | Breast lumps | | | Endometriosis |
| | | Yeast infection | | | Vaginitis | | | PID |

Age of first period: _____ Number of days between periods: ____ Number of days of flow: _____

Menstruation: Flow: ____ Heavy ____ Light ____ Clots ____ Painful ____ Spotting between periods

Color of flow: _____ Start date of last cycle: _____

PMS Symptoms: _____

Menopause: Age of menopause: _____ Menopausal symptoms:_____

Pregnancy: # of pregnancies: _____ # of births: _____ # of miscarriages: _____ # of abortions: _____

# of premature births _____

**Musculoskeletal/Neurological**

| C | P | Condition | C | P | Condition | C | P | Condition |
|---|---|---|---|---|---|---|---|---|
| | | Neck tightness/pain | | | Knee pain | | | Hernia |
| | | Shoulder pain | | | Muscle weakness | | | Seizures |
| | | Hand/wrist pain | | | Muscle pain | | | Tremors |
| | | Back pain | | | Joint sprain | | | Numbness |
| | | Hip pain | | | Joint disorders | | | Tingling |
| | | Sciatica | | | Scoliosis | | | Paralysis |

Other musculoskeletal / neurological: _____

Please feel free to list/describe any other issues you would like to discuss.

_____

_____

_____

_____

The information on this form is correct and accurate to the best of my knowledge.

Signature: _____ Date: _____