ACUPUNCTURE NEW PATIENT INTAKE FORM

ASULA wellness center

Patient Information

Name:

Date of Birth: Gender Pronouns: ☐ He ☐ She ☐ They ☐ Other:

Address:

City: State: Zip:

E-mail Address:

Primary Phone: Phone Type: ☐ Home ☐ Mobile ☐ Work

Occupation or Profession: Employer:

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

- Are your symptoms the result of an accident? *If **"YES"** please see front desk...* ☐ YES ☐ NO

- Is this your first experience with Acupuncture? ☐ YES ☐ NO

- Whom may we thank for referring you to our office?

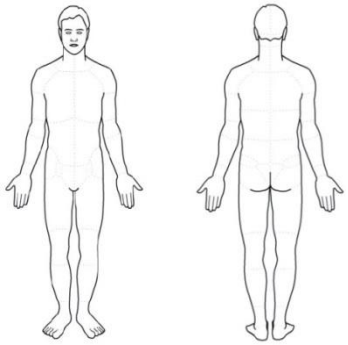
Current MD:

Emergency Contact:

Name *Relation* *Phone#*

Areas of Complaint

PLEASE DRAW ON THE DIAGRAM *to indicate any area(s) where you are currently experiencing pain or tension…*



Please describe the reason for your visit:

1.

2.

3.

SYMPTOM FREQUENCY

- ☐ Constant 75-100% of awake time
- ☐ Frequent 51-75% of awake time
- ☐ Intermittent 26-50% of awake time
- ☐ Occasional 0-25% of awake time

SYMPTOM CHANGES

- ☐ It is worse in the morning
- ☐ It is worse in the afternoon
- ☐ It is worse in the evening
- ☐ It changes with the weather
- ☐ It does not change

SYMPTOM RELIEF

- ☐ Ice
- ☐ Heat
- ☐ Medication
- ☐ Nothing Helps
- ☐ Other

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Please ☑ condition you PRESENTLY HAVE *(i.e. last few weeks).* Write "P" for any PREVIOUS conditions.

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

HEAD AND NECK
- ❑ Dizziness
- ❑ Fainting
- ❑ Neck stiffness
- ❑ Enlarged lymph glands
- ❑ Headaches
  - ◎ Vertex
  - ◎ Occipital
  - ◎ Temple
  - ◎ Frontal
  - ◎ Benign Eye
  - ◎ Migraines
- ❑ Other

EARS
- ❑ Frequent infections
- ❑ Ringing
- ❑ Decreased hearing

EYES
- ❑ Blurred Vision
- ❑ Visual changes
- ❑ Poor night vision
- ❑ Spots or Floaters
- ❑ Eye Inflammation or Stye

NOSE, THROAT, MOUTH
- ❑ Bleeding
- ❑ Sinus infection
- ❑ Hay fever or Allergies
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Changes in taste
- ❑ Difficulty swallowing
- ❑ Changes in smell
- ❑ Oral ulcers or canker sores

SKIN
- ❑ Hives
- ❑ Rashes
- ❑ Eczema
- ❑ Psoriasis
- ❑ Seborrhea
- ❑ Itching
- ❑ Excess sweating
- ❑ Dryness
- ❑ Bruises easily
- ❑ Changes in moles or lumps

INFECTION SCREENING
- ❑ HIV AIDS, or HIV risk: *Self or Partner*
- ❑ TB: *Self or Household*
- ❑ Hepatitis, or Hepatitis risk: *Self or Partner*
- ❑ History of sexually transmitted diseases: *Self or Partner*
- ❑ Gonorrhea
- ❑ Chlamydia
- ❑ Syphilis
- ❑ Genital warts
- ❑ Herpes (oral)

NEUROLOGICAL
- ❑ Numbness or tingling of lips
- ❑ Seizures
- ❑ Tremors
- ❑ Pain
- ❑ Paralysis
- ❑ Epilepsy of Convulsions

RESPIRATORY
- ❑ Chronic cough
- ❑ Coughing up blood
- ❑ Coughing up phlegm frequently
- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Wheezing or Asthma
- ❑ Frequent colds
- ❑ Emphysema
- ❑ Pneumonia repeatedly
- ❑ Other

CARDIOVASCULAR
- ❑ Palpitations
- ❑ Chest pain or tightness
- ❑ Rapid heart beat
- ❑ Irregular heart beat
- ❑ Heart disease
- ❑ Poor circulation
- ❑ Swelling of the ankles
- ❑ Phlebitis
- ❑ Cold hands/feet
- ❑ Cardiac pacemaker
- ❑ High blood pressure
- ❑ Stroke
- ❑ Other

GASTROINTESTINAL
- ❑ Indigestion
- ❑ Nausea
- ❑ Stomach pain
- ❑ Bloating
- ❑ Gas
- ❑ Irritable bowel disease
- ❑ Colitis
- ❑ Crohn's Disease
- ❑ Pancreatitis
- ❑ Celiac Disease
- ❑ Recent changes in bowel habits
- ❑ Diarrhea, #stools/day _____
- ❑ Constipation #stools/wk_____
- ❑ Dry, hard stools
- ❑ Soft, difficult, sticky stools
- ❑ Irregularity or poorly-formed stools
- ❑ Hemorrhoids
- ❑ -with pain or blood
- ❑ Gall bladder disorder
- ❑ Vomiting blood
- ❑ Peptic ulcer
- ❑ Recent change in weight
- ❑ Food cravings
- ❑ Poor Appetite
- ❑ Change in Appetite
- ❑ Other

MUSCLES AND JOINTS
- ❑ Joint disorder
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Difficulty walking
- ❑ Spinal curvature
- ❑ Backache
- ❑ Back pain
- ❑ Fibromyalgia

MALE
- ❑ Pain or itching of genitalia
- ❑ Genital lesions or discharge
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Prostate problems
- ❑ Infertility (e.g. abnormal sperm)
- ❑ Other

FEMALE
- ❑ Frequent Vaginal Infections
- ❑ Frequent yeast infections
- ❑ Infertility
- ❑ Pain or itching of genitalia
- ❑ Genital lesion or discharge
- ❑ Pelvic inflammatory disease
- ❑ Abdominal bleeding
- ❑ Menopausal symptoms (hot flashes, etc.)
- ❑ Breast lumps or cysts
- ❑ Breast swelling and or pain
- ❑ Night sweats
- ❑ Other

URINARY
- ❑ Frequent urinary tract or bladder infections
- ❑ Weak urinary stream
- ❑ Frequent night urination, ___x
- ❑ Frequent day urination, ____x
- ❑ Recent change in bladder habits
- ❑ Kidney disease

GENERAL
- ❑ Fatigue
- ❑ Strong Thirst
- ❑ Aversion to cold
- ❑ Insomnia
- ❑ Frequent dreams/nightmares
- ❑ Depression
- ❑ Agitation
- ❑ Irritability
- ❑ Anxiety
- ❑ History of psychiatric treatment
- ❑ Poor memory
- ❑ Difficulty concentration
- ❑ Sores that don't heal
- ❑ Congenital abnormalities
- ❑ Surgical Implants
- ❑ Unusual bleeding or discharge
- ❑ Jaundice
- ❑ Hernia
- ❑ Epstein Barr virus (EBV)
- ❑ Rheumatic Fever
- ❑ Diabetes mellitus
- ❑ Thyroid Disorder
- ❑ Cancer
- ❑ Anemia or other blood disorder Lupus erythematosus

RECENT CHANGES IN:
- ❑ Weight
- ❑ Appetite
- ❑ Thirst
- ❑ Libido

ACUPUNCTURE INTAKE FORM continued

Family Medical History

Please ☑ If a family member currently has, or has had, any of the following conditions listed below and indicate who.

	CONDITION NAME	WHO?		CONDITION NAME	WHO?
☐	Alcoholism		☐	Diabetes	
☐	Allergies		☐	Drug Abuse	
☐	Asthma		☐	Heart Disease	
☐	Arthritis		☐	High Blood Pressure	
☐	Auto-Immune Disorders		☐	Obesity	
☐	Cancer		☐	Osteoporosis	
☐	Depression		☐	Thyroid Disease	

Medical History (please list any...) Date of last exam:

SURGERIES, INCLUDING DATE OF SURGERY:

SERIOUS INJURIES, ILLNESSES, ACCIDENTS OR TRAUMA:

ALLERGIES (FOOD, ENVIRONMENTAL, MEDICAL):

SENSITIVITIES:

Current Medications & Supplements

Please list and include reason for using medication/supplement.

Women's Health

Most recent menstrual cycle: _____ /_____ /_____

Do you believe you are pregnant? ☐ **YES** ☐ **NO**

Length of cycle: _____
cycle day 1 to next cycle day 1

Days of Flow: _____
 # days bleeding

Is your cycle regular? ☐ YES ☐ NO ☐ MENOPAUSE

Amount: ☐ heavy ☐ moderate ☐ light

Age at First Menses: _____

Please ☑if you experience any of the following conditions (before or during menses) …

☐ Premenstrual Syndrome ☐ Irregular periods ☐ Migraine ☐ Pain or Cramps ☐ Frustration ☐ Nightmares

☐ Fluid Retention ☐ Depression ☐ Clots ☐ Loneliness ☐ Clots

What do you use for menstruation (check any that apply)? ☐ Tampon ☐ Pad ☐ Cup ☐ Period underwear

Date of last pap smear: _____ /_____ /_____ Abnormal pap smear? ☐ YES ☐ NO

_____# of pregnancies _____# of births _____# of miscarriages _____# of children

Do you ever experience pain during intercourse? ☐ Yes ☐ No

Do you take contraceptive pills or use other forms of birth control? ☐ Yes ☐ No

Please list: Currently taking: Previously taken:

Men's Health

Please indicate which of the following areas are troublesome (if any).

☐ Hernias ☐ Sexual difficulty ☐ Urination

☐ Erection problems ☐ Libido ☐ Fertility

☐ Prostate problems ☐ Discharge or sores ☐ Venereal disease

☐ Testicular masses

Diet

What do you typically eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

Which meal is your largest meal of the day? ☐ Breakfast ☐ Lunch ☐ Dinner

Do you have any food allergies, sensitivities or restrictions?

Food Ethics: ☐ Vegan ☐ Vegetarian ☐ Kosher ☐ Paleo ☐ Other:

Percentage of time you cook at home each week: ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

How would you rate your digestion? ☐ Good ☐ Fair ☐ Bad

Alcohol: Wine # of glasses/day/wk? Liquor # ounces/day/wk? Beer # glasses/day/wk?

Caffeine: Coffee cups/day? Teas cups/day? Soda cans/day?

Water: Glasses/day Bottled, filtered or tap?

Bowel movements per day? Any bowel concerns? ☐ Constipated ☐ Diarrhea

Do you crave any types of foods? ☐ Salty ☐ Sweet ☐ Dairy ☐ Pasta/Breads ☐ Other:

ACUPUNCTURE INTAKE FORM continued

Lifestyle

Do you smoke cigarettes (or other substances)? ☐ Yes ☐ No List Other Substance(s):

If yes, how many per day? ☐ 1/2 pack ☐ 1 pack ☐ 2 packs ☐ More than 2 packs

Exercise: Type? Frequency?

Do you have a mindfulness practice? ☐ Yes ☐ No What kind?

How much sleep do you get each night on average? ☐ 6 hours or less ☐ 6-8 hours ☐ 8+ hours

What time do you go to sleep? What time do you wake up?

Do you feel rested when you wake up? ☐ Yes ☐ No

How would you rate your mental concentration? ☐ Strong ☐ Moderate ☐ Weak

How would you rate your usual energy level?

☐ Very high	☐ High	☐ Moderate
☐ Low	☐ Very low	

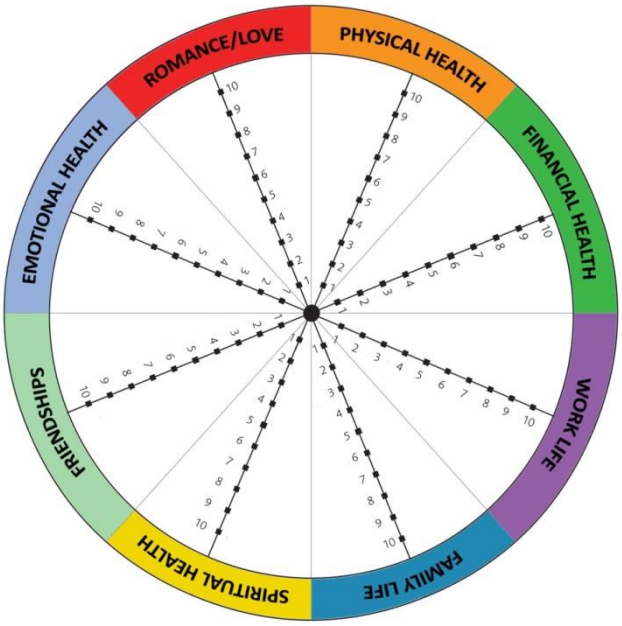
Do you experience any of the following?

☐ Depression	☐ Anxiety	☐ Fear or panic
☐ Loneliness	☐ Worry	☐ High stress level
☐ Anger	☐ Lack of memory	☐ Light-headedness
☐ Lack of energy	☐ Suicidal thoughts or attempts	☐ Irritation

On a scale of 1-10, please rate each area of your life in terms of happiness.

In each section circle the number from 1-10 that best represents your happiness rating.

A score of 10 would mean you are very happy with this area, conversely, a score of 1 would indicate you are very unhappy with this area of your life.



What are your goals/expectations of your sessions at Asula?

1.

2.

3.

How much time and energy can you devote to lifestyle changes outside of treatment sessions?

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Signature: _____ Date: _____

♥ WELCOME TO OUR CLINIC ♥

asula
wellness center