Happy Valley Wellness and Acupuncture

New Patient Intake Form

General Information

Name                                                                        Birthdate                               Age          M F

Address                                                                    City                                          State            Zip

Phone Numbers (mark the best number to contact you with an \*) OK to leave a message? Y N

Home                                              Cell                                                     Work

Email                                                                                                             OK to email information? Y N

Marital Status                                  Number of children             Age of children

Education level                               Occupation                                 Hours per week

Employer

How did you hear about this practice?

Emergency Contact

Name/Relationship                                                                                                      Phone

Health Care Providers

Primary Care/Family Doctor

Specialist (s)

May I contact these providers to ensure coordination of care if needed? Y N

Have you or anyone you know had previous acupuncture experiences? Y N

Social History

How many times per day do you use the following: Do you exercise? Y N

Cigarettes                       Type/Frequency:

Coffee

Tea

Soda

Alcohol

Recreational drugs

Past Medical History

Check any condition that you currently have, have ever been treated for, or were ever diagnosed with:

      Alcohol abuse       Fibromyalgia       Mental illness

      Allergies       Herniated disc       Multiple Sclerosis

      Anxiety       Headaches/Migraines       Pacemaker

      Arthritis       Heart attack/Myocardial infarction      Parkinson’s

      Asthma       Hepatitis/Liver disease       Sciatica

      Atrial fibrillation/irregular heartbeat       High blood pressure/hypertension       Seizures

      Bleeding/clotting disorder       High cholesterol/hyperlipidemia       Sinus infections

      Cancer (type if applicable)       HIV/AIDS        Skin disorder

      Celiac disease/gluten sensitivity       Immune disorder       Stroke

      Congestive heart failure/CHF      Joint replacement       Substance abuse

      COPD       Kidney disease/disorder       Thyroid disease

      Depression       Low blood pressure/hypotension       TIA

      Diabetes       Lyme disease       Ulcers

      Depression       Lymph node removal       Other

List any surgeries or hospitalizations you have experienced with the approximate year:

List any medications or supplements you are currently taking:

Family History

List any physical, medical, or mental illnesses and current age or age of death:

Mother:

Father:

Siblings:

Children:

Grandparents:

Current Symptoms

Please check any symptoms you currently experience on a regular basis:

General:
     Poor appetite      Poor coordination      Poor balance

     Unable to fall asleep      Tremors      Bruise/bleed easily

     Unable to stay asleep      Overeating      Sweat easily/heavily

     Fatigue      Localized weakness      Chills

     Weight loss      Excess thirst      Sudden drop in energy

     Weight gain      Fever      Catch colds easily

     Other (please specify)

Skin/Hair/Nails:

     Rashes      Eczema      Acne

     Itching      Psoriasis      Soft/brittle nails

     Dandruff      Hair loss

     Redness      Hives

     Other (please specify)

Head, Eyes, Ears, Nose, Throat:

     Dizziness      Poor hearing      Bleeding gums

     Eye pain      Earaches      Nosebleeds

     Blurred vision      Headaches      Facial pain

     Floaters      Migraines      Jaw clicking/pain

     Spots in eyes      Recurrent sore throats      Tooth pain

     Night blindness      Sores on lips/tongue      Lightheadedness

     Ringing in ears      Dry mouth/throat

     Other (please specify)

Cardiovascular/Respiratory:

     Dizziness      Chest pain      Pneumonia

     Low blood pressure      Blood clots      Phlegm

     High blood pressure      Difficulty breathing      Pain with deep breaths

     Irregular blood pressure      Palpitations      Shortness of breath

     Irregular heart beat      Cough      Congestion

     Fainting      Asthma/COPD      Difficulty breathing when lying

     Cold hands/feet      Bronchitis      Swelling in hands/feet

     Other (please specify)

Urinary/Genital:

     Pain with urination      Kidney stones      Impotence

     Frequent urination      Blood in urine      Decrease in urine flow

     Unable to hold urine      Urgency to urinate      Sores on genitals

     Waking at night to urinate      Unable to hold urine

     Other (please specify)

Gastrointestinal:

     Nausea      Abdominal pain/cramps      Black stools

     Vomiting      Indigestion      Blood in stools

     Constipation      Heartburn/reflux      Hemorrhoids

     Diarrhea      Food retention      Bad breath

     Gas      Lack of appetite      Sensitive abdomen

     Bloating      Excess appetite      Chronic laxative use

     Belching      Rectal pain

     Other (please specify)

Musculoskeletal:

     Neck pain      Foot/ankle pain      Sciatica

     Back pain      Shoulder pain      Muscle weakness

     Knee pain      Hip pain

     Muscle pain      Hand/wrist pain

     Other (please specify)

Autoimmune/Inflammatory:

     Hashimoto’s disease      Rheumatism      Cellulitis

     Systemic Lupus Erythematosus      Colitis      Sinus issues

     Atopic dermatitis      Crohn’s      Vulvitis

     Neurodermatitis      Allergies      Celiac disease

     Alopecia (baldness)      Food allergies

     Other (please specify)

Female/Gynecological:

     Painful menses      Breast lumps/swelling      Infertility issues

     Irregular menses      Fibroids      PMS

     Vaginal dryness      Endometriosis      Sexually transmitted diseases

     Vaginal discharge/odor      Hot flashes      Decreased sex drive

     Ovarian cysts      Urinary tract infections

     Other (please specify)

Male Reproductive issues:

     Testicular pain      Painful urination

     Decreased sex drive      Penile discharge

     Infertility issues      Inability to maintain/achieve erections

     Other (please specify)

Do you have any scars? Y N Location:

Lifestyle:

How many hours of sleep do you get per night?                 Do you feel rested in the morning? Y N

On a scale of 1-10, how much stress do you have?

On a scale of 1-10, how much energy do you have?

Do you enjoy hobbies? Please list:

How many hours do you work per week?              Do you enjoy your job? Y N

What kind of goals do you have for your health? Circle the most important goal:

What do you hope to achieve with acupuncture?