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 offices to ensure coordination of care if needed? Y/N

Have you had previous acupuncture experiences? Y/N

Social History

How many times per day do you use the following:

Cigarettes _____
Coffee _____
Tea _____
Soda _____
Alcohol _____
Marijuana _____

Recreational drugs (please specify, including prescription drugs, even if obtain legally) _____

Past Medical History

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

____Alcohol abuse
____Fibromyalgia
____Allergies
____Multiple Sclerosis
____Anxiety
____Arthritis
___Parkinson's
____Asthma
____Sciatica
____Seizures
____Bleeding/clotting disorder
____HIV/AIDS
____High cholesterol/hyperlipidemia
____Mental illness
____Herniated disc
____Headaches/Migraines
____Pacemaker
____Heart attack/Myocardial infarction
____Atrial fibrillation/irregular heartbeat
____Hepatitis/Liver disease
___Joint replacement
____High blood pressure/hypertension
____Sinus infections
_____Skin disorder

____Immune disorder
____Lyme disease
____Substance abuse
____COPD
____Thyroid disease
____Depression
____TIA
____Diabetes
____Other

____Stroke
____Congestive heart failure/CHF
____Celiac disease/gluten sensitivity
____Kidney disease/disorder
____Cancer (type if applicable)
____Low blood pressure/hypotension
____Lymph node removal
____Ulcers

_____

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

_____

List any medications or supplements you are currently taking, including doses and time of day (can attach a separate sheet if needed):

_____

Family History

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

Mother: Alive? Y/N, if deceased, please list age of death _____

_____

Father: Alive? Y/N, if deceased, please list age of death _____

_____

Siblings: Alive? Y/N, if deceased, please list age of death next to name

_____

_____

Children: Alive? Y/N, if deceased, please list age of death next to name

_____

Grandparents: Alive? Y/N, if deceased, please list age of death next to relationship

_____
_____
_____
_____

___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?

Adrenal Stress Questionnaire (as adapted from The Institute for Functional Medicine)
Please score only the items you experience on a scale of 1 to 4, as follows:
1 = mild problem 2 = significant problem 3 = major problem 4 = severe problem

Section1: Low Cortisol State
____Lethargic Depression
____Excessive need for sleep
____Chronic Fatigue Syndrome
____Chronic pain
____Fibromyalgia (musculoskeletal tender points)*
____Dizziness when you stand or bend
____ Low blood pressure and/or drop of blood pressure on standing*
____Craving salty foods (pretzels, pickles, salted nuts, chips, etc)
____Poor wound healing*
____Easy bruising
____Fatigue
____Inability to handle even slight stresses
____Hypoglycemia: dizzy, irritable, or sleepy if you go without food for 4-5 hours; symptoms relieved by food
____Scars, elbows, nipples, or skin near nails that are unusually dark*
____Slow healing of cuts*
____Unstable body temperatures (hot or cold)

Section2: Elevated Cortisol States
____Agitated depression
____Weight gain around your abdomen, back of neck, and face/cheeks*
____Stretch marks that are not from weight loss*
____Adult onset diabetes
____Osteoporosis
____Craving sweets
____Trouble falling asleep or staying asleep

Section3: Adrenal Hyperplasia
____Excessive dark male pattern hair growth (in women)*
____Irregular or no periods (not menopausal)
____Eastern European heritage

____Total score

Exercise History (as adapted from The Institute for Functional Medicine)
Have you been cleared for exercise? Yes No

What are you doing on a regular basis that gets you moving and gets your heart rate up?
—Cardio/Aerobic Exercise: (e.g., walking, jogging, running, dancing)
Activity 1 _____times per week _____for ____minutes
Activity 2 _____times per week _____for ____minutes
—Strength/Resistance Exercise: (e.g., resistance machines, kettlebell, Pilates, weightlifting)
Activity 1 _____times per week _____for ____minutes
Activity 2 _____times per week _____for ____minutes
—Flexibility/Stretching Exercise: (e.g., yoga, Pilates, mat work, stretches)
Activity 1 _____times per week _____for ____minutes
Activity 2 _____times per week _____for ____minutes
—Balance Exercise: (e.g., tai chi, qigong, Bosu® ball, dancing)
Activity 1 _____times per week _____for ____minutes
Activity 2 _____times per week _____for ____minutes

How do you monitor your exercise intensity?
____General Intensity
· Light
· Moderate
· Vigorous/hard
____Talk Test
· Able to talk and sing
· Can talk but not sing
· Difficulty talking
____Perceived Exertion
· Less than 3 (out of 10)
· Between 3-4 (out of 10)
· 5 or more (out of 10)
____Heart Rate (HR)*
· Under 64% of maximum
· 64-76% of maximum
· Over 76% of maximum
*Heart rate is not an appropriate measure of exercise intensity if taking a beta-blocker

Are you satisfied with your current exercise program? Yes No
If no, explain

What are your motivators for exercise? (Check all that apply)

_____Prevent heart disease
_____Control blood sugar
_____Increase energy
_____Improve mood
_____Improve sleep
_____Increase mental alertness
_____Increase interest in sex
_____Reduce blood pressure
_____Prevent bone loss
_____Increase self-esteem
_____Decrease stress
_____Weight reduction
_____Better endurance
_____Other_____

What types of aerobic exercise do you prefer? (Check all that apply)

_____Walking
_____Rollerblading
_____Treadmill
_____Elliptical
_____Swimming
_____Water aerobics
_____Cross-country skiing
_____Snowboarding
_____Hiking
_____Jogging
_____Bicycling
_____Stair climber
_____Rowing
_____Aerobics classes
_____Downhill skiing
_____Snowshoeing
_____Other: _____

What do you like most about exercising?

Do you have an exercise partner? Yes No
Do you enjoy group exercise or classes? Yes No
Are you a member of a gym or fitness center? Yes No
Are there any obstacles you have to engaging in movement and physical activity? Yes No
If yes, what are they?

If yes, do you have control over the circumstances surrounding your obstacles? How can you overcome them?

Are any of your obstacles out of your control? If yes, which ones?

What are some possible solutions around these obstacles? What has worked before?

What is the best time of day for you to exercise?
When do you have the most energy and time?

Are you ready to take action to make your exercise program work for you and your goals? Yes No
Do you have any goals related to your strength, tone, body composition, or fitness level? Yes No
If yes, explain

Do you experience any pain or breathing problems while exercising? Yes No
If yes, explain

Do you have any joint or musculoskeletal problems that might flare up during exercise? Yes No
If yes, explain

Have you had any injuries while exercising? Yes No
If yes, explain

Have you experienced a loss of muscle tissue or a decline in strength the last few years? Yes No
Have you fallen in the past few months? Yes No
Do you notice any balance problems? Yes No
If yes, explain

Do you have any conditions that would make exercise inadvisable? (Check all that apply)

_____Acute systemic infection (i.e., fever, body aches, swollen lymph nodes, etc.)

_____Arrhythmias (heartbeat too fast or slow)

_____Recent heart attack

_____Severe congestive heart failure

_____Uncontrolled angina (chest discomfort or pain)

_____Other_____

Nutrition History (as adapted from The Institute for Functional Medicine)

Pre-natal and Post-natal Nutrition

Did your biological parents have any food allergies, intolerances, or sensitivities?

_____Yes (please describe) _____

_____No

_____Unsure

Were you fed breastmilk or formula as an infant?

_____Breastmilk

_____Formula

_____A combination of breastmilk and formula

_____Unsure

Do you know the age at which you began eating solid foods?

_____Yes (please provide an age)_____

No

As an infant, did you experience any food allergies, intolerances, or sensitivities?

_____Yes (please describe) _____

_____No

_____Unsure

Pediatric Nutrition and Eating Patterns

As a child or adolescent, did you experience any reactions to foods?

_____Yes (please describe) _____

_____No

_____Unsure

Did you have consistent, reliable access to healthy foods (i.e., fresh fruits, vegetables, and other nutrient-dense foods) during your childhood and adolescence?

_____Yes

_____No

_____Unsure

As a child or adolescent, were you diagnosed with an eating disorder, or did you have any negative experiences concerning food and body (i.e., frequent dieting, bullying, over-exercising, etc.)?

_____Yes (please describe) _____

_____No

_____Unsure

Adult Nutrition and Current Eating Patterns

Are you currently experiencing an eating disorder, or do you experience other disruptive or disordered behaviors concerning food and body (i.e., binge eating, restricting food(s), compensatory exercise, chronic dieting, yo-yo or "crash" dieting, unproductive fixation on "clean" eating, etc.)?

_____Yes (please describe) _____

_____No

_____Unsure

What are your favorite foods?

What foods do you eat most frequently?

Who prepares your food/meals?

Who purchases your food?

How often do you cook your meals?

When in your life did you eat the most nutritious food?

When in your life did you eat the least nutritious food?

What else would you like me to know about you, your eating habits, nutrition history, and/or relationship to food and body?

What do you hope to achieve as a result of working with me specifically regarding your diet and nutrition??