The Holistic Clinic
Acupuncture and Holistic Health

NEW PATIENT INTAKE FORM Today's Date_____/_____/_____

PERSONAL INFORMATION:

Name_____ Birthdate_____/_____/_____

Address_____

City_____State_____Zipcode_____

Cell Phone #_____Work Phone #_____

☐ Male ☐ Female Occupation_____

Email_____

Chief Complaints:

1._____

2._____

3._____

How long have you had this condition?_____

Is it getting worse? ☐ yes ☐ no Does it bother your ☐ Sleep ☐ Work ☐ Other

What seemed to be the initial cause?_____

What makes it better?_____

What makes it worse?_____

Physician's Name_____ Physician's Phone #_____

Health Insurance Info:_____ Policy #_____

Health Insurance Phone #_____

FAMILY MEDICAL HISTORY

☐ Allergies ☐ Arteriosclerosis ☐ Asthma ☐ Alcoholism ☐ Diabetes ☐ Heart Disease ☐ Stroke

☐ Cancer (type) ☐ High Blood Pressure ☐ Depression

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PAST MEDICAL HISTORY

☐ Aids/HIV	☐ Diabetes	☐ Measles
☐ Alcoholism	☐ Emphysema	☐ Multiple Sclerosis
☐ Allergies	☐ Epilepsy	☐ Mumps
☐ Appendicitis	☐ Goiter	☐ Pacemaker
☐ Arteriosclerosis	☐ Gout	☐ Pneumonia
☐ Asthma	☐ Heart Disease	☐ Trauma
☐ Birth Trauma	☐ Hepatitis	☐ Surgeries
☐ Cancer	☐ Herpes	_____
☐ Chicken Pox	☐ High Blood Pressure	_____

DIET

Appetite ☐ Low ☐ High ☐ Salty Food ☐ Sugary Foods ☐ Coffee/Tea ☐ Alcohol

☐ Vegetarian ☐ Non-Vegetarian ☐ Artificial Sweeteners

Breakfast	Snack	Lunch	Snack	Dinner
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What Pharmaceuticals are you currently taking?

_____

What Supplements are you currently taking?

_____

LIFESTYLE

☐ Marijuana ☐ Drug Usage ☐ Addictions ☐ Stress ☐ Occupational Hazards ☐ Tobacco

Do you Exercise?_____ Frequency_____ Type_____

GENERAL SYMPTOMS

☐ Poor Appetite ☐ Poor Sleep ☐ Bodily Heaviness ☐ Chills ☐ Fatigue ☐ Lack of Strength

☐ Heavy Appetite ☐ Heavy Sleep ☐ Cold Hands/Feet ☐ Recent Weight Loss/Gain ☐ Poor Circulation

☐ Dream-disturbed Sleep ☐ Shortness of Breath ☐ Fever ☐ Chills ☐ Night Sweats

☐ Sweats Easily ☐ Muscle Cramps ☐ Dizziness/Vertigo

HEAD/EYES/EARS/NOSE/THROAT

☐ Eye Strain ☐ Night Blindness ☐ Teeth Problems ☐ Grinding Teeth ☐ TMJ ☐ Face Pain

☐ Eye Pain ☐ Myopia/Presbyopia ☐ Gum Problems ☐ Mouth/Lip Sores ☐ Excessive Saliva

☐ Red Eyes ☐ Glaucoma ☐ Sinus Problems ☐ Asthma ☐ Swollen Glands ☐ Throat Lump

☐ Itchy Eyes ☐ Cataracts ☐ Ear Ringing-High/Low ☐ Earaches ☐ Poor Hearing ☐Headaches

☐ Eye Spots ☐ Migraines ☐ Concussions/Other Head or Neck Problems_____

RESPIRATORY

☐ Difficulty Breathing ☐ Shortness of Breath ☐ Tight Chest ☐ Asthma/Wheezing ☐ Cough-Wet or Dry?

☐ Coughing Blood ☐ Pneumonia ☐ Bronchitis ☐ Difficulty Inhaling/Exhaling? ☐ Color of Phlegm_____

CARDIOVASCULAR

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Heart Palpitations ☐ Rapid Heart Rate ☐ Fainting

☐ Blood Clot ☐ Chest Pain ☐ Difficulty Breathing ☐ Irregular Heartbeat ☐ Phlebitis

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GASTROINTESTINAL

☐ Constipation ☐ Bloating ☐ Black Stools ☐ Intestinal Pain/Cramping ☐ Gas ☐ Vomiting

☐ Mucous in Stools ☐ Rectal Pain ☐ Diarrhea ☐ Nausea ☐ Bloody Stools ☐ Burning Anus

☐ Gas ☐ Vomiting ☐ Mucous in Stools ☐ Rectal Pain ☐ Acid Reflux ☐ Hemorrhoid

□ Itchy Anus Bowel Movements- How Often?_____

MUSCULOSKELETAL

□ Neck/Shoulder Pain □ Mid Back Pain □ Muscle Pain □ Joint Pain □ Muscle Fatigue □ Rib Pain

□ Lower Back Pain □ Limited Range of Motion □ Limited Use □ Lack of Strength

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SKIN AND HAIR

□ Rashes □ Hives □ Ulcers □ Eczema □ Psoriasis □ Acne □ Dandruff □ Itching □ Hair Loss

□ Changes in Hair/Skin □ Fungal Infections □ Dry Skin/Hair

NEUROPSYCHOLOGICAL

□ Seizures □ Numbness □ Tics □ Poor Memory □ Depression □ Anxiety □ Irritability

□ Easily Stressed □ Abuse Survivor □ Post-Traumatic Stress □ Seeing a Therapist

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GENITOURINARY

□ Painful Urination □ Frequent Urination □ Urgent Urination □ Blood in Urine □ Unable to Hold Urine

□ Incomplete Urination □ Venereal Disease □ Bed wetting □ Wake to Urinate □ Kidney Stone

□ Increased Libido □ Decreased Libido □ Premature Ejaculation □ Nocturnal Emission □ Impotence

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GYNECOLOGY

Age Menses Began_____ Duration of Flow_____ Length of Cycle (in a 28 day cycle)_____

□ Breast Lumps □ Irregular Periods □ Painful Periods □ PMS □ Clots □ Vaginal Sores □ Odor

□ # of Pregnancies_____ □ # of Live Births_____ □ # of Miscarriages_____

Age at Menopause_____ Date of last PAP_____ Date of Last Menses_____

OTHER INFORMATION YOUR PRACTITIONER MAY NEED: