NEW PATIENT INTAKE FORM

1. PATIENT INFORMATION

Full Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Date of Birth: _____ Age: _____

Email Address: _____ Occupation: _____

Please do not text to the automatic reminder text message number, because We will not receive those messages.
Please call or text (941) 724 1312 is the best way to reach us.

2. EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

3. HEALTH HISTORY

Have you had Acupuncture or TCM before? ☐ Yes ☐ No

What was your experience? ☐ Very good ☐ Good ☐ No change

Are you currently under a doctor's care? ☐ Yes ☐ No

Who and what for:

_____

_____

Are there other therapies you are involved in? ☐ Yes ☐ No

If yes, please list: _____

Family Physician: _____

Phone: _____

4. REASON FOR VISIT

What is the primary reason for seeking care at our office?

_____

_____

When did it begin? _____

What was the initial cause? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities? (Check all that apply)

☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Standing

☐ Emotional ☐ Relationships ☐ Social Life

☐ Other: _____

5. SIGNS & SYMPTOMS – Please check any that apply to you

- ☐ Fatigue / Low Energy
- ☐ Sleeping Issue
- ☐ Headaches
- ☐ Dizziness / Vertigo
- ☐ Blurry Vision
- ☐ Dry Eyes
- ☐ Tinnitus
- ☐ Muscle Pain / Tension
- ☐ Stress / Anxiety
- ☐ Depression
- ☐ Irritability
- ☐ Poor Memory / Focus
- ☐ Weight Gain
- ☐ Mood Swings
- ☐ Painful Period
- ☐ Irregular Period
- ☐ Digestive Problems
- ☐ Bloating / Gas
- ☐ Stomach Pain
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Acid Reflux / Heartburn
- ☐ Poor Appetite
- ☐ Hair Loss
- ☐ Allergies/Sinus Issues
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Runny Nose
- ☐ Sore Throat
- ☐ Palpitation
- ☐ Low Sex Drive
- ☐ Cold Hands / Feet
- ☐ Hot Flashes / Night Sweats
- ☐ Sensitive to Cold
- ☐ Thirst / Dry Mouth
- ☐ Frequent Urination
- ☐ Wake to Urinate
- ☐ Skin Problems / Rashes

6. MEDICATIONS & ALLERGIES

Do you have any allergies? ☐ Yes ☐ No

If yes, please list: _____

_____

Do you take any medications? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

Do you take any supplements or herbs?

☐ Yes ☐ No

If yes, please list: _____

_____

_____

_____

7. HEALTH HISTORY

Do you currently have or have you had any of the following?

☐ High Blood Pressure	☐ Arthritis	☐ Liver Disease
☐ Low Blood Pressure	☐ Anemia	☐ Kidney Issue
☐ Diabetes	☐ Stroke	☐ Autoimmune
☐ Thyroid Disorder	☐ HIV	☐ Cholesterol
☐ Hepatitis	☐ Cancer	☐ Heart Disease

Do you sleep well? ☐ Yes ☐ No

Do you dream often? ☐ Yes ☐ No

Do you have a high point during the day? When?

_____

Do you have a low point during the day? When?

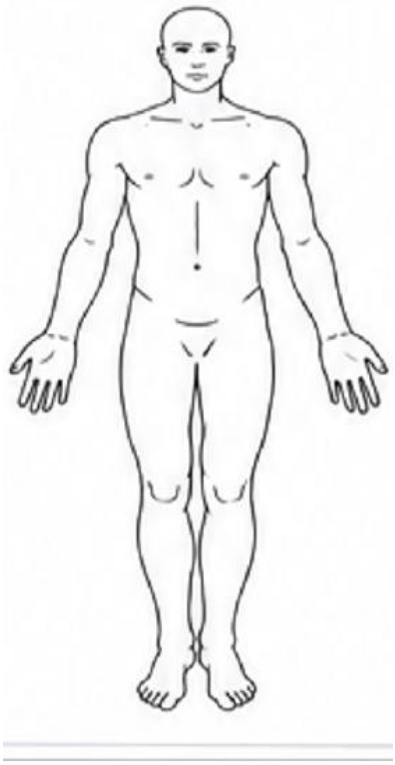
_____

What are your hobbies / pleasures?

_____

8. PAIN / BODY DIAGRAM

Please circle or mark areas of pain, discomfort, numbness, or tension.



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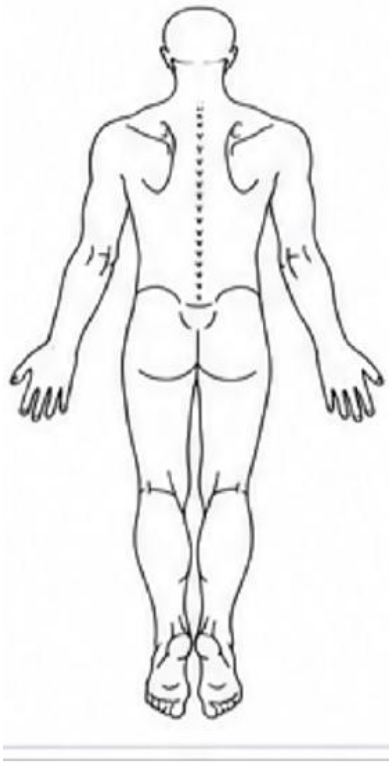

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