New Patient Intake Form Today's Date: _____

Name: _____ Cell Phone: _____

Date of Birth: ___/____/____ Age: _____ Home Phone: _____

Work Phone: _____

Marital Status: __S __M __D __W___ Partnership

Mailing Address:

Street/PO Box:_____ City:_____ State & Zip:_____

Main Residence Address:

Street/PO Box:_____ City:_____ State & Zip:_____

Occupation: _____ Referred By: _____

Ht:_____ Wt:_____ Email Address_____

Subscribe to my seasonal e-newsletter: Yes /No

Emergency Contact Name/Phone:

_____

Have you had acupuncture before? __Y __N Chinese Herbal Medicine? __Y __N

Reason for visit today:_____

How long have you had this condition? _____

Is it getting worse? _____

Does it bother your: __Sleep __Work __Other: _____

What seemed to be the initial cause? _____

What makes it better? _____ What makes it worse_____

Are you under the care of a physician now? __Y __N

If yes, for what?_____

Physician's Name: _____ Physician'sPhone:_____

Other current therapies:

_____

"Chinese Medicine questions:"

what season do you prefer_____ what climate do you prefer_____

how is your energy level_____ how is your appetite_____

how is your sleep? _____ bedtime:_____ #of hours_____

difficulty falling asleep/ wake frequently # of times_____ at which times_____

how is your digestion_____ _____

# of daily bowel movements____stool color & consistency: (circle) normal, loose , hard, light-colored, dark, watery, mucus blood

How often do you urinate daily_____ at night?_____ are you thirsty_____

__ Headaches __ Migraines __ Concussion __ Other head/neck problems:

_____

How do you plan to pay for treatments?: ____Cash____ Check____

Insurance Company Name:_____ID#:_____

I ascertain that all information given above is true and correct to the best of my knowledge:

Please discuss my case with my primary care physician: _____

Signature:_____Date:_____