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New Patient Information

General Information

Name ____ Today's Date ___________________

Street Address ____ Unit _______

City _______________________________________ State ______________ Zip ____________

Preferred Phone _________________________ Email __________________________________

Birth Date (include year) ______/_______/______ Age ______ Gender ____ Height _____ Weight _____

Occupation _______________________________ Employer ________________________________

Marital Status __________________ Referred by ___________________________________

Emergency Contact: Name _____________________________Phone _________________________

Under 18- Responsible Party Information

Name: _________________________ Relationship to Patient: __________________________

Healthcare Providers Involved In Your Care:

Physicians: GP/Primary Care __________________________

OB/GYN: _______________________________

Specialist (describe) _________________________

Chiropractor: _______________________________

Massage Therapist: ___________________________

Physical Therapist: ___________________________

Psychotherapist: _____________________________

Fees

It is our policy that you pay the entire session fee or co-pay at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.

Insurance Company ____

Insurance Company Phone Number (Provider Line) _____________________________
ID # ____________________________

[Please bring a photocopy of your insurance card (front and back) or bring your card to your first appointment so we can make a copy at the clinic.]

Cancellation Policy

If you need to change or cancel your appointment, please notify us within a minimum of 24 hours notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

☐ I understand the cancellation policy.

Signature:_______________________________ Date: _____/_____/_____

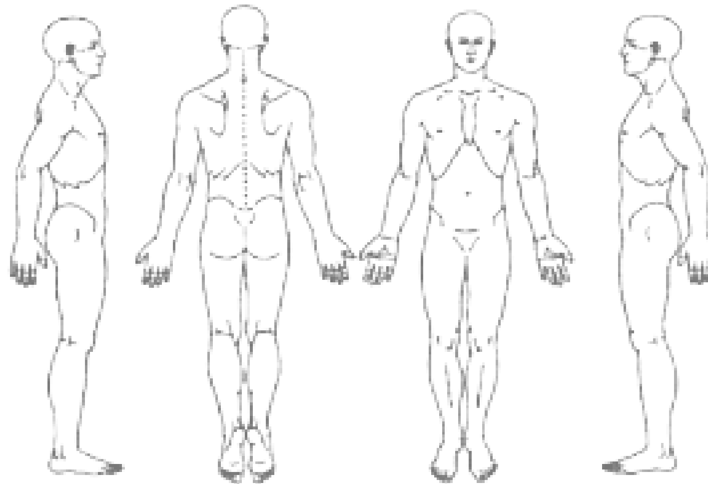
Health History

Have you had acupuncture before? ________ If so, for what reason? _________________________

Main issue(s) you are seeking treatment for and length of time experiencing each: _________________
____

Diagnoses from a medical professional and approximate dates of diagnosis (if applicable):
____
____

Please mark any areas of pain or discomfort:



Please list areas of pain or discomfort below with the 1-10 pain scale and a brief history:

(1: barely noticeable pain, 10: excruciating pain)

____
____

Please list your major health concerns in order of importance to you:

____
____

Check those that apply to your past medical history

- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis or rheumatism
- ☐ Asthma
- ☐ Attempted suicide
- ☐ Birth Trauma
- ☐ Bleeding disorder
- ☐ Blood disease
- ☐ Cancer or tumor
- ☐ Diabetes
- ☐ Emphysema
- ☐ Eating disorder
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hepatitis/Liver disease
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Immune disorder
- ☐ Joint replacement
- ☐ Kidney disorder
- ☐ Low blood pressure
- ☐ Lyme's disease
- ☐ Lymph nodes removed
- ☐ Mental illness
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Polio
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ Sciatica
- ☐ Scarlet fever
- ☐ Seizures/Epilepsy
- ☐ Sinus infections
- ☐ Skin disease
- ☐ Special diet
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease/STD
- ☐ Other____________________

Please check any symptoms that you have experienced in the past or currently experience:

Liver/Gallbladder

□ Depression / Stress
□ Headaches / Migraines
□ Red / Dry / Itchy Eyes
□ Visual Problems / Blurred Vision
□ Dizziness
□ Gallstones
□ Feeling of Lump in Throat
□ Clenching Teeth at Night
□ Muscle Cramping / Twitching
□ Neck/Shoulder Pain / Tightness □ Seizures/Tremors
□ Poor Circulation
□ Soft/Brittle Nails
□ Bitter Taste in Mouth
□ PMS/Menstrual Problems
□ Tendonitis
□ Pain Below Ribcage
□ Do you crave: Sour
□ Tend to be Irritable / Angry

Heart/Small Intestine

□ Heart Palpitations
□ Rapid or Irregular Heartbeat □ Chest Pain
□ High Blood Pressure
□ Low Blood Pressure
□ Insomnia / Sleep Problems
□ Vivid Dreams / Nightmares
□ Easily Startled
□ Dark Urine
□ Red Complexion
□ Do you crave: Bitter
□ Anxiety / Nervous or Restless

Spleen/Stomach

□ Body Heaviness
□ Hard to get up in Morning
□ Muscles Often Feel Tired
___ Energy Level: 1-10 (low to high)
□ Edema(□Hands □Feet)
□ Easily Bruising / Bleeding
□ Bad Breath
□ Sweetish Taste in Mouth
□ Lack of Taste
□ Excess or Low Appetite (circle which)
□ Excess or Lack of Thirst (circle which)
□ Nausea / Vomiting
□ Gas / Belching
□ Hemorrhoids
□ Organ Prolapse (i.e. uterus)
□ Chronic Loose Stools
□ Abdominal Pain
□ Indigestion / Heartburn

□ Brain Foggy
□ Mouth Ulcers
□ Tendency to Gain Weight
□ Do you crave: Sweet
□ Over-thinking / Worry

Lung/Large Intestine

□ Bloody Cough
□ Dry Cough
□ Chronic Cough
□ Cough with Sputum
□ Nasal Discharge
□White □Yellow □Green
□ Post Nasal Drip
□ Sinus Infection / Congestion
□ Itchy, Red, or Painful Throat
□ Dry Mouth / Nose / Throat
□ Skin Rashes / Hives
□ Snoring
□ Shortness of Breath
□ Allergies / Asthma
□ Low Immunity
□ Catch Colds Easily
□ Bronchitis
□ Black or Bloody Stools
□ Constipation
□ IBS
□ Diarrhea
□ Colitis / Spastic Colon
□ Do you crave: Pungent / Spicy □ Grief / Sadness

Kidney/Urinary Bladder

□ Urinary Problems (i.e. night-time) ______________
□ Bladder Infection
□ Incontinence
□ Weakness / Pain in Low Back
□ Osteoporosis
□ Feel Cold or Hot Easily (circle which)
□ Cold Hands / Feet
□ Low or Excess Sex Drive (circle which)
□ Dark Circles under Eyes
□ Thyroid Problems _________________________
□ Poor Memory
□ Hair Loss / Grey Hair
□ Hearing Problems / Tinnitus
□ Cavities
□ Hot Flashes / Night Sweats
□ Impotence or Premature Ejaculation (circle which) □ Do you crave: Salt
□ Fear

Neurological/Psychological

	past	current		past	current
Anxiety	☐	☐	poor memory	☐	☐
Depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐	mood swings	☐	☐
Irritability	☐	☐	ADD/ADHD	☐	☐
Parkinsons	☐	☐	Multiple Sclerosis	☐	☐

Please elaborate:

____

For Women Only:

	past	current		past	current
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐

age of first menses _____________ duration of typical period ____________________
duration of typical cycle _______________ date of last PAP _____________________
# of pregnancies _____________________ # of live births (+ years) _______________
# of miscarriages _____________________ # of abortions _______________________

Are you currently pregnant or breastfeeding? ____

Have you been through menopause? Age? ____

Did you experience a difficult menopause?

____
____

Have you ever taken birth control pills? When and for how long? ________________________

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

____
____

Please elaborate:

____

OPTIM ACUPUNCTURE

For Men Only:

	past	current		past	current
erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐

Please elaborate:

____

____

Lifestyle

Current medications/herbs/supplements (please list dosages and how long you have been taking each):

1) ________________________ Duration: _____________________________
2) _______________________ Duration: __________________________

Dietary Preference (if applicable):

- ❏ vegetarian
- ❏ gluten-free
- ❏ paleo
- ❏ pescetarian
- ❏ Keto
- ❏ Atkins
- ❏ other

Breakfast: ____

Lunch: ____

Dinner: ____

Have you used antibiotics in the past? If so, when and how often?

____

Current exercise routine:

____

Do you or have you ever used tobacco? (Yes/No)

If so, how often? ____

Do you or have you ever drank alcohol heavily? (Yes/No)

If so, how many drinks/week? ____

Do you or have you ever taken recreational drugs? (Yes/No)

If so, what and how often?

Drug(s):

1) ______________________________
2) ______________________________

Frequency:________________________________

Are you currently taking any of the following medications? *(circle if yes and indicate how often)*

- ❏ Advil/Motrin/Ibuprofen how often? _____ a day
- ❏ Aleve/Naproxen how often? _____ a day
- ❏ Prednisone/Prednisolone how often? _____ a day
- ❏ Celebrex/Celecoxib how often? _____ a day
- ❏ Bayer/Aspirin how often? _____ a day
- ❏ Acetaminophen/Tylenol how often? _____ a day

Allergies

- ❏ antibiotics (i.e, penicillin)
- ❏ sulfonamides (sulfa drugs), both antibiotic and non-antibiotic
- ❏ aspirin
- ❏ NSAIDS
- ❏ anti-seizure medications, like Lamictal (lamotrigine)
- ❏ chemotherapy drugs
- ❏ monoclonal antibody therapies, like Rituxan (rituximab)
- ❏ egg
- ❏ nuts
- ❏ shellfish
- ❏ Linseed
- ❏ Sesame seed
- ❏ Peach
- ❏ Banana
- ❏ Avocado
- ❏ Kiwi fruit
- ❏ Passion fruit
- ❏ Celery
- ❏ Garlic
- ❏ Mustard seeds
- ❏ Aniseed
- ❏ Chamomile

Other: ____

Have you ever had a seizure? If yes, indicate date of last: ____________________

Please list any major surgeries/hospitalizations and approximate dates:

1. _____________________________ Date: (___/___/___)
2. _____________________________ Date: (___/___/___)

Please list any other relevant information or issues you would like to discuss:

Thank you for filling out the Intake forms..