

New Patient Intake Form

Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section. Thank you!

Sierra Acupuncture & Healing Arts (775) 841-3336

Referred By:

Today's Date:

Patient's Name:

Last

First

Middle

Age

Date of Birth

Mailing Address:

Street

Apt #

City

State

Zip

Phone:

Home

Cell

Work

Social Security #

Occupation:

How Long:

Emergency Contact:

Name

Address

City/State

Phone #

Marital Status: Single Married Separated Divorced Widowed

Present Marriage (Year Married):

Previous Marriage (Year Married and Duration):

Religious Preference:

Health Insurance:

Phone:

Address:

Policy #:

Personal Medical History

Have you had acupuncture before? Yes No

Chinese herbal medicine? Yes No

Chief Complaint:

Previous Diagnosis:

(How and when did your illness/injury occur? Please be as specific as possible)

1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

How long have you had this condition? _____ Is it getting worse? _____.

Does it bother your Sleep Work Sex Life Other (What?) _____.

What seemed to be the initial cause? _____.

What seems to make it better? _____ . What seems to make it worse? _____.

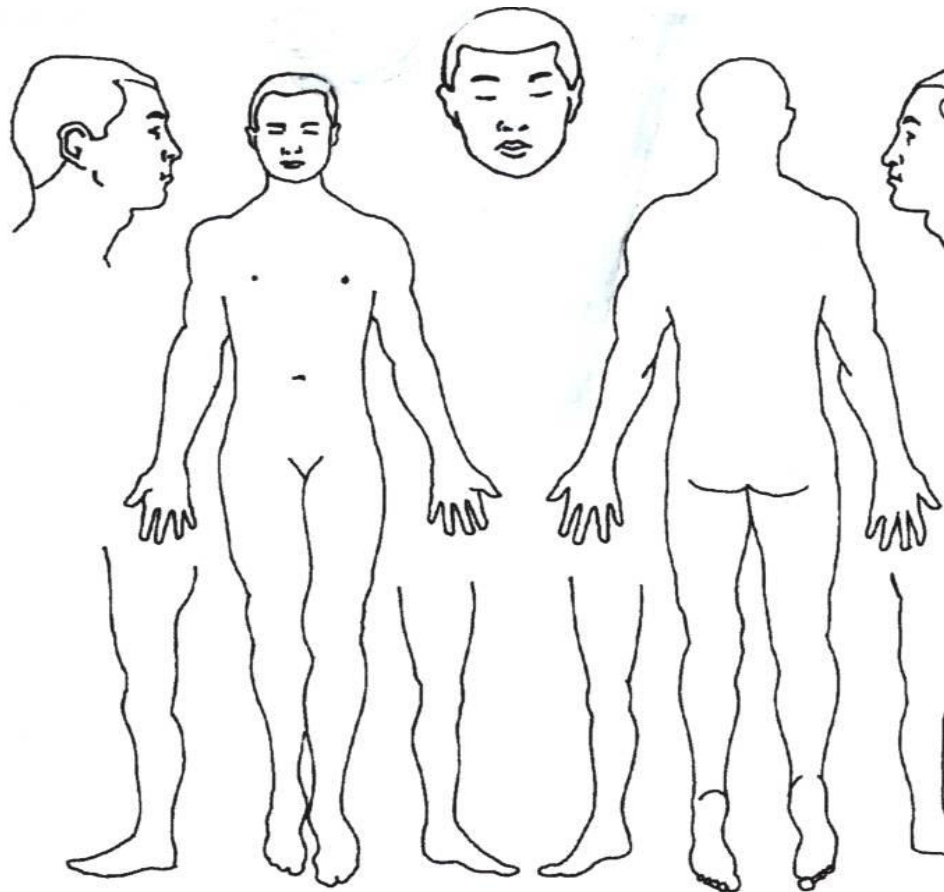
Have you consulted another Doctor about these problems? _____.

If yes, Doctor's name and diagnosis: _____.

What kinds of treatment or therapy have you tried? _____.

Please mark painful or distressed areas on the charts below

Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
≈	weak
#	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
-	colder
+	hotter
Physical	
⊙	sores
*	rashes
<< >>	spasms



FAMILY HISTORY

	Health:			Medical Problems	Cause of Death and Age
	Good	Poor	Deceased		
Yourself					
Mother					
Father					
Brothers					
Sisters					
Children					
Spouse					

YOUR PAST MEDICAL HISTORY

<input type="checkbox"/> Aids/HIV <input type="checkbox"/> Allergies: _____ _____ _____ <input type="checkbox"/> Alcoholism <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Asthma	<input type="checkbox"/> Birth Trauma (prolonged labor, forceps delivery, etc.) <input type="checkbox"/> Cancer <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Goiter <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Herpes	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Measles <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pleurisy <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Seizures	<input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disorders <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Major Trauma: _____ _____ <input type="checkbox"/> Other:
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<p>List of previous illnesses/hospitalizations or surgeries</p> <p style="text-align: center;"><u>Year:</u></p> <ol style="list-style-type: none"> 1. _____. 2. _____. 3. _____. 4. _____. 5. _____. 6. _____. 7. _____. 8. _____. 9. _____. 10. _____. 	<p>List any current medicines, homeopathics, vitamins, minerals or herbs you are taking now:</p> <p style="text-align: center;"><u>Reason:</u></p> <ol style="list-style-type: none"> 1. _____. 2. _____. 3. _____. 4. _____. 5. _____. 6. _____. 7. _____. 8. _____. 9. _____. 10. _____.
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<p>Date of Last:</p> <p>_____ Physical</p> <p>_____ Prostate Test</p> <p>_____ Blood tests (which?)</p> <p>_____ Cholesterol Test</p> <p>_____ Pap Smear</p> <p>_____ HIV Test</p> <p>_____ Mammography</p> <p>_____ Electrocardiogram</p>	<p>Year of Immunization</p> <p>_____ Tetanus</p> <p>_____ Smallpox</p> <p>_____ Typhoid</p> <p>_____ Polio</p> <p>_____ Influenza</p> <p>_____ Other</p>	<p>Have you ever taken cortisone type drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have a long history of antibiotic use? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Who is your general practitioner? _____.

Who is your OBGYN? _____.

Other Specialists? _____.

Occupation

Occupational stress factors (physical, psychological, chemical): _____

Lifestyle/nutrition

<input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Marijuana <input type="checkbox"/> Drugs <input type="checkbox"/> Stress	<input type="checkbox"/> Coffee <input type="checkbox"/> Soft Drinks <input type="checkbox"/> Artificial Sweetener <input type="checkbox"/> Sugar <input type="checkbox"/> Salty food	<p style="text-align: center;"><u>Average Daily Menu:</u></p> a.m.: _____ _____
Your Favorite:		Regular Exercise:
1. FLAVOR	2. SEASON	Type _____ Frequency _____
<input type="checkbox"/> Sour	<input type="checkbox"/> Spring	Type _____ Frequency _____
<input type="checkbox"/> Bitter	<input type="checkbox"/> Summer	Type _____ Frequency _____
<input type="checkbox"/> Sweet	<input type="checkbox"/> Late Summer	
<input type="checkbox"/> Spicy/Pungent	<input type="checkbox"/> Fall/Autumn	
<input type="checkbox"/> Salty	<input type="checkbox"/> Winter	
3. COLOR		
<input type="checkbox"/> Green		
<input type="checkbox"/> Red		
<input type="checkbox"/> Yellow		
<input type="checkbox"/> White		
<input type="checkbox"/> Blue/Black		

What is your energy level? (circle one)
1 2 3 4 5 6 7 8 9 10

Do you prefer to be inside _____ or outside _____ ?

Do weather changes affect you? _____
How _____

General

- | | | |
|---|--|---|
| <input type="checkbox"/> Poor Appetite
<input type="checkbox"/> Weight Gain
<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Cravings
<input type="checkbox"/> Changes in Appetite
<input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Night Sweats
<input type="checkbox"/> Fever
<input type="checkbox"/> Sweating Easily
<input type="checkbox"/> Not Sweating Enough
<input type="checkbox"/> Chills
<input type="checkbox"/> Tremors | <input type="checkbox"/> Insomnia
<input type="checkbox"/> Disturbed Sleep
<input type="checkbox"/> Localized Weakness
<input type="checkbox"/> Sudden Energy Drop (time of day?)
<input type="checkbox"/> Poor Balance
<input type="checkbox"/> Bleeding or Bruising Easily |
|---|--|---|

Skin and Hair

- | | | |
|---|---|--|
| <input type="checkbox"/> Rashes
<input type="checkbox"/> Ulcerations
<input type="checkbox"/> Hives
<input type="checkbox"/> Hair Loss | <input type="checkbox"/> Eczema
<input type="checkbox"/> Pimples
<input type="checkbox"/> Dandruff
<input type="checkbox"/> Any other skin or hair problems: _____ | <input type="checkbox"/> Recent Moles
<input type="checkbox"/> Changes in texture of hair or skin
<input type="checkbox"/> Itching |
|---|---|--|

Head, Eyes, Nose, Throat

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness
<input type="checkbox"/> Glasses
<input type="checkbox"/> Eye Pain
<input type="checkbox"/> Color Blindness
<input type="checkbox"/> Eyestrain
<input type="checkbox"/> Poor hearing
<input type="checkbox"/> Dry Throat
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Grinding Teeth
<input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Concussions
<input type="checkbox"/> Spots in front of eyes
<input type="checkbox"/> Poor Vision
<input type="checkbox"/> Cataracts
<input type="checkbox"/> Spots in eyes
<input type="checkbox"/> Earaches
<input type="checkbox"/> Dry Mouth
<input type="checkbox"/> Recurrent sore throats
<input type="checkbox"/> Sores on lips or tongue
<input type="checkbox"/> Gum Problems | <input type="checkbox"/> Migraines
<input type="checkbox"/> Headaches (where? when?)
<input type="checkbox"/> Night Blindness
<input type="checkbox"/> Blurry Vision
<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Mucus
<input type="checkbox"/> Copious Saliva
<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Facial Pain
<input type="checkbox"/> Jaw Clicks |
|--|--|---|

Cardiovascular

- | | | |
|--|---|---|
| <input type="checkbox"/> Dizziness
<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Fainting
<input type="checkbox"/> Cold Hands and Feet
<input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Swelling of feet
<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Difficulty in breathing
<input type="checkbox"/> Phlebitis |
|--|---|---|
- Any other heart or blood vessel problems: _____

Respiratory

- Cough
- Coughing up blood
- Asthma

- Bronchitis
- Pain with deep inhalation
- Pneumonia

- Difficulty in breathing when lying down
- Excessive phlegm (color?)

Any other lung problems: _____

Gastrointestinal

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Gas

- Belching
- Black stools
- Blood in stools
- Indigestion
- Bad Breath

- Rectal pain
- Hemorrhoids
- Abdominal pain or cramps
- Chronic laxative use

Any other problems with stomach or intestines: _____

Genitourinary

- Pain on urination
- Frequent urination
- Blood in urine

- Urgency to urinate
- Unable to hold urine
- Kidney stones

- Decrease in flow
- Impotence
- Sores on genitals

Do you wake up to urinate? _____ If so how often? _____

Any particular color to your urine? _____

Any other genital or urinary problems _____

Reproductive and Gynecologic

- Premenstrual changes
- Menstrual clots
- Painful menses
- Unusual menses

- Heavy menstrual flow
- Light menstrual flow
- Irregular menses
- Other problems

- Premature births
- Miscarriages
- Abortions

Age at first menses _____ Age at menopause _____ Number of pregnancies _____

Time between cycles _____ Durations of bleeding _____ First day of last menses _____

Do you practice birth control? _____ If so, what type? _____ For how long? _____

Any other gynecologic problems: _____

Musculoskeletal

- Neck pain
- Muscle pains
- Knee pain

- Back pain
- Muscle weakness
- Foot/ankle pains

- Hand/wrist pains
- Shoulder pains
- Hip pain

Any other joint or bone problems: _____

Neuropsychological

- Seizures
- Dizziness
- Loss of balance
- Areas of numbness

- Poor Memory
- Lack of coordination
- Concussion
- Depression

- Anxiety
- Bad temper
- Easily susceptible to stress

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

Comments

Please list any other problems you would like to discuss: _____

