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? _____.

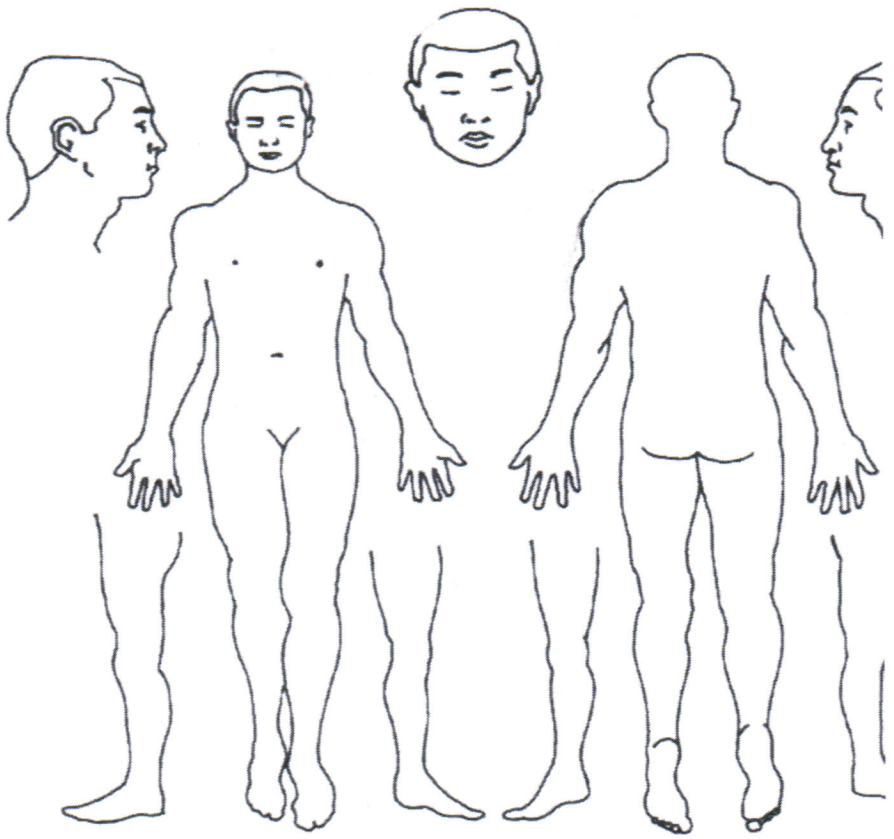
If yes, Doctor's name and diagnosis: _____.

_____.

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	
Ø	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

- ☐ Aids/HIV
- ☐ Allergies:

_____

_____

_____

- ☐ Alcoholism
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Trauma (prolonged labor, forceps delivery, etc.)
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Major Trauma:

_____

_____

- ☐ Other:

List of previous illnesses/hospitalizations or surgeries

Year:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.
6. _____.
7. _____.
8. _____.
9. _____.
10. _____.

List any current medicines, homeopathics, vitamins, minerals or herbs you are taking now:

Reason:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.
6. _____.
7. _____.
8. _____.
9. _____.
10. _____.

Date of Last:

_____Physical
_____Prostate Test
_____Blood tests (which?)
_____Cholesterol Test
_____Pap Smear
_____HIV Test
_____Mammography
_____Electrocardiogram

Year of Immunization

_____Tetanus
_____Smallpox
_____Typhoid
_____Polio
_____Influenza
_____Other

Have you ever taken cortisone type drugs? ☐ Yes ☐ No

Do you have a long history of antibiotic use? ☐ Yes ☐ No

Who is your general practitioner? _____.
Who is your OBGYN? _____.
Other Specialists? _____.

Occupation

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

_____.

Lifestyle/nutrition

☐ Alcohol
☐ Tobacco
☐ Marijuana
☐ Drugs
☐ Stress

☐ Coffee
☐ Soft Drinks
☐ Artificial Sweetener
☐ Sugar
☐ Salty food

Your Favorite:

1. FLAVOR	2. SEASON	3. COLOR
☐ Sour	☐ Spring	☐ Green
☐ Bitter	☐ Summer	☐ Red
☐ Sweet	☐ Late Summer	☐ Yellow
☐ Spicy/Pungent	☐ Fall/Autumn	☐ White
☐ Salty	☐ Winter	☐ Blue/Black

Average Daily Menu:

a.m.:_____

_____

noon:_____

_____

p.m.:_____

_____

Regular Exercise:

Type_____Frequency_____
Type_____Frequency_____
Type_____Frequency_____

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

☐ Poor Appetite
☐ Weight Gain
☐ Weight Loss
☐ Cravings
☐ Changes in Appetite
☐ Strong Thirst

☐ Night Sweats
☐ Fever
☐ Sweating Easily
☐ Not Sweating Enough
☐ Chills
☐ Tremors

☐ Insomnia
☐ Disturbed Sleep
☐ Localized Weakness
☐ Sudden Energy Drop (time of day?)
☐ Poor Balance
☐ Bleeding or Bruising Easily

Skin and Hair

☐ Rashes
☐ Ulcerations
☐ Hives
☐ Hair Loss

☐ Eczema
☐ Pimples
☐ Dandruff
☐ Any other skin or hair problems:_____

☐ Recent Moles
☐ Changes in texture of hair or skin
☐ Itching

Head, Eyes, Nose, Throat

☐ Dizziness
☐ Glasses
☐ Eye Pain
☐ Color Blindness
☐ Eyestrain
☐ Poor hearing
☐ Dry Throat
☐ Sinus Problems
☐ Grinding Teeth
☐ Teeth Problems

☐ Concussions
☐ Spots in front of eyes
☐ Poor Vision
☐ Cataracts
☐ Spots in eyes
☐ Earaches
☐ Dry Mouth
☐ Recurrent sore throats
☐ Sores on lips or tongue
☐ Gum Problems

☐ Migraines
☐ Headaches (where? when?)
☐ Night Blindness
☐ Blurry Vision
☐ Ringing in ears
☐ Mucus
☐ Copious Saliva
☐ Nose Bleeds
☐ Facial Pain
☐ Jaw Clicks

Cardiovascular

☐ Dizziness
☐ Low Blood Pressure
☐ Chest Pain
☐ Irregular Heartbeat

☐ High Blood Pressure
☐ Fainting
☐ Cold Hands and Feet
☐ Swelling of hands

☐ Swelling of feet
☐ Blood Clots
☐ Difficulty in breathing
☐ 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:

Sierra Acupuncture & Healing Arts
512 North Division St. Carson City, NV 89703
775-841-3336

NUTRITIONAL INTAKE FORM

Name:_____ Date: _____

Please fill out the following dietary information:

1. Describe your present diet in one brief sentence: _____

_____

2. Do you like to cook? Yes _____ No _____

3, By percentage, how often do you eat at home? _____% Eat out? _____%

4. What are some of your favorite foods? _____

5. What foods or flavors do you crave? _____

6. What foods or flavors do you have an aversion to? _____

7. What percentage of your food is: cooked/warm _____% raw/cold _____%?

8. How many cups of liquid do you drink in an average day? _____

9. Number of meals per day: _____ Do you eat between meals? _____

10. Do you eat a little or a lot? _____ Is your appetite regular? _____

11. Has your diet differed in the past? How?_____

_____

_____

12. As a child, which of these two types of food did you eat more of?

_____eggs, meat, cheese, fish, salty foods or _____fruit, milk, sweets, liquids, ice cream

13. Have you ever experienced periods of extreme weight gain or loss, or extreme changes in eating habits? Yes____ No____ If yes, please explain briefly: _____

_____

14. Do you smoke tobacco? _____ If yes, how much and how frequent? _____

15. Do you drink alcohol? _____ If yes, what and how much? _____

16. Do you ever take any drugs? _____ What kind? _____

17. What vitamins or supplements do you take on a regular basis? _____

_____

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18. Do you eat when feeling: sad_____, fearful_____, angry_____, happy_____, worried_____?
(please check appropriate items)

19. Do you usually eat in a relaxed manner, or on the run? _____

20. Is there anything else you would like to add? _____

_____

_____

21. Are there any specific areas in which you would like Nutritional/Dietary Guidance? _____

_____

_____

List amounts and kinds of foods eaten on an average day – and on occasion:

Whole grain: _____

Grain products: _____

Vegetables (note cooked or raw): _____

_____

Fruit (note cooked or raw): _____

Beans and tofu: _____

Sea vegetables: _____

Soup: _____

Nuts, seeds, and their butters: _____

Fish: _____

Meat: _____

Eggs: _____

Dairy: _____

Salt and salty condiments (in cooking and at the table): _____

Spices: _____

Beverages: _____

Water: _____

Desserts: _____

Snack foods: _____

Seasonal changes: _____