New Patient Intake Form

Today's Date _____

Name _____ SS# _____ Birthdate _____

Marital Status _____ Age _____

Address _____ ☐ M ☐ F Ht _____ Wt _____

_____

Email _____

City, State, Zip _____ Occupation _____

Home Phone _____ Work _____ Cell _____

Emergency Contact's Name & Phone _____

Referred by _____

Reason for visit today _____ Have you had acupuncture before? ☐ Yes ☐ No

Chinese herbal medicine? ☐ Yes ☐ No

How long have you had this condition? _____

Is it getting worse? _____ Does it bother your Sleep Work Other (specify) _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Are you under the care of a physician now? ☐ Yes ☐ No If yes, for what? _____

Physician's name _____ Physician's phone _____

Other concurrent therapies: _____

Some insurance plans require preauthorization for acupuncture. Please note: I do not directly accept insurance. I collect full payment up front. I will provide you with a 'superbill' which is a receipt with insurance codes and diagnosis codes on it for you to submit to your insurance company. Any insurance coverage and payment should be directly reimbursed to you from your insurance company. With that being said, I will do my best to help you get reimbursed from insurance via providing any information and forms that your insurance company may require from me directly. Should you have any questions, please contact Ayesha Atique at (office) 630.393.9800 ext. 214 or e-mail atique.acupuncture@gmail.com.

Family Medical History

Allergies (list)

☐ Arteriosclerosis
☐ Asthma
☐ Alcoholism
☐ Cancer (type) _____
☐ Depression
☐ Diabetes *(type)* _____
☐ Heart disease
☐ High blood pressure
☐ Seizures
☐ Stroke

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

☐ AIDs/HIV
☐ Alcoholism
☐ Allergies
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Birth trauma (your own birth)
☐ Cancer
☐ Chicken pox
☐ Diabetes (Type: _____)
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart disease
☐ Hepatitis (Type: _____)
☐ Herpes (Type: _____)
☐ High blood pressure
☐ Measles
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker (Date: _____)
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Seizures
☐ Stroke
☐ Surgery (list) _____
☐ Thyroid disorders
☐ Major trauma (Car, fall, etc–list) _____
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal disease
☐ Whooping cough
☐ Other (Specify) _____

Your Diet

Appetite ☐ Low ☐ High

☐ Coffee/Tea ☐ Soft Drinks/Fruit Juices

Protein Intake ☐ Low ☐ High

☐ Artificial ☐ Sweeteners

☐ Sugar ☐ Salty foods

Thirst for water: # glasses per day _____

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Pharmaceuticals taken in the last 2 months:

Vitamins/supplements taken in the last 2 months:

Practitioner Use Only

Your Lifestyle

- ❑ Alcohol
- ❑ Tobacco
- ❑ Marijuana
- ❑ Drugs
- ❑ Stress
- ❑ Occupational hazards

Regular Exercise
Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Strongly like cold drinks
- ❑ Strongly like hot drinks
- ❑ Recent weight loss/gain
- ❑ Poor sleep
- ❑ Heavy sleep
- ❑ Dream-disturbed sleep
- ❑ Fatigue
- ❑ Lack of strength
- ❑ Bodily heaviness
- ❑ Cold hands or feet
- ❑ Poor circulation
- ❑ Shortness of breath
- ❑ Fever
- ❑ Chills
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Muscle cramps
- ❑ Vertigo or dizziness
- ❑ Bleed or bruise easily
- ❑ Peculiar taste (Describe)

Head, Eyes, Ears, Nose, Throat

- ❑ Glasses (What age:)
- ❑ Eye strain
- ❑ Eye pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Spots in eyes
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Night blindness
- ❑ Myopia or Presbyopia
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Teeth problems
- ❑ Grinding teeth
- ❑ TMJ
- ❑ Facial pain
- ❑ Gum problems
- ❑ Sores on lips or tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Sinus problems
- ❑ Excessive phlegm
  Color:
- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Lumps in throat
- ❑ Enlarged thyroid
- ❑ Nosebleeds
- ❑ Ringing in ears (High or Low?)
- ❑ Poor hearing
- ❑ Earaches
- ❑ Headaches
- ❑ Migraines
- ❑ Concussions

Other head or neck problems
_____
_____
_____

Respiratory

- ❑ Difficulty breathing when lying down
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Asthma/wheezing
- ❑ Difficult inhalation? exhalation?
- ❑ Cough
  Wet or Dry?_____
  Thick or thin?_____

Color of phlegm
_____

- ❑ Coughing up blood
- ❑ Pneumonia

Cardiovascular

- ❑ High blood pressure
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Fainting
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Tachycardia
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heartbeat

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Acid regurgitation
- ❑ Gas
- ❑ Hiccup
- ❑ Bloating
- ❑ Bad breath
- ❑ Diarrhea
- ❑ Constipation
- ❑ Black stools
- ❑ Bloody stools
- ❑ Mucous in stools
- ❑ Hemorrhoid
- ❑ Itchy anus
- ❑ Intestinal pain or cramping
- ❑ Burning anus
- ❑ Rectal pain
- ❑ Anal fissures
- ❑ Laxative use
  What kind?
  How often?

Bowel movements:
Frequency_____ Texture/form_____
Color_____ Odor_____

Musculoskeletal

- ❑ Neck/shoulder pain
- ❑ Muscle pain
- ❑ Upper back pain
- ❑ Low back pain
- ❑ Joint pain
- ❑ Rib pain
- ❑ Limited range of motion
- ❑ Limited use

Other (Describe)
_____

Skin and Hair

- ❑ Rashes
- ❑ Hives
- ❑ Ulcerations
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Dandruff
- ❑ Itching
- ❑ Hair loss
- ❑ Change in hair/skin texture
- ❑ Fungal infections

Other hair or skin problems
_____
_____

Neuropsychological

- ❑ Seizures
- ❑ Numbness
- ❑ Tics
- ❑ Poor memory
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily stressed
- ❑ Abuse survivor
- ❑ Considered/attempted suicide
- ❑ Seeing a therapist

Other (Specify)
_____
_____

Genitourinary

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Venereal disease
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stone
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission

Gynecology

- ❑ Age menses began
  _____
  Length of cycle (day 1 to day 1)
  _____
- ❑ Duration of flow
  _____
- ❑ Irregular periods
- ❑ Painful periods
- ❑ PMS
- ❑ Vaginal discharge
  (color)_____
- ❑ Vaginal sores
- ❑ Vaginal odor
- ❑ Clots
- ❑ Breast lumps
- # Pregnancies_____
- # Live births_____
- # Premature births_____
- Age at menopause_____

Date of last PAP
_____

Date last period began
_____

Other

_____

_____

_____

Women's Health/Fertility Form

CONFIDENTIAL

Menstrual History

Age at which Menses Began _____

Age at which it stopped _____

Are your periods painful? ❑ Yes ❑ No

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? ❑Light ❑Normal ❑ Heavy

What color is the blood? ❑Light red ❑Red ❑Dark Red ❑Brown ❑Black

Is there clotting? ❑Yes ❑No

Do you have premenstrual tension? ❑Yes ❑No

Does your face break out before or during your period? ❑Yes ❑No

Do your breasts become tender premenstrually? ❑Yes ❑No

Do you retain water during your period? ❑Yes ❑No

Do you bleed or spot between periods? ❑Yes ❑No

Are your menstrual cycles spaced irregularly? ❑Yes ❑No

How many days are there from one period to the next? _____

Date of last menstrual period _____

	Number	Years
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times has a D&C been performed?	_____	_____

Complications? _____

Have you ever had an abnormal pap smear? ❑Yes ❑No

Have you ever had a cervical biopsy, operation, cauterization or conization? ❑Yes ❑No

Have you ever had a venereal disease? ❑Yes ❑No

Do you get yeast infections regularly? ❑Yes ❑No

Have you ever been diagnosed with a chlamydial infection? ❑Yes ❑No

Do you have chronic vaginal discharge? ❑Yes ❑No

Do you have any sores on your genitalia? ❑Yes ❑No

Have you ever had pelvic inflammatory disease? ❑Yes ❑No

Were you treated for it? ❑Yes ❑No

How? _____

_____

Date of last Pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps? ❑Yes ❑No

Have you ever been diagnosed with endometriosis? ❑Yes ❑No

Have you been diagnosed with pelvic adhesions? ❑Yes ❑No

Have you been diagnosed with any pelvic abnormalities? ❑Yes ❑No

Have you taken any medications other than contraceptives for gynecological conditions?

Medicine	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began? ❑Yes ❑No

How? _____

Do you ovulate on your own? ❑Yes ❑No

On what day of your cycle? _____

Do your breasts get tender at/during ovulation? ❑Yes ❑No

Do you get premenstrual low back pain? ❑Yes ❑No

Do your bowel movements become loose at the beginning of your period? ❑Yes ❑No

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Fertility History

How long have you been trying to conceive?_____

Is there a history of infertility in your family? ❑Yes ❑No

Describe: _____

Have you had fertility treatments? ❑Yes ❑No

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? ❑Yes ❑No

When? _____ How long? _____

Have your fallopian tubes been evaluated medically? ❑Yes ❑No

What were the results? _____

Have you had any tubal operations? ❑Yes ❑No

Have you had any hormone laboratory tests performed? ❑Yes ❑No

What were the results? _____

Do you have a single partner with whom you have been trying to conceive? ❑Yes ❑No

How long have you been married or living together?_____

Has he had a fertility workup? ❑Yes ❑No

What were the results? _____

Is your partner supportive of your wish to conceive? ❑Yes ❑No

Have you taken oral contraceptives? ❑Yes ❑No

When?_____ How long?_____

Have you ever had an IUD? ❑Yes ❑No

When? _____ How long?_____

Have you ever taken DepoProvera? ❑Yes ❑No

When? _____ How long? _____

Have you had a diagnosis relating to infertility? ❑Yes ❑No

What was it? _____

How is your sexual energy? ❑Low ❑Normal ❑High

Are you experiencing any sexual problems? ❑Yes ❑No

Does your partner experience any sexual dysfunction? ❑Yes ❑No

Do you douche regularly? ❑Yes ❑No

With what? _____

Do you use vaginal lubricants? ❑Yes ❑No

Are you more than 20% over your ideal body weight? ❑Yes ❑No

Are you more than 20% below your ideal body weight? ❑Yes ❑No

Do you have a stressful occupation? ❑Yes ❑No

Do you exercise regularly? ❑Yes ❑No

Do you have excessive facial hair? ❑Yes ❑No

Do you have excessively oily skin? ❑Yes ❑No

Have you experienced excessive loss of head hair? ❑Yes ❑No

Have you noticed discharge from your nipples? ❑Yes ❑No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? ❑Yes ❑No

Have you been exposed to any known environmental toxins or hormones? ❑Yes ❑No

Are you presently taking steroids? ❑Yes ❑No

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