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## HearthsideHealing.com

# Acupuncture
# New Patient Intake Form

Name: Age: Birth Date:

Address:

City: State: Zip:

Phone number: Social Security Number:

Email:

Your Occupation:

Emergency Contact Name: Contact Phone:

Name and location of Primary Care Physician:

Do you have health insurance?

Insurance Co. Name:

Policy#:

Phone #:

**Please indicate if any of the following pertain to you:**

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker

□ Blood-Thinning Medication □ Pregnancy

**Please indicate how frequently you consume the following:**

Coffee: Soda: Water:

Alcohol: Tobacco: Sugar:

**Please list any prescription or over-the-counter medications and supplements you are presently taking:**

Medication / Supplement Reason For how long now?

_____

_____

_____

_____

**Health History**

Please indicate your top 3 health concerns for which you are seeking treatment and how long you have been experiencing them:

1. _____
2. _____
3. _____

What are your health goals?

_____

_____

_____

What other forms of treatment have you sought?

_____

_____

What helps your condition?

_____

What aggravates your condition?

_____

Please list any surgeries or major health incidents (accidents, etc.) in your life and the date of occurrence:

_____

_____

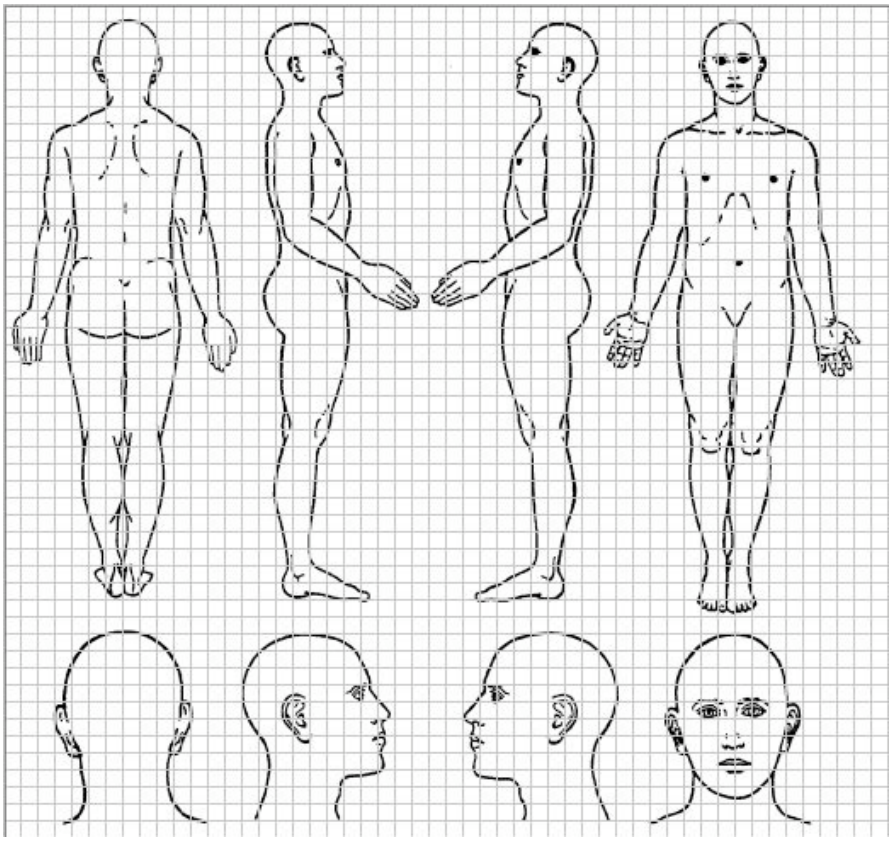
If you experience any physical pain, please indicate where it is and when it began:

_____

How would you characterize your physical pain? □ dull/achy □ sharp/stabbing □ burning □ tingling /numbness

□ electrical □ continuous □ comes and goes □ fixed location □ moves around □ shooting/ radiating

Please indicate where your pain is in the figure below:



**Symptoms Survey**

Please indicate the symptoms or conditions you currently experience or have experienced them in the past:

| ***Earth*** | **Currently** | **Past** | ***Wood*** | **Currently** | **Past** |
|---|---|---|---|---|---|
| Excessive appetite | □ | □ | Eye Problems | □ | □ |
| Loose stools / diarrhea | □ | □ | Jaundice | □ | □ |
| Digestive problems | □ | □ | Difficulty ingesting | □ | □ |
| Gas or bloating | □ | □ | Belching | □ | □ |
| Obsession | □ | □ | Acid Reflux / heart burn | □ | □ |
| Worry thoughts | □ | □ | Easily Frustrated/ angered | □ | □ |
| Lack of appetite | □ | □ | Depression | □ | □ |
| Fatigue | □ | □ | Difficulty making decisions | □ | □ |
| Low energy after a meal | □ | □ | Gallstones | □ | □ |
| Sweet cravings | □ | □ | Ringing in the ears | □ | □ |
| Hemorrhoids | □ | □ | Brittle hair or nails | □ | □ |
| Low blood pressure | □ | □ | High cholesterol | □ | □ |

| ***Fire*** | **Currently** | **Past** | ***Metal*** | **Currently** | **Past** |
|---|---|---|---|---|---|
| Insomnia | □ | □ | Cough | □ | □ |
| Heart palpitations | □ | □ | Shortness of breath | □ | □ |
| Nightmares | □ | □ | Decreased sense of smell | □ | □ |
| Mentally restless | □ | □ | Colitis/diverticulitis | □ | □ |
| Chest pain | □ | □ | Tightness in the chest | □ | □ |
| Poor memory | □ | □ | Constipation | □ | □ |
| Sadness/loneliness | □ | □ | Grief/ Nostalgia | □ | □ |

| | | | | | |
|---|---|---|---|---|---|
| Agitation/Fidgeting | □ | □ | Claustrophobia | □ | □ |

| ***Water*** | **Currently** | **Past** | ***Blood & Dampness*** | **Currently** | **Past** |
|---|---|---|---|---|---|
| Lower back pain | □ | □ | Arthritis | □ | □ |
| Knee pain/ problems | □ | □ | Sluggishness/Grogginess | □ | □ |
| Hearing impairment | □ | □ | Nausea | □ | □ |
| High or low libido | □ | □ | Heavy feeling | □ | □ |
| Hair loss | □ | □ | Dark circles under eyes | □ | □ |
| Urinary problems | □ | □ | Blood clotting disorder | □ | □ |

I usually feel : □ Hot □ Cold □ I'm often thirsty

**Lifestyle**

How many hours of sleep do you get each night?

_____

Do you experience: □ Difficulty falling asleep □ Staying asleep □ Interrupted sleep

□ Nightmares □ Vivid dreams □ Wake up not well-rested/groggy

How many bowel movements do you have in a day or week?

_____

Are your bowel movements: □ Well-formed □ Loose □ Small pebbles □ Tan □ Almost black □ Easy to pass □ Difficult to pass □ Sticky, like you have to wipe a lot

How would you rate your energy level on a scale of 1-10, with 10 being the highest:

_____

How would you rate your stress level on a scale of 1-10, with 10 being the highest:

_____

Please list your primary sources of stress:

_____

_____

How much do you think about them? How much do they impact your life?

_____

_____

How many hours do you work per week? _____ Do you like your work? _____

What do you do in order to manage your stress and take care of yourself?

_____

_____

Anything else you'd like me to know?

_____