2424 O'Neal Lane Ste B.
Baton Rouge, LA 70816
Tel. (225) 636 - 6666
www.BRAcupunctureWellness.com

# New Patient Intake Form

This information is strictly confidential. If we do not sincerely believe that you will respond favorably to acupuncture we will not accept your case, but will refer to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. If you have any questions, don't hesitate to ask one of our staff members for help.

## PATIENT INFORMATION

Today's Date: ________________

Name ____________________________________ SSN ______________ Age _______ Date of Birth ______________

Height _______ Weight _______ Sex ❑ M ❑ F Marital Status ❑Single ❑Married ❑Divorced ❑Widowed ❑Partnered

Home Address ____________________________________________ City _______________ State ______ Zip _________

Home Phone ________________________ Cell Phone _______________________ Email _________________________

Occupation ____________________________________ Employer/School Name ____________________________________

Business Address ____________________________________________________ Work Phone ________________________

Emergency Contact: Name ______________________ Relationship ___________________ Phone _______________________

Primary Physician /Referring Physician ____________________________________________ Phone _______________________

Insurance Carrier _______________________________________________ Policy Number ____________________________

How did you hear about us? ❑Family/Friend ❑Health Professional ❑Internet ❑Other ________ Referred by _______________

Have you received acupuncture before? ❑Yes ❑No If yes, when? _________ from who? __________ for what? __________

Have you used Chinese herbal medicine before? ❑Yes ❑No If yes, please list formula:___________________________________

## CHIEF COMPLAINT

Main complaint ______________________________________________________________________________________

How long have you had this problem? ______________________________________________________________________

What seems to cause this problem? _______________________________________________________________________

Have you been given a diagnosis? ❑Yes ❑No If yes, what? ________________________________________________________

by whom? Physician's Name _________________ Phone ______________

To what extent does this problem interfere with your daily activities (work, exercise, sleep, sex, etc.)? ___________________________

_____________________________________________________________________________________________________

What kinds of treatment have you tried? How did your condition change? ________________________________________________

_____________________________________________________________________________________________________

What makes it better? _______________________________________ Worse? _______________________________________

Please rate your current pain/discomfort on a scale of 1-10: very slight ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 unbearable

Is there anyone in your family with the same/similar problems? _____________________________________________________

List any other health problems you have. ___________________________________________________________________

_____________________________________________________________________________________________________

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## MEDICAL HISTORY

Please check any of the following which have ever affected you and indicate date.

- ❑ Addiction __________
- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma
- ❑ Breast lumps
- ❑ Breathing problems
- ❑ Bronchitis
- ❑ Bursitis
- ❑ Cancer _____________
- ❑ Candida
- ❑ Chicken pox
- ❑ Chronic fatigue
- ❑ Colitis/ Bowel disease
- ❑ Diabetes
- ❑ Digestive disorders
- ❑ Eating disorder
- ❑ Elevated liver enzymes
- ❑ Emotional imbalance
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Food, chemical, drug poisoning
- ❑ Fibromyalgia
- ❑ Gall stones
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Heart disease
- ❑ Hernia
- ❑ Hepatitis
- ❑ Herpes
- ❑ High cholesterol
- ❑ Hypertension
- ❑ Hypotension
- ❑ Other ____________________________________________________________________
- ❑ HIV positive
- ❑ Kidney stones
- ❑ Malaria
- ❑ Measles
- ❑ Meningitis
- ❑ Mononucleosis
- ❑ Multiple sclerosis
- ❑ Mumps
- ❑ Nephritis
- ❑ Neuralgia
- ❑ Paralysis
- ❑ Prostate problems
- ❑ Rheumatism
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Stroke
- ❑ STD _______________
- ❑ Thyroid problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid fever
- ❑ Ulcers
- ❑ Urinary problems
- ❑ Whooping cough

Surgeries, Hospitalizations and Significant Trauma's (auto accidents, falls, loss of loved one, etc)

| DATE | EVENT |
| --- | --- |
| | |
| | |
| | |
| | |

Allergies and adverse reactions ____________________________________________________________

______________________________________________________________________________________

Medications taken in last 3 months, including vitamins, supplements, over-the-counter medicines, herbal medicines.

| MEDICATION | DOSAGE | REASON | HOW LONG | LAST CHECKUP DATE |
| --- | --- | --- | --- | --- |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do you have a pacemaker? ❑Yes ❑No Do you bleed for a long time? ❑Yes ❑No

Do you have any of the following conditions currently? ❑Cold/ Flu ❑Infection/Inflammation ❑Menstruation ❑Pregnancy/Lactation

## FAMILY MEDICAL HISTORY

Please indicate any significant illnesses your blood relative (grandparent, parent or sibling) have had:

- ❑ Cancer type ___________ who ___________ when ____________
- ❑ Diabetes who ___________ when ____________
- ❑ Emotional Disorders who ___________ when ____________
- ❑ Heart Disease who ___________ when ____________
- ❑ Hepatitis who ___________ when ____________
- ❑ High Blood Pressure who ___________ when ___________
- ❑ Infectious Diseases who ___________ when ___________
- ❑ Rheumatic Fever who ___________ when ___________
- ❑ Seizures who ___________ when ___________
- ❑ Tuberculosis who ___________ when ___________

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## PERSONAL / SOCIAL HISTORY

How many hours per night do you sleep? ________ When do you usually go to bed? ___________ Do you wake rested? ❑Yes ❑No

Do you exercise regularly? ❑Yes ❑No What kind of exercise? ____________________________________________

What are your hobbies/ things you most enjoy doing?____________________________________________

Are you or have you been on a restricted diet? What kind and why? ____________________________________________

____________________________________________________________________________________________

Please indicate the use and frequency of the following:

Cigarettes ❑Yes ❑No how many per day? __________ since when? ____________ Alcohol ❑Yes ❑No amount ___________

Recreational drugs ❑Yes ❑No type _________ amount ________ since when? ________ Coffee ❑Yes ❑No amount ________

Tea ❑Yes ❑No amount ___________ Soda ❑Yes ❑No amount ____________ Water ❑Yes ❑No amount __________

Please describe your average daily diet:

Morning ____________________________________________________________________________

Afternoon ___________________________________________________________________________

Evening ____________________________________________________________________________

How do you feel about the following areas of your life?

| | GREAT | GOOD | FAIR | POOR | BAD | COMMENTS |
|---|---|---|---|---|---|---|
| Significant-other | ❑ | ❑ | ❑ | ❑ | ❑ | ____________ |
| Family | ❑ | ❑ | ❑ | ❑ | ❑ | ____________ |
| Diet | ❑ | ❑ | ❑ | ❑ | ❑ | ____________ |
| Sex | ❑ | ❑ | ❑ | ❑ | ❑ | ____________ |
| Self | ❑ | ❑ | ❑ | ❑ | ❑ | ____________ |
| Work | ❑ | ❑ | ❑ | ❑ | ❑ | ____________ |
| Spirituality | ❑ | ❑ | ❑ | ❑ | ❑ | ____________ |

## SYMPTOM SURVEY

Please check any of the following that applies to you now or in the past 3 months.

### General

| PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Poor appetite | ❑ | ❑ | Allergies | ❑ | ❑ | Shortness of breath |
| ❑ | ❑ | Excessive appetite | ❑ | ❑ | Fever | ❑ | ❑ | Poor coordination |
| ❑ | ❑ | Strong thirst | ❑ | ❑ | Chills | ❑ | ❑ | Vertigo / Dizziness |
| ❑ | ❑ | Poor sleeping | ❑ | ❑ | Localized weakness | ❑ | ❑ | Bleed or bruise easily |
| ❑ | ❑ | Fatigue | ❑ | ❑ | Bodily heaviness | ❑ | ❑ | Tremors |
| ❑ | ❑ | Night sweats | ❑ | ❑ | Weight loss | ❑ | ❑ | Mood change |
| ❑ | ❑ | Sweat easily | ❑ | ❑ | Weight gain | ❑ | ❑ | Nervousness / Irritability |
| ❑ | ❑ | Swollen glands | ❑ | ❑ | Hot or cold intolerance | ❑ | ❑ | Sudden energy drop |
| ❑ | ❑ | Frequent infection | ❑ | ❑ | Cold hands or feet | | | when ______________ |
| ❑ | ❑ | Other: ____________ | | | | | | |