New Patient Information

Name _____ Today's Date _____

Street Address _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date (include year) _____ Age _____

Sex assigned at birth _____ gender identity _____ preferred pronouns _____

Height _____ Weight _____

Occupation _____

Marital Status _____ Referred by _____

Emergency Contact: Name _____

Relationship: _____Phone _____

Other Practitioners Involved In Your Care:

Name _____ Phone _____

Name _____ Phone _____

If receiving acupuncture, what are you seeking treatment for? _____

_____

How long have you had this condition? _____

What therapies have you already tried? _____

_____

_____

Have you had acupuncture before? _____ If so, for what reason? _____

_____

Diagnoses from a medical professional and approximate dates of diagnosis (if applicable):

_____

_____

_____

What are your health and wellness goals? Why are they important to you?

_____

_____

_____

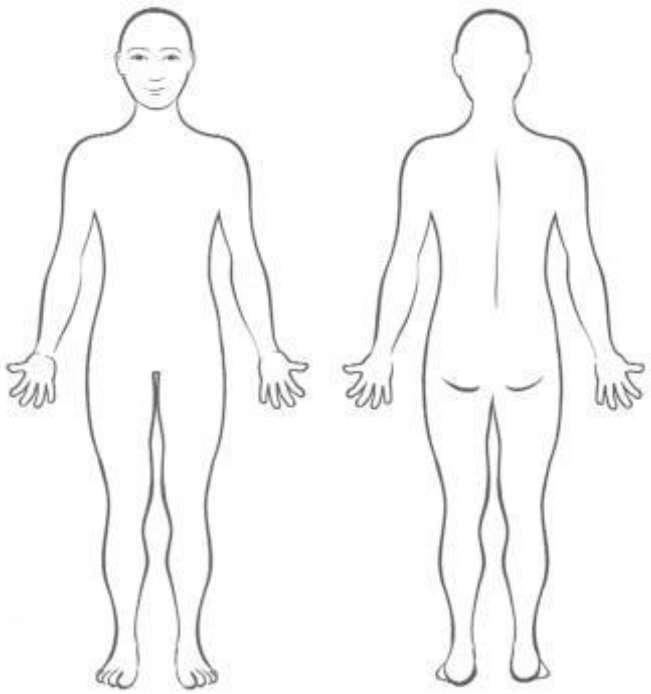
What's the most important thing you'd like to share about your health story? _____

_____

_____

_____

Please mark any areas of pain or discomfort or where you feel stress in your body:



Please list areas of pain or discomfort below with the 1-10 pain scale:

(1: barely noticeable pain, 10: excruciating pain)

_____

_____

_____

_____

Do you experience any pain, stiffness, or swelling on a regular basis? If so, please explain: _____

_____

_____

HEALTH HISTORY

Please circle any significant illnesses and indicate date:

Cancer	Hepatitis	Diabetes
High blood pressure	Epilepsy	Heart Attack
Stroke	Ulcer Disease	Liver Disease
Colon Polyps	Other _____	

Please elaborate and list any major surgeries/hospitalizations and approximate dates:

_____

_____

_____

_____

Have you used antibiotics in the past? If so, when and how often?

_____

_____

_____

_____

Allergies (medications/foods/chemicals/etc.):

_____

_____

_____

_____

Please check any symptoms that you have experienced in the past or currently experience:

General

	past	current		past	current
Long covid	☐	☐	swollen/sore lymph nodes	☐	☐
weight loss/gain	☐	☐	autoimmune disease	☐	☐
brain fog or confusion	☐	☐	blood sugar imbalance	☐	☐
dizziness/vertigo	☐	☐	bleed or bruise easily	☐	☐
fatigue during the day	☐	☐	frequent illness or infection	☐	☐

Please elaborate:

_____

_____

_____

Sleep

	past	current
Trouble falling asleep	☐	☐
Trouble staying asleep	☐	☐

On average how many hours do you sleep per night? _____

What's your quality of sleep? _____

What is your energy like most days? _____

_____

Skin & Hair

	past	current		past	current
rashes/hives	☐	☐	psoriasis	☐	☐
eczema	☐	☐	itchy skin	☐	☐
dry skin	☐	☐	acne	☐	☐
oily skin	☐	☐	loss of hair/thinning hair	☐	☐

Please elaborate:

_____

_____

_____

_____

Head, Ears, Eyes, Nose & Throat

	past	current		past	current
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	dizziness/vertigo	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision	☐	☐	sore throat	☐	☐
vision loss	☐	☐	swollen throat	☐	☐

Please elaborate:

_____

_____

_____

_____

Cardiovascular/Circulatory

	past	current		past	current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐	palpitations	☐	☐
heart arrhythmia	☐	☐	heart murmur	☐	☐
shortness of breath	☐	☐	elevated tryglicerides	☐	☐
			high cholesterol	☐	☐

Please elaborate:

_____

_____

_____

_____

Respiratory

	past	current		past	current
pain on inhaling	☐	☐	sneezing	☐	☐
chest tightness	☐	☐	seasonal/other allergies	☐	☐
cough	☐	☐	phlegm production	☐	☐
asthma	☐	☐	nasal congestion	☐	☐
wheezing	☐	☐	difficulty swallowing	☐	☐
pain behind the eyes	☐	☐			

Please elaborate:

_____

_____

_____

Genito-Urinary

	past	current		past	current
difficulty urinating	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐			
pain upon urination	☐	☐	genital pain	☐	☐
bacterial vaginosis	☐	☐	yeast infections	☐	☐

Please elaborate:

_____

_____

_____

_____

Neurological/Psychological

	past	current		past	current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	easily susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐	mood swings	☐	☐
irritability	☐	☐	ADD/ADHD	☐	☐
Parkinsons	☐	☐	Multiple Sclerosis	☐	☐
forgetfulness	☐	☐	Brain fog	☐	☐

Please elaborate:

_____

_____

_____

_____

Digestive

	past	current		past	current
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus in stool	☐	☐
chronic bad breath	☐	☐	blood in stool	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐
increased appetite	☐	☐	decrease in appetite	☐	☐

Please elaborate:

_____

_____

_____

Number of bowel movements per day on average? _____

HORMONE HEALTH

For Women Only:

	past	current		past	current
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐
PCOS	☐	☐	endometriosis	☐	☐

age of first menses _____ # days of typical period _____

duration of typical cycle _____ date of last PAP _____

# of pregnancies _____ # of live births (+ years) _____

# of miscarriages _____

Are you currently pregnant or breastfeeding? _____

Signs or symptoms of hormonal imbalance? _____

Have you ever taken birth control pills? When and for how long? _____

Have you had any known toxin exposure? _____

_____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

_____

_____

Have you been through menopause? Age? _____

Did you experience a difficult menopause?

_____

_____

_____

Please elaborate on any of the above:

_____

_____

_____

For Men Only:

	past	**current**		**past**	**current**
erectile dysfunction/impotence	☐	☐	prostate issues	☐	☐
varicocele	☐	☐			

Please elaborate:

_____

_____

_____

LIFESTYLE:

Current medications/herbs/supplements (please list dosages and how long you have been taking each):

_____

_____

_____

_____

_____

_____

NUTRITION INFORMATION

Do you follow any specific way of eating? (vegetarian, gluten-free, paleo, etc.)

_____

_____

_____

_____

_____

What foods did you grow up eating? _____

_____

_____

How would you describe your past relationship or history with food? Do any specific memories about food or eating come to mind? _____

_____

_____

Describe your current relationship with food _____

_____

_____

Do you have any known food allergies or intolerances? _____

Do any of the following apply to you?

Challenges preparing meals _____

Challenges with access to food _____

What does a typical day of eating look like for you? Please list a few foods/meals and drinks you usually consume throughout the day.

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

Do you have any cravings for specific or types of food? _____

_____

What if anything would you like to change about your nutrition? _____

_____

_____

How much water do you drink per day?

_____

Do you or have you ever used tobacco? If so, how often?

_____

_____

_____

Do you regularly drink alcohol? If so, how many drinks/week?

_____

_____

Do you or have you ever taken recreational drugs? If so, how often?

_____

_____

PHYSICAL ACTIVITY:

What role does movement, including sports, exercise, and physical activity play in your life?

_____

_____

_____

MENTAL AND EMOTIONAL HEALTH

How would you describe your overall mental and emotional health? _____

_____

_____

_____

How do you like to support your mental health? _____

_____

_____

How do you cope with stress? _____

_____

_____

On a scale of 1-5 (where 1=never and 5 = always), rate how often you experience each of the following:

Anger: _____ Excitement: _____ Fear:_____ Joy: _____

Love:_____ Sadness: _____ Stress: _____ Worry: _____

What role does spirituality play in your life, if any? _____

_____

_____

Who do you live with, if anyone? _____

How many hours per week do you typically work? _____

What hobbies or recreational activities do you enjoy? _____

_____

Family Medical History

□ Cancer □ Seizures □ High blood pressure □ Stroke □ Diabetes

□ Heart Attack □ Hepatitis □ Asthma □ Other _____

Please elaborate:

_____

_____

_____

Please list any other relevant information or issues you would like to discuss:

Thank you for taking the time to fill out these forms. Please let us know if you have any questions or concerns.