New Patient Intake Form

Please provide as complete information as possible, even if you do not feel certain questions pertain to your present condition. All the information you provide is confidential and is useful in determining the best treatment plan for you.

Name:______________________________________ Today's Date:_________________

Date of Birth:_________________ Age:________ Occupation: ____________________________________

Sex: M F Address: __________________________________Phone:___________________________________

City, State, Zip: ______________________________ Work Phone: ___________________________________

E-mail:______________________________________ Home Phone: __________________________________

Number of Children:__________________________ Preferred #: Home Cell Work

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnership

How did you hear about us: ☐ Friend/Family ☐ Doctor ☐ Website/Ad ☐ Other: _____________________________

Emergency Contact:____________________Relationship:___________________Phone: ________________________

Your Current Doctor(s): Name:_______________________________ Phone #: ______________________________

Address:____ May we contact your Doctor: Y N

Date of last physical exam:_________Date of last blood panel:________Diagnosis: ____________________________

Please attach any lab work that you would like considered. Please attach a copy of your insurance card as well, thank you!

Insurance:____________________________________ Policy ID : __________________DOB(policy holder)_________

Phone #:______________________Address:____________________________Group #:___________________________

Have you had acupuncture before? (If so, by what type of Practitioner?) _____________________________________

What are your primary reasons for coming in to treatment?

1 ____

2 ____

3 ____

When did you first notice this condition/How long has it been going on? ___________________________________

Do you have/take any of the following?

☐ Pacemaker ☐ Clotting Disorder ☐ Contagious Disease

☐ Sleeping Aids ☐ Blood thinners (Warfarin, Coumadin etc) ☐ Thyroid Medication

☐ Cortisone (Steroids) ☐ Diet Pills ☐ Laxatives

☐ Antacids (Tums, etc) ☐ Pain Relievers ☐ Tranquilizers/Sedatives

Please list all allergies,prescriptions, herbs, supplements you are currently taking and include any major surgeries/hospitalizations:

Name	Dosage	Reason for taking	Date began taking

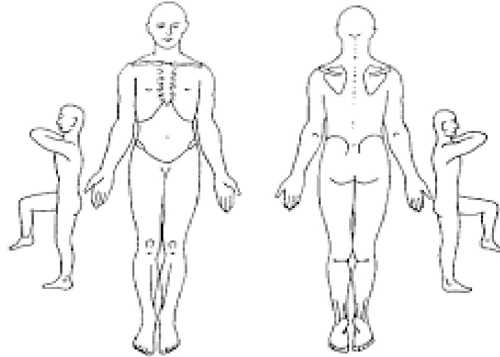
Height:__________________ **Weight:**_________________ **Desired Weight:** _______________________

If you are experiencing pain or discomfort, please indicate where below & rate: 1 2 3 4 5 6 7 8 9 10

What makes the pain worse: ____

What makes the pain better:____

Have you had a medical evaluation(s): ☐ X-Ray ☐ MRI ☐ CT Scan ☐ EKG ☐ Ultrasound ☐ Blood Test
Other:_______________________ Finding(s):____



Is there anything else that you would like us to know?

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____.

Thank you for taking the time to answer these questions, we appreciate your time and effort.

I certify that the information that I have provided above is correct and accurate to the best of my knowledge. I understand that the diagnosis and treatment plan that will be given by Integrative Acupuncture Clinic is based upon Traditional Chinese medical principles and natural treatment only and does not constitute a western medical diagnosis. I understand that if no substantial improvement is made in the condition in which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements that I am concurrently taking. Your signature verifies that you have read the attached informed consent, mandatory disclosure and HIPPA policy. Copies are available upon request. Thank you!

____ ___________________________ ______________

Patient's (or Patient's Representative's) Signature **Patient's Name** **Date**

____ ______________

Practitioner's Signature **Date**

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