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2615 Ashby Ave. Berkeley, CA 94705
New Patient Intake Form

Name: _____ **Today's Date:** _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work/Cell Phone:** _____

Email: _____

Age: _____

Are you currently working? ☐ **yes** ☐ **no**

If yes, what kind of work do you do? _____

Emergency Contact: Name: _____ **Phone:** _____

Primary Care Provider : _____

Referred by: _____

Major Complaints In Order of Importance to you:

Complaint	**Since**	**Causes**

Have you had acupuncture before? ☐ Yes ☐ No
If yes, when and for what condition?

_____
_____

Please list any serious conditions that you have been diagnosed with by a healthcare provider:

_____
_____

Name: Date:

Please mark the appropriate squares in the following list of symptoms.
If you have had a symptom in the past and do not have it now, mark the square like this: ☒
If you are having the symptom at the present time, fill in the square like this: ■

HEAD + FACE
☐ Dizziness
☐ Headaches
☐ Memory Loss
☐ Other

EYES
☐ Blurry Vision
☐ Eyelid Twitching
☐ Pain
☐ Other

NOSE
☐ Frequent Colds
☐ Sinus Infection
☐Bleeding
☐ Hay fever or Allergies

MOUTH
☐ Dental Problems
☐ Gum Problems
☐ Teeth Grinding
☐ TMJ
☐ Changes in Tastes

THROAT
☐ Sore Throat
☐ Hoarseness
☐ Difficulty Swallowing

HEART + CHEST
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chest Pain or Tightness
☐ Palpitations
☐ Irregular Heartbeat
☐ Other

RESPIRATORY
☐ Asthma
☐ Cough
☐ Congestion
☐ Shortness of Breath
☐ Frequent Colds

CIRCULATION
☐ Easy Bruising or Bleeding
☐ Cold Limbs, Hands, or Feet
☐ Raynaud's Syndrome

GASTROINTESTINAL
☐ Excessive Appetite
☐ Low Appetite
☐ Stomach Acid/Reflux
☐ Gas/Bloating
☐ Stomach or Abdominal Pain
☐ Nausea
☐ Diarrhea/Loose Stools
☐ Constipation
☐ Rectal Bleeding / Hemorrhoids
☐ Other

URINATION
☐ Painful/Difficult
☐ Diminished Bladder Control
☐ Nocturnal
☐Bleeding
☐ Other

SKIN
☐ Acne
☐ Dryness
☐ Changes in Moles or Lumps
☐ Rashes
☐ Eczema
☐ Night Sweats
☐ Excessive Sweating

NEUROLOGICAL
☐ Tremors
☐ Numbness or Tingling
☐ Lack of Coordination
☐ Nerve Pain
☐ Other

☐ PAIN – Please describe area:

SLEEP
☐ Insomnia
☐ Drowsiness
☐ Excessive Dreaming / Nightmares
☐ Waking Easily
☐ Other

GENERAL
☐ Fatigue
☐ Depression
☐ Anxiety
☐ Irritability
☐ Anger
☐ Fever and/or Chills
☐ Thirst
☐ Feel Cold or Hot

FEMALE
☐ Frequent Urinary Tract Infections
☐ Frequent Vaginal Infections
☐ Pelvic Inflammatory Disease
☐ Abnormal Pap Smear
☐ Low Libido
☐ Painful Menstruation
☐ Premenstrual Syndrome
☐ Abnormal Bleeding / Irregular Period
☐ Menopausal Symptoms
☐ Breast Pain
☐ Breast Lumps
☐ Nipple Discharge

MALE
☐ Prostate Problem
☐ Weak Urinary Stream
☐ Impotence
☐ Low Libido

DO YOU EXERCISE?
☐ Yes ☐ No
If so, what do you do and how often?

Name: Date:

FOOD & DIET

Please list the foods you mostly eat, the foods you crave regularly, and the tastes you prefer:

Please list any foods you are allergic to:

MEDICATIONS, SUPPLEMENTS, & HABITS:

Please check any of the following you are currently taking or have taken in the past. (P for past, C for current)

___ Aspirin
___ Antacids
___ Hay Fever Medication
___ Steroids
___ Antibiotics
___ Birth Control Pills
___ Ibuprofen
___ Herbs
___ Vitamins
___ Pain-Killers
___ Anti-Inflammatories
___ Psychiatric Drugs
___ Sleeping Pills
___ Laxatives
___ Marijuana
___ Caffeine
___ Alcohol
___ Tobacco
___ Amphetamines
___ Cocaine

Please list any medications or supplements you are currently taking that are not listed above:

Please list any medications you are allergic to:

Have you had any major injuries, hospitalizations or surgeries?

Injury/Hospitalization/Surgery	Date	Complications?

Name: _____ Date: _____

PERSONAL & FAMILY HISTORY

Please check the following conditions that you or your family members have experienced.
Mark P for Personal and F for family.

___ AIDS / HIV
___ Alcoholism
___ Allergies
___ Anemia / Blood Disorders
___ Appendicitis
___ Arthritis
___ Asthma
___ Cancer or Tumors
___ Chemical Dependency
___ Diabetes
___ Eating Disorder
___ Heart Disease
___ Hepatitis, Liver Disease
___ Herpes
___ High Blood Pressure
___ Kidney or Bladder Disease
___ Psychiatric Diagnosis
___ Seizures / Epilepsy
___ Intestinal Disorders
___ Stroke
___ Thyroid Disorder
___ Tuberculosis
___ Ulcers
___ Other (Specify)

WOMEN ONLY

Age at first menses: _____ Number of days between periods: _____ Date of last period: _____
Days of flow: _____ Bleeding is: ☐ Normal ☐ Light ☐ Heavy ☐ Clots
Number of pregnancies: _____ Miscarriages: _____ Abortions: _____
Number of children: _____ Their ages: _____ Cesareans: _____
Have you passed menopause: ☐ Yes ☐ No Age of onset: _____ Completion: _____
Do you use birth control? ☐ Yes ☐ No Type? _____

OTHER

Is there anything else relevant to your health condition that you would like us to know or discuss with you?

CONFIDENTIALITY POLICY

Licensed Acupuncturists are required by law to keep medical records for all patients. The information you provide is for the sole purpose of providing you with the best medical care. Your records will not be released to any other persons without your express, written consent.