ACUPUNCTURE
WELLNESS CENTER LLC
EAT WELL - LIVE WELL - BE WELL

3712 MacArthur Blvd. Ste 208. New Orleans, LA 70114
Tel. 504-362-8020
info@nolaacupuncture.com
www.nolaacupuncture.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 _____	❑ Candida	❑ Fibromyalgia	❑ HIV positive	❑ Rheumatism
❑ AIDS	❑ Chicken pox	❑ Gall stones	❑ Kidney stones	❑ Scarlet fever
❑ Alcoholism	❑ Chronic fatigue	❑ Glaucoma	❑ Malaria	❑ Seizures
❑ Anemia	❑ Colitis/ Bowel disease	❑ Goiter	❑ Measles	❑ Stroke
❑ Appendicitis	❑ Diabetes	❑ Gout	❑ Meningitis	❑ STD _____
❑ Arteriosclerosis	❑ Digestive disorders	❑ Heart disease	❑ Mononucleosis	❑ Thyroid problems
❑ Arthritis	❑ Eating disorder	❑ Hernia	❑ Multiple sclerosis	❑ Tonsillitis
❑ Asthma	❑ Elevated liver enzymes	❑ Hepatitis	❑ Mumps	❑ Tuberculosis
❑ Breast lumps	❑ Emotional imbalance	❑ Herpes	❑ Nephritis	❑ Typhoid fever
❑ Breathing problems	❑ Emphysema	❑ High cholesterol	❑ Neuralgia	❑ Ulcers
❑ Bronchitis	❑ Epilepsy	❑ Hypertension	❑ Paralysis	❑ Urinary problems
❑ Bursitis	❑ Food, chemical, drug poisoning	❑ Hypotension	❑ Prostate problems	❑ Whooping cough
❑ Cancer _____		❑ Other _____		

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 _____	❑ High Blood Pressure	who _____	when _____
❑ Diabetes	who _____	when _____	❑ Infectious Diseases	who _____	when _____
❑ Emotional Disorders	who _____	when _____	❑ Rheumatic Fever	who _____	when _____
❑ Heart Disease	who _____	when _____	❑ Seizures	who _____	when _____
❑ Hepatitis	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: _____						

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Psychological

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
❑	❑	Depression	❑	❑	Irritability	❑	❑	Lose control of emotions
❑	❑	Anxiety	❑	❑	Bad temper	❑	❑	Suicidal thoughts / attempt
❑	❑	Panic attacks	❑	❑	Easily stressed	❑	❑	Seeing a therapist
❑	❑	Other: _____						

Skin and Hair

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
❑	❑	Rashes	❑	❑	Dry skin	❑	❑	Itching
❑	❑	Eczema	❑	❑	Pimples	❑	❑	Tumors / Lumps
❑	❑	Hives	❑	❑	Recent moles	❑	❑	Change in hair or skin texture
❑	❑	Loss of hair	❑	❑	Ulceration			
❑	❑	Other: _____						

Head, Eye, Ears, Nose, and Throat

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
❑	❑	Dizziness	❑	❑	Color blindness	❑	❑	Ringing in ears
❑	❑	Headache	❑	❑	Recent change in vision	❑	❑	Poor hearing
❑	❑	Migraine	❑	❑	Cataracts	❑	❑	Ear pain
❑	❑	Concussions	❑	❑	Glaucoma	❑	❑	Sinus problems
❑	❑	Facial pain	❑	❑	Spots in the eyes	❑	❑	Runny nose
❑	❑	Sore throat	❑	❑	Night blindness	❑	❑	Sneezing
❑	❑	Sores in lips or tongue	❑	❑	Blurry vision	❑	❑	Nasal congestion
❑	❑	Grinding teeth	❑	❑	Eye pain	❑	❑	Peculiar smells
❑	❑	Jaw clicks	❑	❑	Dry eyes	❑	❑	Nose bleedings
❑	❑	Gum problems	❑	❑	Red eyes	❑	❑	Peculiar tastes _____
❑	❑	Teeth problems	❑	❑	Itchy eyes	❑	❑	Other:
❑	❑	Excessive saliva	❑	❑	Excessive phlegm			_____

Cardiovascular

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
❑	❑	High blood pressure	❑	❑	Irregular heartbeat	❑	❑	Fainting
❑	❑	Low blood pressure	❑	❑	Palpitations	❑	❑	Swelling of hands
❑	❑	Blood clots	❑	❑	Chest pain	❑	❑	Swelling of ankles / feet
❑	❑	High cholesterol	❑	❑	Heart murmur	❑	❑	Cold hands and/or feet
❑	❑	Poor circulation	❑	❑	Heart valves problems	❑	❑	Anemia
❑	❑	Other: _____						

Respiratory

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
❑	❑	Cough	❑	❑	Shortness of breath	❑	❑	Sleep apnea
❑	❑	Bronchitis	❑	❑	Pain with deep breath	❑	❑	Frequent colds / flu
❑	❑	Emphysema	❑	❑	Tightness of chest	❑	❑	Phlegm color _____
❑	❑	Asthma / wheezing	❑	❑	Difficulty breathing when			amount _____
❑	❑	Pneumonia			lying down			
❑	❑	Other: _____						

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Gastrointestinal

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❑	❑	Constipation	❑	❑	Burning sensation of anus	❑	❑	Gas/ bloating
❑	❑	Diarrhea	❑	❑	Rectal pain	❑	❑	Indigestion
❑	❑	Blood in stool	❑	❑	Hemorrhoids	❑	❑	Abdominal cramps
❑	❑	Undigested food in stools	❑	❑	Chronic laxative use	❑	❑	Nausea / Vomiting
❑	❑	Foul smelling stools	❑	❑	Pain with defecation	❑	❑	Hiccups
❑	❑	Black stools	❑	❑	Incomplete feeling of	❑	❑	Belching
❑	❑	Light colored stools			defecation	❑	❑	Bad breath
❑	❑	Other: _____						

Genito-Urinary

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
❑	❑	Pain on urination	❑	❑	Unable to hold urine	❑	❑	Herpes
❑	❑	Urgency to urinate	❑	❑	Bedwetting	❑	❑	Current outbreak of herpes
❑	❑	Decrease in urine flow	❑	❑	Sperm in urine	❑	❑	Increased libido
❑	❑	Blood in urine	❑	❑	Urinary Tract Infections	❑	❑	Decreased libido
❑	❑	Frequent urination	❑	❑	Sore on genitals	❑	❑	Erectile Dysfunction
❑	❑	Nighttime urination	❑	❑	Itchiness on genitals	❑	❑	Premature ejaculation
❑	❑	Incomplete feeling after	❑	❑	STD _____	❑	❑	Ejaculation during sleep
		urination	❑	❑	Other: _____			

Gynecological (Women only / If you've already had menopause, please describe your past menstruation)

Is there any possibility that you are pregnant? ❑ Yes ❑ No Date of last pap smear: _____

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
❑	❑	Painful periods	❑	❑	Vaginal discharge	❑	❑	Mastitis
❑	❑	Irregular periods			Color _____	❑	❑	Fibroids
❑	❑	Abnormal uterine bleeding			Odor _____	❑	❑	Endometriosis
❑	❑	Infertility	❑	❑	Breast lumps / nodules	❑	❑	Yeast infection / vaginitis
❑	❑	Other: _____						

Age of first period: _____ Number of days between periods: _____ Number of days of flow: _____

Menstruation Menstrual flow: ❑ Heavy ❑ Light ❑ Clots ❑ Painful ❑ Spotting between periods Color of flow: _____

Start date of last cycle: _____ PMS symptoms: _____

Menopause Age of menopause: _____ Menopausal symptoms: _____

Pregnancy # pregnancies: _____ # births: _____ # miscarriages: _____ # abortions: _____ # premature births: _____

Musculoskeletal / Neurological

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
❑	❑	Neck tightness/pain	❑	❑	Knee pain	❑	❑	Hernia
❑	❑	Shoulder pain	❑	❑	Muscle weakness	❑	❑	Seizures
❑	❑	Hand/wrist pain	❑	❑	Muscle pain/soreness	❑	❑	Tremors
❑	❑	Back pain	❑	❑	Joint sprain	❑	❑	Numbness
❑	❑	Hip pain	❑	❑	Joint disorders	❑	❑	Tingling
❑	❑	Sciatica	❑	❑	Scoliosis	❑	❑	Paralysis
❑	❑	Other: _____						