jennifer layne
ACUPUNCTURE AND WELLNESS

NEW PATIENT INTAKE FORM

NAME _____ DATE OF BIRTH _____

HOME PHONE _____ CELL PHONE _____

ADDRESS _____

EMAIL _____

EMERGENCY CONTACT NAME/PHONE _____

OK TO TEXT TO CONFIRM APPTS? ❑ YES ❑ NO

OCCUPATION: _____

REFERRED BY A CURRENT PATIENT? IF SO, WHOM? _____

HAVE YOU HAD PREVIOUS ACUPUNCTURE CARE? ❑ YES ❑ NO

IF SO, PLEASE DESCRIBE WHAT CONDITION YOU WERE BEING TREATED FOR AND THE OUTCOME: _____

_____

_____

PLEASE EXPLAIN THE REASON FOR YOUR VISIT TODAY: _____

MAIN COMPLAINTS:

1. _____

Briefly Explain: _____

Rate Intensity of your complaint 1-10: _____

2. _____

Briefly Explain: _____

Rate Intensity of your complaint 1-10: _____

Have you had previous treatment for your complaint(s)? ❑ YES ❑ NO

If so, please elaborate: _____

_____

Have you done any self treatment for your complaint(s)? ❑ YES ❑ NO

Ex- Heat/Cold/Stretch/Yoga/Exercise, etc.

If so, please elaborate: _____

_____

Have you had a formal medical diagnosis for your complaints? ❑ YES ❑ NO

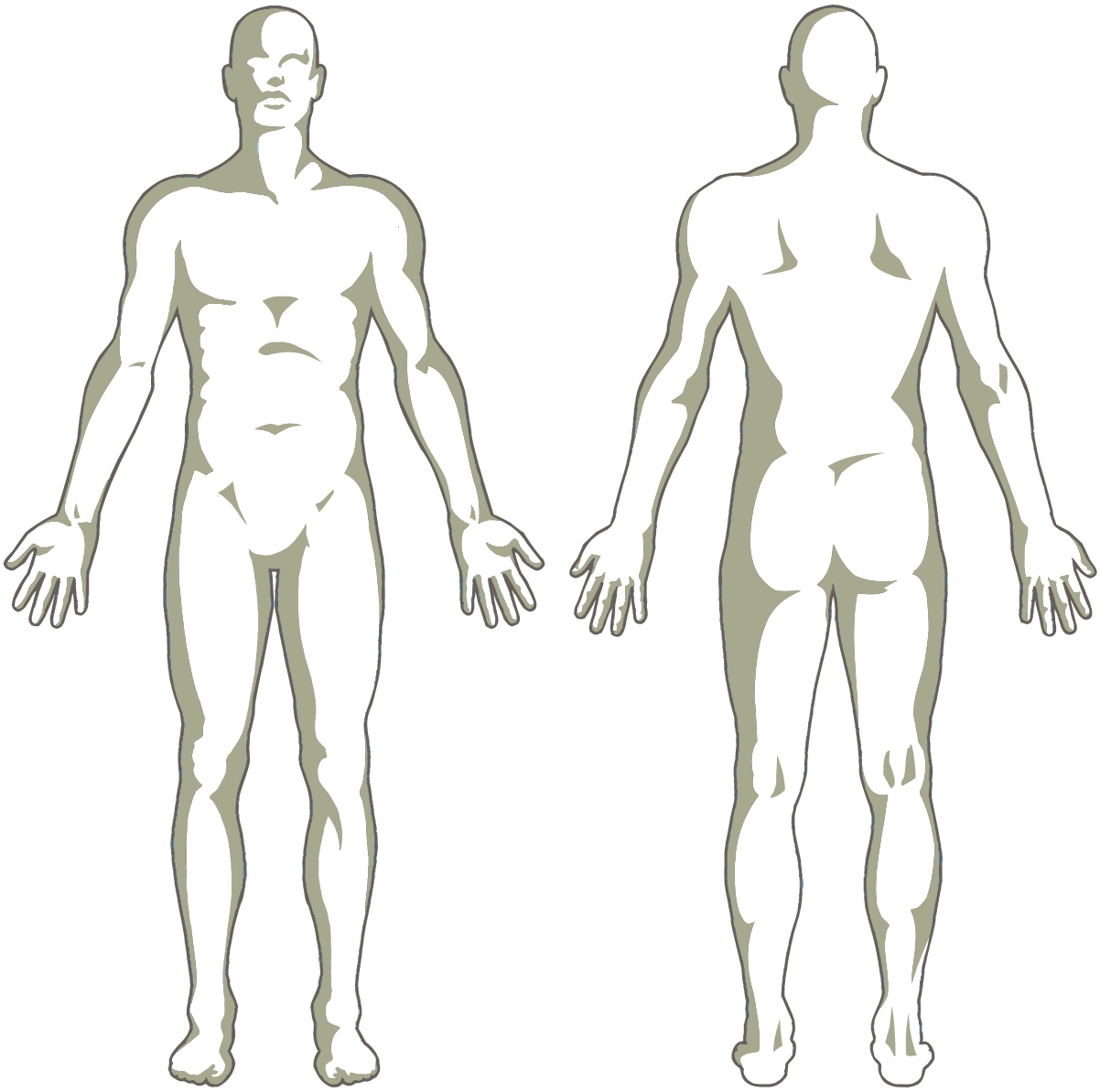
If so, by whom and what was the diagnosis? _____

_____

Have you had any imaging done (X-Ray, MRI, etc)? ❑ YES ❑ NO

If so, when and what was the result? _____

Please shade areas of pain/discomfort:



Please list any previous major illnesses and/or surgeries:

1._____ Date:_____

2._____ Date:_____

3._____ Date:_____

Provide a short description of your:

Diet: _____

Sleep: _____

Stress Level: _____

Physical Activity: _____

Water Intake: _____

Current Medications/Supplements: _____

Please explain any history of, or current complaints/dysfunction in the following systems:

Gastrointestinal: _____ Allergies/Sinus: _____

Respiratory: _____ Headaches: _____

Cardiac: _____ Immunity: _____

Urinary: _____ Emotional Health: _____

Female Only:

Date of last menstrual period: _____ Are you on any birth control? _____

Length of cycle: _____ Are you currently pregnant? _____

Duration of period: _____ Are you trying to conceive? _____

Is your period regular? _____ Do you have any children? If so, how many: _____

Please elaborate on any other information regarding your gynecological health which you feel is relative: _____

_____

Please indicate if any of the following conditions pertain to you:

- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ High Blood Pressure
- ❑ Seizures
- ❑ Pacemaker
- ❑ Blood Thinner RX
- ❑ Pregnancy

Significant Family Health History:

Parents: _____

Grandparents: _____

Siblings: _____

Do you have any questions/concerns about acupuncture? _____

_____

Do you have any other general health questions that you are curious about? _____

_____

Patient Signature: _____ Date: _____