Nueces Acupuncture and Oriental Medicine

- New Patient Intake Form -

The following information is helpful to the diagnostic procedure and enables us to provide you with better treatment.

Date: ______________________________
Name: ____
Gender: □ Female □ Male Birth Date: ______________________________
Address: ____
State: ____ Zip Code: _________________________
Phone: ____ E-mail: ___________________________
Relationship Status: _______________________________ No. of Children: ______________
Occupation: ____
Emergency contact name: ____
Emergency contact phone: _______________________________
Primary care Doctor: ____
Is this your first time getting acupuncture? □ Yes □ No
How did you hear about us? ____

Goals: What would you most like to achieve with acupuncture treatments?

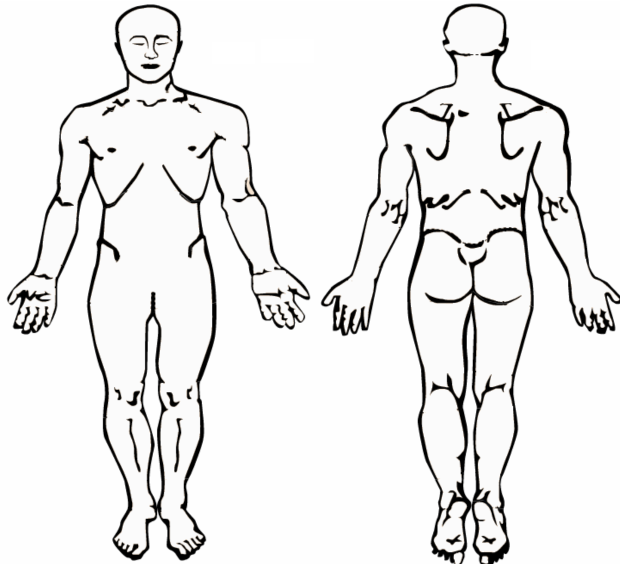
Major Symptoms: Please list in order of importance what symptoms are of concern to you (most concerning to least, along with the duration of the symptom).

1. ____
2. ____
3. ____

Are you in pain now?
□ Yes □ No
Use the illustration to locate painful or distressed areas by using the symbol that best describes the feeling:

X: Sharp/Stabbing
P: Pins/Needles
D: Dull/Aching
N: Numbness
T: Tightness/Spasms

Please rate your pain level:
Low < 1 2 3 4 5 6 7 8 9 > High
When did the pain started?
____



Pain aggravating factors (heat, cold, pressure…): ______________________________
Pain alleviating factors (heat, cold, pressure…): ______________________________

Medical History:

Do you have or had any of the following conditions? If yes, please indicate date of diagnosis.

- □ Cancer (specify type)
- □ HIV
- □ Diabetes
- □ Mental Illness
- □ Heart Disease
- □ Seizures
- □ Hepatitis Stroke
- □ High Blood Pressure
- □ Thyroid Disease
- □ High Cholesterol

Please list any surgeries or major injuries with dates.

____

____

List any medications or supplements you have taken in the last 2 months.

____

____

Do you have a pacemaker or any metal devices in your body? □ Yes □ No.
If so, which: ______________________
Intolerant of, or allergic to: □ Alcohol Swabs □ Iodine □ Arnica □ Massage Oil

Family History:

Indicate close family members with any of the following:

- □ Cancer (specify type)
- □ High Cholesterol
- □ Diabetes
- □ Mental Illness
- □ Heart Disease
- □ Stroke
- □ High Blood Pressure
- □ Alcoholism

Lifestyle Habits

Do you have an exercise routine? □ Yes □ No
Please describe:

____

How many hours per night do you sleep on average? ___________
Do you wake rested? □ Yes □ No
Do you smoke? □ Yes □ No. If yes, how many cigarettes per day?
Do you drink alcohol? □ Yes □ No. How many drinks/week and type:
Do you drink coffee? □ Yes □ No. How many cups/day?
Water intake (how much/day):
Briefly describe your dietary habits (#meals/day; type of food; snacks):

____

____

____

____

Energy:

How is your energy? Low < 1 2 3 4 5 6 7 8 9 10 > High
What time of the day is your energy?

Highest: □ 6am-12pm □ 1pm-5pm □ 6pm-12am
Lowest: □ 6am-12pm □ 1pm-5pm □ 6pm-12am

Do you fatigue easily? □ Yes □ No

Emotions:

How do you feel emotionally?

____

____

____

How is your level of stress? Low < 1 2 3 4 5 6 7 8 9 10 > High

Do you experience?

- ☐ Panic attacks
- ☐ Depression
- ☐ Anxiety/Worry
- ☐ Irritability
- ☐ Nervousness
- ☐ Fear Attacks
- ☐ Mood Swings
- ☐ Difficulty Making Decisions
- ☐ Poor Memory
- ☐ Difficult Concentration
- ☐ Suppressing Emotions
- ☐ Frequent Sighing
- ☐ Easily Startled

Bowel movements:

How often? _____ time(s) a day, or _____ time(s) a week

I have or had:

- ☐ Irregular Bowel Movements
- ☐ Constipation
- ☐ Diarrhea
- ☐ Painful bowel movements
- ☐ Undigested food in stools
- ☐ Burning sensation
- ☐ Hemorrhoids
- ☐ Itchiness
- ☐ Loose stools
- ☐ Hard stools
- ☐ Blood in stools
- ☐ Gas

Urination:

How often? _____ times per day. Color: ☐ Pale yellow ☐ Dark yellow/orange

I have or had:

- ☐ Trouble starting stream
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Dribbling when sneezing
- ☐ Burning Pain
- ☐ Other_____________

Please select the symptoms you have or have had in the past year:

Energy and Immunity:

- ☐ Fatigue
- ☐ Allergies (which?)____________
- ☐ Anemia
- ☐ Chronic Fatigue Syndrome
- ☐ Thyroid Problems
- ☐ Tendency to Catch Colds

Head, Eye, Ear, Nose, and Throat

- ☐ Eye Dryness
- ☐ Eye Floaters or Spots
- ☐ Blurry Vision
- ☐ Poor Night Vision
- ☐ Ringing in Ears
- ☐ Hearing Difficulties
- ☐ Headaches / Migraines
- ☐ Teeth Grinding / TMJ
- ☐ Sore Throat
- ☐ Chronic Sinus Congestion
- ☐ Dry Mouth
- ☐ Bad Breath
- ☐ Mouth Sores / Ulcers
- ☐ Bleeding Gums
- ☐ Increase in Thirst

Kidney/Urinary

- ☐ Painful Urination
- ☐ Frequent Urinary Tract Infections
- ☐ Frequent / Urgent Urination
- ☐ Edema / Swelling

Respiratory/Cardiovascular

- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Chest Pain
- ☐ Heart Palpitations / Fluttering
- ☐ Poor Circulation (Cold hands/feet)
- ☐ Chronic Cough
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Sensitive to the cold
- ☐ Sensitive to heat

Gastrointestinal

- ☐ Ulcers
- ☐ Changes in Appetite
- ☐ Nausea / Vomiting
- ☐ Belching
- ☐ Bloating / Pain
- ☐ Gas
- ☐ Heartburn / Acid Reflux
- ☐ Sudden Weight Change

Skin

- ☐ Rashes/Eczema/Hives/Psoriasis
- ☐ Dry Hair or Hair Loss
- ☐ Changes in Skin Color
- ☐ Easy Bruising
- ☐ Acne
- ☐ Dry / Itchy Skin
- ☐ Brittle Nails

Sleep

- ☐ Insomnia
- ☐ Nightmares
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Waking Up Early
- ☐ Restless Sleep
- ☐ Excessive Dreaming

Neurological

- ☐ Vertigo / Dizziness
- ☐ Numbness / Tingling
- ☐ Poor Concentration or Memory

Musculoskeletal

- ☐ Neck / Shoulder Pain
- ☐ Muscle: Spasms/Cramps/Weakness
- ☐ Arm Pain
- ☐ Finger Pain/Tingling/Numbness
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg / Knee Pain
- ☐ Foot / Ankle Pain
- ☐ Hip / Pelvic Pain
- ☐ Arthritis

Men's Health

- ☐ Prostate Enlargement
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Decreased libido

Women's Health:

Are you pregnant? ☐ Yes ☐ No; No of pregnancies: _____ Age of first menses: _____

Menstrual cycle: ☐ Regular ☐ Irregular; Length ___________ Length of bleeding _______

Typical color & characteristics:

☐ Dark Red ☐ Bright Red ☐ Pale Red ☐ Heavy Flow ☐ Light Flow

During my cycle I experience:

- ☐ Strong PMS Symptoms
- ☐ Irritability
- ☐ Breast-tenderness
- ☐ Cravings
- ☐ Cramps
- ☐ Clots in menstrual blood
- ☐ Moodiness
- ☐ Bloating

I have or had:

□ Abnormal Vaginal Discharge.
Color? ___________
□ Unusual Vaginal Discharge Odor
□ Vaginal Dryness
□ Breast Lumps / Cysts
□ Uterine Fibroids
□ Endometriosis
□ Ovarian Cysts
□ Frequent Yeast Infections

Acupuncture Appointments:

- Please bring this completed new patient questionnaire with you to your first appointment.
- Please bring or wear loose clothing (shorts, t-shirts) to each appointment.
- Please eat a light meal or snack before your appointment; an empty stomach may cause dizziness.
- Please do not eat or drink food that may change the color of your tongue or brush your tongue the day of your appointment (Coffee, fizzy drinks, juice, licorice, beetroot, etc.).
- While contra-indications for acupuncture are rare, sometimes a small local bruise can occur.

What to expect at your first visit?

Your first visit will take a little over one hour and will include an acupuncture treatment. We will discuss your health questionnaire and any concerns you have prior to the treatment. I will make a diagnosis, a treatment plan and may give a few suggestions regarding your condition. If you have any questions please do not hesitate to email at info@nuecesacupuncture.com or call at (512) 662-4242.

Financial Policy:

Payment is due at time of service for all patients. A fee will be charged for missed appointments or cancellations without a 24-hour notification.

I also understand that these treatments may produce some bruising and I release the practitioner from liability in the event that that should occur.

_______________________________________ ____________________
Patient Signature Date

____
Patient Printed Name