ELIXIR ACUPUNCTURE & HERBAL MEDICINE CENTER

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New Patient Intake Form

Patient's Name _____ Birthday _____/____/_____ Age: ____ Sex: ___ Date: _____/____/20_____

Presenting Complaints (What are the Presenting Complaints you'd like us to assist you with?)

- **Where do you feel the pain?**
- **How long have you had this problem?**
- **Does the pain radiate / Or move anywhere else in your body? Yes No, if yes draw arrow**
- **How would you describe your pain? / Or can you tell me what type of pain?**

  Sharp Burning Numbness Tingling Throbbing Dull /Achy Stabbing Constant
- **Do you have pain when you?**
  Walk Bend Sit Run Stand Exercise Lift Push Pull Rest At night Other: _____
- **Is your pain worse when you?**
  Walk Bend Sit Run Stand Exercise Lift Push Pull Rest At night Other: _____
- **Pain began: Gradually Suddenly Don't know**
- **Which of the following areas do you have pain, discomfort, or restriction of motion:**
  Neck Shoulder Arm Hands Wrist Upper Back Mid Back Lower Back Pelvis Hip
  Legs Knees Feet Ankles Other: _____
- **Does your pain interfere with your: Sleep Work Daily routine**
- **When is the pain worst: Morning Afternoon Evening Night**
- **What makes the pain better? Rest Massage Ice Pack Heat Pack Dark Room Sunlight Medicine**
- **What makes the pain worse? Rest Massage Ice Pack Heat Pack Dark Room Sunlight**
- **Rate your pain on a scale from 1-10 (1= minimal pain, 10 = severe pain) P/L= /10**

Severity	**Minimal pain:** an annoyance, causes no handicap in physical activities	**Slight pain:** tolerable, causes some handicap in physical activities	**Moderate pain:** Tolerable, causes marked handicap in physical activities	**Severe pain:** Precludes performance of physical activities
Frequency	**Occasional:** occurs about 25% of the time.	**Intermittent:** occurs about 50% of the time.	**Frequent:** occurs about 75% of the time.	**Constant:** occurs 90-100% of the time.

Right

Mark Pain Areas

Front **Left** ***Back***

HEALTH CONDITION

Are you taking any medication? If yes, please list all:

Name of medication	*purpose*	*Frequency / Dose*

Allergies Known (Include Medication / Chemical / Food / other:) _____

Past Medical History

Surgeries: _____

Traumas: (Auto accident/ fall/ other:) _____

All medical: _____

Please check all that apply to you

□Allergies	□ Anxiety	□ AIDS/HIV	□ Arthritis
□ Asthma	□ Back pain	□ Blood clotting problem	□ Blurred vision
□ Breathing difficulties	□ Cancer	□ Carpal tunnel syndrome	□ Chest pain
□ Chronic Fatigue	□ Constipation	□ Depression	□ Diabetes
□ Diarrhea	□ Difficult Concentration	□ Digestion problem	□ Dizziness
□ Fibromyalgia	□ Feeling cold	□ Feeling hot	□ Foot pain
□ Frequent urination	□ Gastrointestinal disorder	□ Gout	□ Glaucoma
□ Hepatitis	□ High blood pressure	□ Headache	□ Heart problem
□ Hives	□ Insomnia	□ Irritable bowel movement	□ Immune deficiency
□ Itchiness	□ Lupus	□ Lyme's disease	□ Menstrual disorder
□ Neck pain	□ Numbness & tingling	□ Palpitation (heart)	□ Poor appetite
□ Persistent cough	□ Sciatica	□ Shoulder pain	□ Spinal misalignment
□ Spinal fusion	□ Skin problem	□ Stress	□ Tendonitis
□ TMJ			
□ Other (please specify)			

Family Medical History

List family members (parents, siblings) with history of ***diabetes, hypertension, heart disease, cancer, autoimmune disease, and significant medical condition***

Mother's side: _____

Father's side: _____

Social History

Do you smoke? □Yes □ No, never smoked □No, I have quit smoking
If yes, how many packs of cigarettes do you smoke a day? _____

How much coffee, tea, or caffeinated beverage do you consume?
□ 1-2 cups per day □ 2-5 cups per day □ >5 cups per day □ occasional/ social □None

How much alcohol do you consume per week?
□ 1-2 drinks per day □ 2-5 drink per day □>5 cups per day □ occasional/ social □None

Please describe any use of drugs (i.e., Recreational drugs) for non-medical purposes: _____

Nutrition

- **Do you have diabetes? □Yes □No If yes, Do you take insulin? □Yes □No**
- **Do you feel thirsty during the day or night? □Yes □No Dry mouth: □ Yes □No**
- **Bitter taste in your mouth? □Yes □No when: □ In the Morning □ Whole Day**
- **Do you drink lots of water? □Yes □No If yes, why? □Thirst □For health □Habit**
- **Do you sweat during the night or day? _____**
- **How is your appetite? _____**
- **How is your digestion? □Good □Bad □Bloating □Stomach Gas □Acid Reflux □Heartburn**
- **How is your bowel movement? How many times a day? ____ □Constipated □Diarrhea**
- **Is stool well-formed / Or loose_____ □Abdominal cramp**
- **How is your urination? □Normal □Frequent □Burning Sensation What color? □Yellow □Clear**
- **How many hours do you sleep at night? _____. Do you wake up at night? □Yes □No**
- **Do you wake up during the night to go to the bathroom? □Yes □No**
- **Do you have headache? □Yes □No If yes, where? □Back □Sides □Forehead □Top □Whole**
- **Do you have dizziness? □Yes □No Do you have palpitation? □Yes □No**
- **Do you have a lot of stress in your life? □Yes □No Work related? □Yes □No**
- **Do you get angry easily? □Yes □No Do you cry easily? □Yes □No**
- **Do you have feeling of nausea? □Yes □No Do you vomit often? □Yes □No**
- **Do you ever feel a lump in your throat? □Yes □No Do you have lots of phlegm? □Yes □No**
- **Do you exercise regularly? □Yes □No**
- **Do you have any problem with hearing? □Yes □No**
- **Do you wear a hearing aid? □Yes □No**

Gynecological History: *Women's Health / Women's Fertility*

Menstruation

- **Age of the first period: ____**
- **Date of last two menstrual periods (LMP): _____/_____/ _____ and _____/ _____/ _____**
- **Current Length of Cycles (i.e., 28 days)? □Less? □More?**
- **Menstruation: □Normal □Irregular □Painful**
- **Do your periods come at regular intervals? □Yes □No**
- **Usual # of days bleeding/ Average number of days of flow: _____**
- **Volume: How heavy is the bleeding? □Light □Medium □Heavy**
- **What color is the blood? □Pale □Dark Red □Bright Red □Red □Brown**
- **Were there any Clots? □Yes □No When: _____**
- **Do you have cramps? □Yes □No If yes, □before □During □ after your period**
- **Do you have the following menstruation related signs/ symptoms?**

  □Mood Change □Breast Tenderness □Bloating □Constipation □Lower Back Pain □Acn

  Other _____

History of Pregnancy:

 # Of Pregnancies ___ # of live Births ___ Miscarriages____ C-section: ___ Premature births: ___ Abortions: _____

Hysterectomy: Year: _____ Hot Flash: ____ If yes, how many? ____ Night Sweats: ____ If yes, how many? _____

- **Are you currently pregnant? □Yes □No Are you trying to get pregnant? □ Yes □No**
- **Do you use any contraception? □Yes □ No**

  If yes, please describe

Type	From when to when/ How long?	Reason discontinued

- **Do you *ovulate* on your own? □Yes □ No What Date? _____**
- **Do your breasts get tender at / during *ovulation*? □Yes □ No**
- **Have you had fertility treatments?**

  If yes, where and when _____

  By whom? _____ What type? _____

- **Have you taken medication to help you *Ovulate*? □Yes □ No**

  What? _____ When? _____ How long? _____

- **Have your fallopian tubes been evaluated medically? □Yes □ No**

  What were the results? _____

- **Do you have a lot of stress in your life / occupation?**

  On scale of 1-10 what is your stress level? ____/10.

- **Urinary tract infections: □Yes □ No How frequently? _____**

- **Have you had discharge from your nipples? □Yes □ No**
- **Date of last mammogram: _____ Mammogram: Normal Abnormal**

- **Do you have chronic vaginal discharges (describe color and /or Smell)? □Yes □No**
- **Date of last Pap Smear: _____ Pap Smear: Normal Abnormal**

- **Have you taken any medications for gynecological conditions other than contraceptives?**

  Medication Reason How long

  _____ _____ _____

- **Have you ever been diagnosed with any of the following?**

  Uterine fibroids □Yes □No Endometriosis □Yes □No Polys □Yes □No

  PCOS (polycystic ovarian syndrome) □Yes □No

- **Breast (lumps, cysts, tenderness, etc.):**
- **Libido (sex drive) is: □ Low □Normal □ High**
- **Do you have any pain during intercourse? □Yes □No Is your pain related to your periods? □Yes □No**

Menopause

Menopause (date of onset): _____ Symptom: _____ Any bleeding since? _____

Are you currently on Hormone Replacement Therapy (HRT)? □Yes □No

How long have you been on HRT? _____ Any Side effect? _____

Men Only

Do you experience any of the following? (Please check all that applies)

□Feeling coldness or numbness in the external genital □ Pain or swelling in testicles

□Impotence/ erectile dysfunction □ premature ejaculation

Patient Name _____ Date: ____/_____/20_____