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New Patient Intake Form

Please complete this form as thoroughly as possible; all answers are confidential

Name: ______________________________ Date of Birth: ______________

Address: ____

Phone: ____________________ Email: ______________________

Married ( ) Single ( ) Widowed ( ) Divorced ( ) Separated ( ) Partnered ( )

Occupation: ____

In case of an emergency please contact (include name and phone number): ____________________

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Who referred you to this office? ______________________________

Have you had an acupuncture treatment before? ______________________

What health concerns would you like to address through treatment?

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What are your treatment goals? ______________________________

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Are you currently working with any other health care practitioners (please list)? ______________

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List ALL significant illnesses, traumas, hospitalizations, surgeries, accidents from childhood to present (please be detailed and include approximate age/dates):

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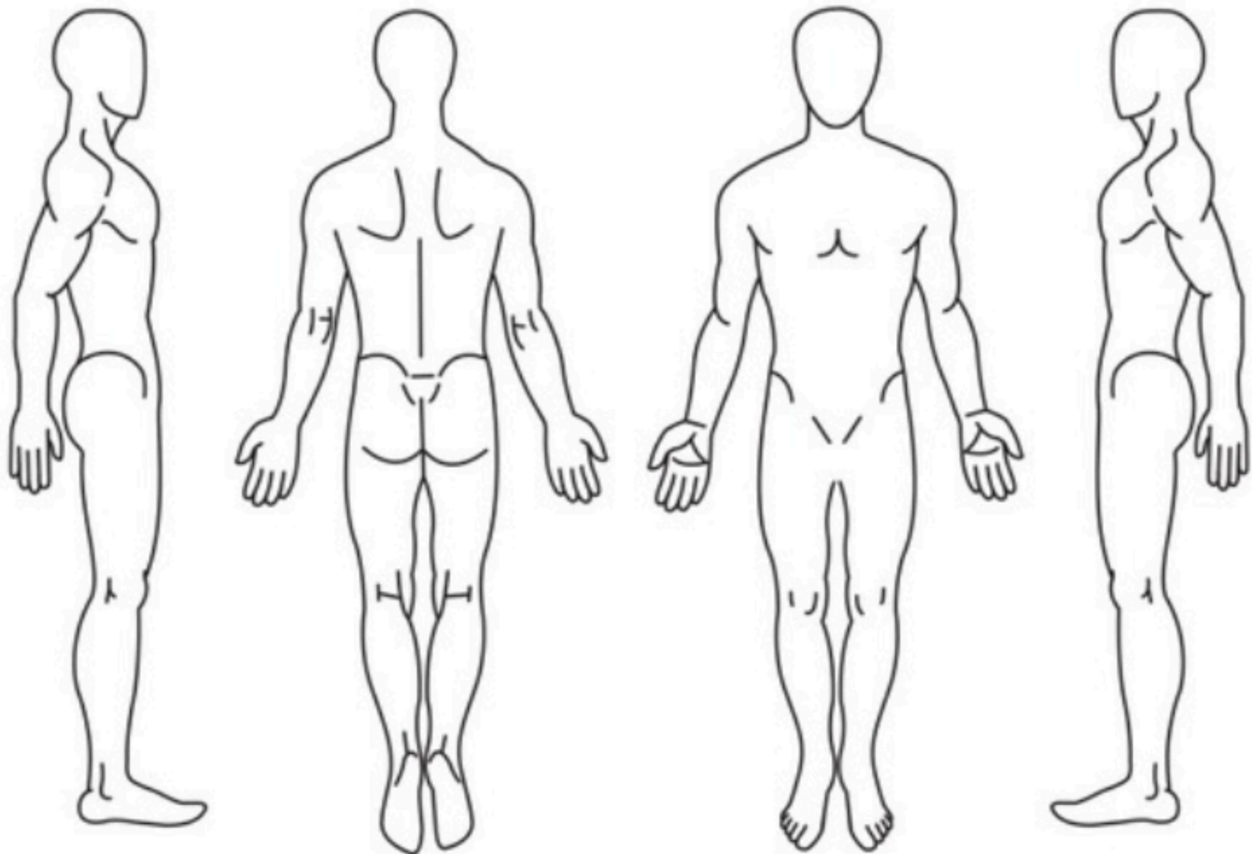
Please indicate on the diagram any areas of pain/tension/numbness/tingling and label accordingly:



Please list current medications including over the counter and prescription (attach separate sheet if necessary):

Name	Dosage/ Frequency/ Duration	For what reason are you taking this?

Supplements/vitamins/herbs currently used (attach separate sheet if necessary):

Name	Dosage/ Frequency/ Duration	For what reason are you taking this?

Level of daily stress: 1 (least) ____ 1O (most).

Have you recently had any unusually stressful experiences (e.g., divorce, death of someone close, bankruptcy, loss of job, illness, injury, etc...)? Please describe. ____

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What are the main stress factors in your life? ____

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What are the main ways you relax and reduce stress? ____

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What types of exercise/movement do you presently participate in (How often)? ____________________

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How many hours per week do you work/volunteer? ____

Are you satisfied with your primary relationship or support system? ____________________

Do you know anything about your birth and if so please describe? ____________________

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Any pertinent family history (please note here if you were adopted)?____

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*if applicable - Are you pregnant? ______________________ Trying to become pregnant? _________________

*if applicable - Please list any children you birthed (either vaginally or cesarean), terminations, and/or losses. Please include years and any other helpful information (e.g., traumatic birth, significant blood loss, postpartum depression/anxiety).

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Is there anything else you would like me to know? ____

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- Our office policy requires payment on the day of your visit.
- Kindly allow 24-hour minimum notice for change or cancellation of appointment.
- No shows will owe for full value. We absolutely forgive emergencies.
- There will be a $30.00 fee for returned checks.

I, the undersigned, have read and understand the above policies:

____

Signature Date