



Mary Helen Robert, LAc

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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): \_\_\_\_\_

\_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

Have you had an acupuncture treatment before? \_\_\_\_\_

What health concerns would you like to address through treatment?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your treatment goals? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

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

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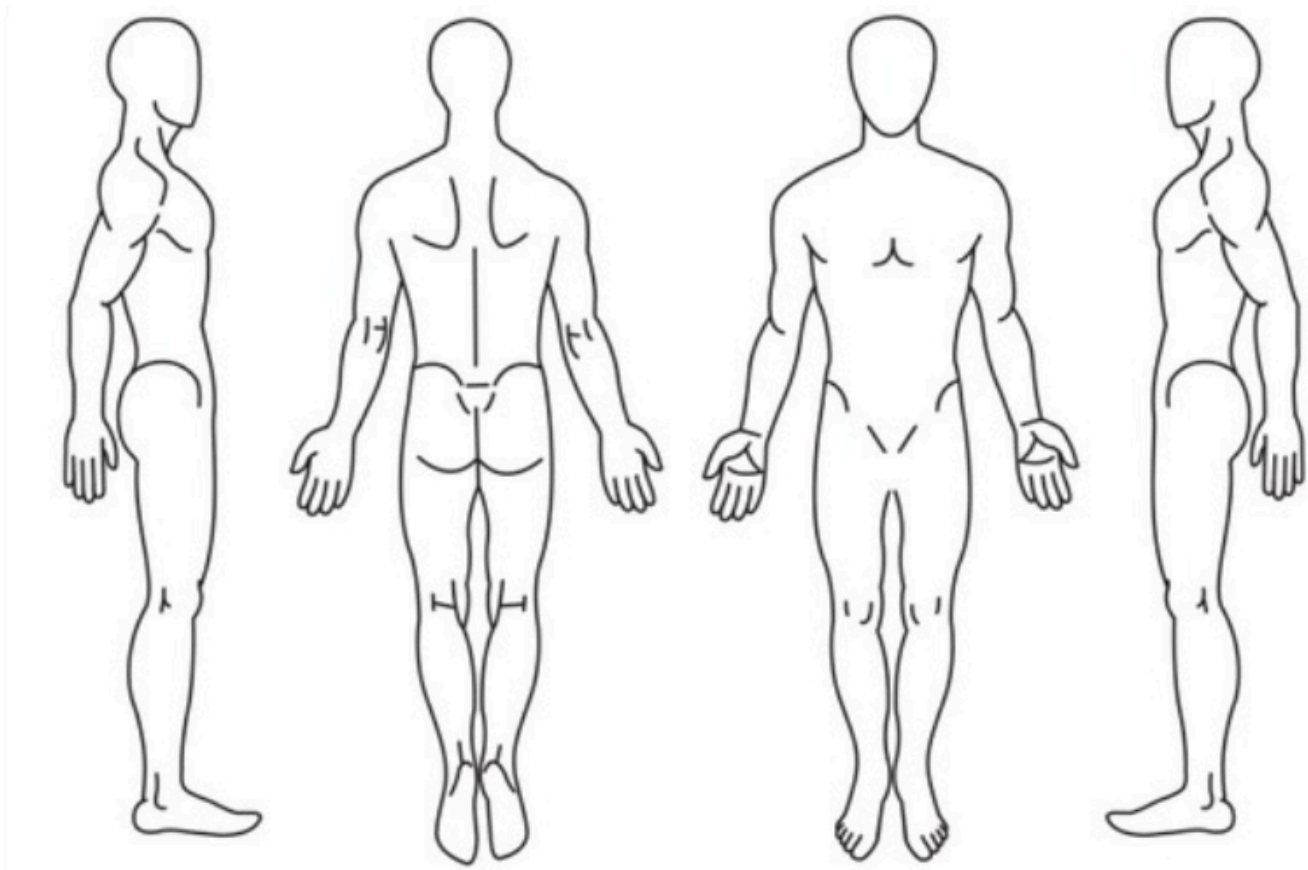
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**Please indicate on the diagram any areas of pain/tension/numbness/tingling and label accordingly:**



**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) \_\_\_\_ 10 (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. \_\_\_\_\_

\_\_\_\_\_

What are the main stress factors in your life? \_\_\_\_\_

\_\_\_\_\_

What are the main ways you relax and reduce stress? \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*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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Any pertinent family history (please note here if you were adopted)? \_\_\_\_\_

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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