New Patient Intake Form*

Please answer the questions as honestly and thoroughly as possible. This will provide insight into your current state of health and your health history. The information is strictly confidential and will not be released to any person without your request.

Today's Date *

mm/dd/year

Name *

Date of Birth *

mm/dd/year

Age *

Email *

Phone Number *

Is it OK to email or send text messages for appointment reminders?

- [ ] YES
- [ ] NO

Would you like to be added to our mailing list to receive newsletters, specials and other information? We NEVER distribute our mailing list to any party.

- [ ] YES
- [ ] NO

Street Address *

Street

City

State

Postal Code

Country

Emergency Contact Name, Phone Number and Their Relationship to You: *

Primary Physician and Phone Number *

Current Relationship Status

single, married, partnered, widowed, etc

Occupation / Employer / School *

Please check all that apply: *

- ○ full-time
- ○ part-time
- ○ self-employed
- ○ student
- ○ unemployed
- ○ retired

OFFICE POLICY

If you need to change or cancel your appointment, please do so with 24 hours notice. Failure to do so will result in being charged the full price of your visit.
Missed appointment fees are the responsibility of the individual.

Please sign here to indicate you understand the office policy *

Signature

Is this your first time getting acupuncture? *

- Yes
- No

How did you find this clinic? *

Please describe the TOP THREE HEALTH ISSUES you would like to address. When did this/these issue(s) start and what treatments have you tried? Please list any alleviating or aggravating factors:

1. *

2.

3.

Please list any known allergies or food sensitivities. If none, please indicate: *

Please list any past surgeries, injuries or hospitalizations, including the year:

Do you, or does anyone in your family have a history of:

Arthritis

- you
- family

Asthma/COPD

- you
- family

Autoimmune Disease

- you
- family

Blood Disorder/Anemia

- you
- family

Cancer

- you
- family

Diabetes

- you
- family

Drug/Alcohol Abuse

- you
- family

Eating Disorder

- you
- family

Trauma/Abuse

- you
- family

Heart Disease

- you
- family

Hepatitis

- you
- family

Hypertension

- you
- family

Inflammatory Bowel Disease

- you

Irritable Bowel Syndrome

- you

Kidney Disease

- you

- [ ] family

- [ ] family

- [ ] family

Mental Illness/Depression

- [ ] you
- [ ] family

Seizure Disorder

- [ ] you
- [ ] family

Stroke

- [ ] you
- [ ] family

Thyroid Disease (hyper or hypo)

- [ ] you
- [ ] family

Do you have any infectious diseases?

- [ ] Yes
- [ ] No

If yes, please identify:

Please use this space to elaborate on any of the above information.

Please list all current medications and supplements, both prescription and over-the-counter. Please state the dosage and reason for the medication or supplement. If none, please indicate: *

Do you use any of the following substances?

- [ ] Alcohol
- [ ] Cigarettes/tobacco
- [ ] Marijuana
- [ ] Stimulants: Cocaine, Crack, Speed, Methamphetamines, other
- [ ] Opioids: Heroin, Methadone, Morphine, Oxycodone, Fentanyl, other
- [ ] 1-3 times /week
- [ ] 4-6 times/week
- [ ] daily

Please generally describe your diet, including any restrictions and cravings:. *

Diet: Please state what you typically eat for breakfast, lunch, dinner and snacks: *

Appetite *

1 = poor appetite, little desire to eat
5 = average
10 = strong appetite, ravenous

Do you exercise regularly? If so, what and how often? *

TEMPERATURE - please check all that you have experienced in the past 6 months:

- [ ] Absence of thirst
- [ ] Chills
- [ ] Cold hand or feet
- [ ] Cold "in the bones"
- [ ] Excessive thirst
- [ ] Hot at night
- [ ] Hot flashes
- [ ] Hot hands, feet or chest
- [ ] Hot in the afternoon
- [ ] Night sweats

EYES, EARS, NOSE, THROAT - please check all that you have experienced in the past 6 months:

- [ ] Poor vision
- [ ] Poor night vision
- [ ] Red eyes
- [ ] Itchy eyes
- [ ] Spots in vision
- [ ] Sinus congetion
- [ ] Sinus infection
- [ ] Phlegm
- [ ] Hay fever/allergies
- [ ] Sore throat

- [ ] Thirst, no desire to drink
- [ ] Unusual sweats

- [ ] Swollen glands
- [ ] Mouth sores
- [ ] Poor hearing
- [ ] Ringing in ears
- [ ] Ear infection
- [ ] Excessive earwax
- [ ] Dental problems
- [ ] Teeth grinding/TMJ

MOISTURE - please check all that you have experienced in the past 6 months:

- [ ] Dandruff
- [ ] Dry, brittle nails
- [ ] Dry eyes
- [ ] Dry hair
- [ ] Dry lips
- [ ] Dry mouth
- [ ] Dry nose
- [ ] Dry skin
- [ ] Dry throat
- [ ] Nosebleeds
- [ ] Itching
- [ ] Edema/swelling
- [ ] Tumors/lumps
- [ ] Oily hair
- [ ] Oily skin
- [ ] Pimples
- [ ] Rashes
- [ ] Weight gain or loss

RESPIRATORY - please check all that you have experienced in the past 6 months:

- [ ] Asthma
- [ ] Bronchitis
- [ ] Cough
- [ ] COPD
- [ ] Frequent colds
- [ ] Phlegm Production
- [ ] Shortness of Breath
- [ ] Tuberculosis

GASTRO-INTESTINAL - please check all that you have experienced in the past 6 months:

- [ ] Bad breath
- [ ] Belching
- [ ] Constipation
- [ ] Dry stool
- [ ] Diarhea
- [ ] Excessive hunger
- [ ] Foul-smelling stools
- [ ] Gas/bloating
- [ ] Hemorrhoids
- [ ] Hernia
- [ ] Indigestion/heartburn
- [ ] Nausea
- [ ] Vomitting
- [ ] Poor appetite
- [ ] Pain/cramps
- [ ] Pain with bowel movement
- [ ] Rectal pain
- [ ] Tired after bowel movement

GENERAL - please check all that you have experienced in the past 6 months:

- [ ] Bleed, bruise easily
- [ ] Blood pressure high or low
- [ ] Irregular heartbeat
- [ ] Body or limbs heavy/weak
- [ ] Difficulty concentrating
- [ ] Dizziness/lightheadedness
- [ ] Energy drop after eating
- [ ] Energy drop during day
- [ ] Fatigue
- [ ] Headaches/migraines
- [ ] Heart palpitations
- [ ] Mitral valve prolapse
- [ ] Pacemaker

Energy level *

0 = low energy
6/7 = normal
10 = high

Current stress level *

0 = no stress
5 = moderate
10 = high stress

- [ ] Chest pain
- [ ] Poor memory
- [ ] Shortness of breath
- [ ] Wired or ungrounded feeling

What are your current stressors, i.e: job, finances, relationship, family etc.....?

ORTHO-NEURO - please check all that you have experienced in the past 6 months:

- [ ] Muscle tightness
- [ ] Pain
- [ ] Broken bones
- [ ] Numbness/tingling
- [ ] Tremors
- [ ] Paralysis

EMOTIONS - please check those which you experience:

- [ ] Anger
- [ ] Irritability
- [ ] Anxiety
- [ ] Worry
- [ ] Obsessive thinking
- [ ] Sadness
- [ ] Grief
- [ ] Depression
- [ ] Panic attacks
- [ ] Frequent sighing
- [ ] Joy
- [ ] Fear
- [ ] Timidness/shyness
- [ ] Indecisiveness

SLEEP - please check all that you have experienced in the past 6 months:

- [ ] Difficulty falling asleep
- [ ] Waking during night
- [ ] Waking to urinate
- [ ] Disturbing dreams
- [ ] Restless sleep
- [ ] Not rested upon waking

Do you use sleep aids? If yes, which ones

GENITO-URINARY - please check all that you have experienced in the past 6 months:

- [ ] Changes in sex drive
- [ ] Genital lesions
- [ ] Genital pain/itching
- [ ] Yeast infection
- [ ] Genital discharge
- [ ] Pain with orgasm
- [ ] Pain on penetration
- [ ] Frequent urination
- [ ] Pain/burning on urination
- [ ] Urgency to urinate
- [ ] Difficult to stop or start urination
- [ ] Incontinence
- [ ] Urinary tract infection
- [ ] Blood in urine

Please use this space to elaborate on any of the above information.

WOMEN (if applicable)

Age at first menses:

Average length of full cycle (eg. 28 days):

Average length of menses (eg. 3-5 days):

Last menses start date:

Is your period:

- [ ] Heavy
- [ ] Light
- [ ] Painful
- [ ] Irregular

Color of menstrual blood

- [ ] Pale/light red
- [ ] Red
- [ ] Bright red
- [ ] Dark red
- [ ] Dark red/brown
- [ ] If fluctuates. mark all that apply

Please check if you experience any of the following:

- [ ] Cramps
- [ ] Mood changes prior to menstration
- [ ] Breast lumps or tenderness
- [ ] Digestive changes
- [ ] Mid-cycle spotting
- [ ] Clots in blood during menses
- [ ] Headaches near or after menses
- [ ] Painful intercourse
- [ ] Vaginal discharge
- [ ] Hot flashes or nightsweats
- [ ] Unwanted facial hair
- [ ] Pelvic pain

What type of birth control do you use, if any?

Do you have or have you been diagnosed with:

- [ ] Endometriosis
- [ ] Polycystic ovarian syndrome (PCOS)
- [ ] Pelvic inflammatory disease (PID)
- [ ] Infertility
- [ ] Prolapse
- [ ] Urinary tract infection

Are you, or could you be pregnant? *

- ○ Yes
- ○ No

If yes, how many months?

Are you trying to get pregnant? *

- ○ Yes
- ○ No

Number of pregnancies:

Number of births:

Number of abortions or miscarriages:

Do you have/have you taken?

- [ ] Birth control pill/patch
- [ ] HRT (hormone replacement therapy)
- [ ] NHRT (natural hormone replacement therapy)
- [ ] Progesterone cream (OTC)
- [ ] Immediate family member with history of breast, uterine or ovarian cancer

Have you ever had fibroid tumors or ovarian cysts?

When was your last Pap smear and where was it done? Have you ever had an abnormal Pap smear?

Did your mother take DES when she was pregnant?

- [ ] Yes
- [ ] No

MENOPAUSE (if applicable)

Age when changes began:

Last menses start date:

Please check if you experience any of the following:

- [ ] Hot flashes
- [ ] Vaginal dryness
- [ ] Loss of sex drive
- [ ] Night sweats
- [ ] Poor memory
- [ ] Low energy
- [ ] Mood swings

MEN (if applicable)

Please check if you have or experience any of the following:

- [ ] Erectile dysfunction
- [ ] Premature ejaculation
- [ ] Infertility
- [ ] Vasectomy
- [ ] Painful testicles or lumps/swelling of testicles

Please use this space to share any other information relevant to your health concerns and your visit today.

Thank you for taking the time to answer these questions honestly. We appreciate your time and effort.

I certify that the information that I have provided above is correct and accurate to the best of my knowledge. I understand that the diagnosis and treatment plan that will be given by Wild Rose Medicine is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that if no substantial improvement is made in the condition in which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements that I am concurrently taking.

Please sign here *

Signature

Today's Date *

mm/dd/year

Patient Portal Link: https://acusimple.com/access/4577/#/portal/forms/91478/