BR ACUPUNCTURE WELLNESS

2424 O'Neal Lane Ste B.
Baton Rouge, LA 70816
Tel. (225) 636 - 6666
www.BRAcupunctureWellness.com

# New Patient Intake Form

This information is strictly confidential. If we do not sincerely believe that you will respond favorably to acupuncture we will not accept your case, but will refer to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. If you have any questions, don't hesitate to ask one of our staff members for help.

## PATIENT INFORMATION

Today's Date: _____

Name _____ SSN _____ Age _____ Date of Birth _____

Height _____ Weight _____ Sex ❑ M ❑ F Marital Status ❑Single ❑Married ❑Divorced ❑Widowed ❑Partnered

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Occupation _____ Employer/School Name _____

Business Address _____ Work Phone _____

Emergency Contact: Name _____ Relationship _____ Phone _____

Primary Physician /Referring Physician _____ Phone _____

Insurance Carrier _____ Policy Number _____

How did you hear about us? ❑Family/Friend ❑Health Professional ❑Internet ❑Other _____ Referred by _____

Have you received acupuncture before? ❑Yes ❑No If yes, when? _____ from who? _____ for what? _____

Have you used Chinese herbal medicine before? ❑Yes ❑No If yes, please list formula:_____

## CHIEF COMPLAINT

Main complaint _____

How long have you had this problem? _____

What seems to cause this problem? _____

Have you been given a diagnosis? ❑Yes ❑No If yes, what? _____

by whom? Physician's Name _____ Phone _____

To what extent does this problem interfere with your daily activities (work, exercise, sleep, sex, etc.)? _____

_____

What kinds of treatment have you tried? How did your condition change? _____

_____

What makes it better? _____ Worse? _____

Please rate your current pain/discomfort on a scale of 1-10: very slight ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 unbearable

Is there anyone in your family with the same/similar problems? _____

List any other health problems you have. _____

_____

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## MEDICAL HISTORY

Please check any of the following which have ever affected you and indicate date.

- ❑ Addiction _____
- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma
- ❑ Breast lumps
- ❑ Breathing problems
- ❑ Bronchitis
- ❑ Bursitis
- ❑ Cancer _____
- ❑ Candida
- ❑ Chicken pox
- ❑ Chronic fatigue
- ❑ Colitis/ Bowel disease
- ❑ Diabetes
- ❑ Digestive disorders
- ❑ Eating disorder
- ❑ Elevated liver enzymes
- ❑ Emotional imbalance
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Food, chemical, drug poisoning
- ❑ Fibromyalgia
- ❑ Gall stones
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Heart disease
- ❑ Hernia
- ❑ Hepatitis
- ❑ Herpes
- ❑ High cholesterol
- ❑ Hypertension
- ❑ Hypotension
- ❑ Other _____
- ❑ HIV positive
- ❑ Kidney stones
- ❑ Malaria
- ❑ Measles
- ❑ Meningitis
- ❑ Mononucleosis
- ❑ Multiple sclerosis
- ❑ Mumps
- ❑ Nephritis
- ❑ Neuralgia
- ❑ Paralysis
- ❑ Prostate problems
- ❑ Rheumatism
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Stroke
- ❑ STD _____
- ❑ Thyroid problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid fever
- ❑ Ulcers
- ❑ Urinary problems
- ❑ Whooping cough

Surgeries, Hospitalizations and Significant Trauma's (auto accidents, falls, loss of loved one, etc)

| DATE | EVENT |
|---|---|
| | |
| | |
| | |
| | |

Allergies and adverse reactions _____

_____

Medications taken in last 3 months, including vitamins, supplements, over-the-counter medicines, herbal medicines.

| MEDICATION | DOSAGE | REASON | HOW LONG | LAST CHECKUP DATE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do you have a pacemaker? ❑Yes ❑No Do you bleed for a long time? ❑Yes ❑No

Do you have any of the following conditions currently? ❑Cold/ Flu ❑Infection/Inflammation ❑Menstruation ❑Pregnancy/Lactation

## FAMILY MEDICAL HISTORY

Please indicate any significant illnesses your blood relative (grandparent, parent or sibling) have had:

- ❑ Cancer type _____ who _____ when _____
- ❑ Diabetes who _____ when _____
- ❑ Emotional Disorders who _____ when _____
- ❑ Heart Disease who _____ when _____
- ❑ Hepatitis who _____ when _____
- ❑ High Blood Pressure who _____ when _____
- ❑ Infectious Diseases who _____ when _____
- ❑ Rheumatic Fever who _____ when _____
- ❑ Seizures who _____ when _____
- ❑ Tuberculosis who _____ when _____

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## PERSONAL / SOCIAL HISTORY

How many hours per night do you sleep? _____ When do you usually go to bed? _____ Do you wake rested? ❑Yes ❑No

Do you exercise regularly? ❑Yes ❑No What kind of exercise? _____

What are your hobbies/ things you most enjoy doing?_____

Are you or have you been on a restricted diet? What kind and why? _____

_____

Please indicate the use and frequency of the following:

Cigarettes ❑Yes ❑No how many per day? _____ since when? _____ Alcohol ❑Yes ❑No amount _____

Recreational drugs ❑Yes ❑No type _____ amount _____ since when? _____ Coffee ❑Yes ❑No amount _____

Tea ❑Yes ❑No amount _____ Soda ❑Yes ❑No amount _____ Water ❑Yes ❑No amount _____

Please describe your average daily diet:

Morning _____

Afternoon _____

Evening _____

How do you feel about the following areas of your life?

| | GREAT | GOOD | FAIR | POOR | BAD | COMMENTS |
|---|---|---|---|---|---|---|
| Significant-other | ❑ | ❑ | ❑ | ❑ | ❑ | |
| Family | ❑ | ❑ | ❑ | ❑ | ❑ | |
| Diet | ❑ | ❑ | ❑ | ❑ | ❑ | |
| Sex | ❑ | ❑ | ❑ | ❑ | ❑ | |
| Self | ❑ | ❑ | ❑ | ❑ | ❑ | |
| Work | ❑ | ❑ | ❑ | ❑ | ❑ | |
| Spirituality | ❑ | ❑ | ❑ | ❑ | ❑ | |

## SYMPTOM SURVEY

Please check any of the following that applies to you now or in the past 3 months.

### General

| PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Poor appetite | ❑ | ❑ | Allergies | ❑ | ❑ | Shortness of breath |
| ❑ | ❑ | Excessive appetite | ❑ | ❑ | Fever | ❑ | ❑ | Poor coordination |
| ❑ | ❑ | Strong thirst | ❑ | ❑ | Chills | ❑ | ❑ | Vertigo / Dizziness |
| ❑ | ❑ | Poor sleeping | ❑ | ❑ | Localized weakness | ❑ | ❑ | Bleed or bruise easily |
| ❑ | ❑ | Fatigue | ❑ | ❑ | Bodily heaviness | ❑ | ❑ | Tremors |
| ❑ | ❑ | Night sweats | ❑ | ❑ | Weight loss | ❑ | ❑ | Mood change |
| ❑ | ❑ | Sweat easily | ❑ | ❑ | Weight gain | ❑ | ❑ | Nervousness / Irritability |
| ❑ | ❑ | Swollen glands | ❑ | ❑ | Hot or cold intolerance | ❑ | ❑ | Sudden energy drop |
| ❑ | ❑ | Frequent infection | ❑ | ❑ | Cold hands or feet | | | when _____ |
| ❑ | ❑ | Other: _____ | | | | | | |

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## Psychological

| PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Depression | ❑ | ❑ | Irritability | ❑ | ❑ | Lose control of emotions |
| ❑ | ❑ | Anxiety | ❑ | ❑ | Bad temper | ❑ | ❑ | Suicidal thoughts / attempt |
| ❑ | ❑ | Panic attacks | ❑ | ❑ | Easily stressed | ❑ | ❑ | Seeing a therapist |
| ❑ | ❑ | Other: | | | | | | |

## Skin and Hair

| PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Rashes | ❑ | ❑ | Dry skin | ❑ | ❑ | Itching |
| ❑ | ❑ | Eczema | ❑ | ❑ | Pimples | ❑ | ❑ | Tumors / Lumps |
| ❑ | ❑ | Hives | ❑ | ❑ | Recent moles | ❑ | ❑ | Change in hair or skin texture |
| ❑ | ❑ | Loss of hair | ❑ | ❑ | Ulceration | | | |
| ❑ | ❑ | Other: | | | | | | |

## Head, Eye, Ears, Nose, and Throat

| PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Dizziness | ❑ | ❑ | Color blindness | ❑ | ❑ | Ringing in ears |
| ❑ | ❑ | Headache | ❑ | ❑ | Recent change in vision | ❑ | ❑ | Poor hearing |
| ❑ | ❑ | Migraine | ❑ | ❑ | Cataracts | ❑ | ❑ | Ear pain |
| ❑ | ❑ | Concussions | ❑ | ❑ | Glaucoma | ❑ | ❑ | Sinus problems |
| ❑ | ❑ | Facial pain | ❑ | ❑ | Spots in the eyes | ❑ | ❑ | Runny nose |
| ❑ | ❑ | Sore throat | ❑ | ❑ | Night blindness | ❑ | ❑ | Sneezing |
| ❑ | ❑ | Sores in lips or tongue | ❑ | ❑ | Blurry vision | ❑ | ❑ | Nasal congestion |
| ❑ | ❑ | Grinding teeth | ❑ | ❑ | Eye pain | ❑ | ❑ | Peculiar smells |
| ❑ | ❑ | Jaw clicks | ❑ | ❑ | Dry eyes | ❑ | ❑ | Nose bleedings |
| ❑ | ❑ | Gum problems | ❑ | ❑ | Red eyes | ❑ | ❑ | Peculiar tastes _____ |
| ❑ | ❑ | Teeth problems | ❑ | ❑ | Itchy eyes | ❑ | ❑ | Other: |
| ❑ | ❑ | Excessive saliva | ❑ | ❑ | Excessive phlegm | | | |

## Cardiovascular

| PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | High blood pressure | ❑ | ❑ | Irregular heartbeat | ❑ | ❑ | Fainting |
| ❑ | ❑ | Low blood pressure | ❑ | ❑ | Palpitations | ❑ | ❑ | Swelling of hands |
| ❑ | ❑ | Blood clots | ❑ | ❑ | Chest pain | ❑ | ❑ | Swelling of ankles / feet |
| ❑ | ❑ | High cholesterol | ❑ | ❑ | Heart murmur | ❑ | ❑ | Cold hands and/or feet |
| ❑ | ❑ | Poor circulation | ❑ | ❑ | Heart valves problems | ❑ | ❑ | Anemia |
| ❑ | ❑ | Other: | | | | | | |

## Respiratory

| PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Cough | ❑ | ❑ | Shortness of breath | ❑ | ❑ | Sleep apnea |
| ❑ | ❑ | Bronchitis | ❑ | ❑ | Pain with deep breath | ❑ | ❑ | Frequent colds / flu |
| ❑ | ❑ | Emphysema | ❑ | ❑ | Tightness of chest | ❑ | ❑ | Phlegm color _____ |
| ❑ | ❑ | Asthma / wheezing | ❑ | ❑ | Difficulty breathing when | | | amount _____ |
| ❑ | ❑ | Pneumonia | | | lying down | | | |
| ❑ | ❑ | Other: | | | | | | |

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## Gastrointestinal

| PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Constipation | ❑ | ❑ | Burning sensation of anus | ❑ | ❑ | Gas/ bloating |
| ❑ | ❑ | Diarrhea | ❑ | ❑ | Rectal pain | ❑ | ❑ | Indigestion |
| ❑ | ❑ | Blood in stool | ❑ | ❑ | Hemorrhoids | ❑ | ❑ | Abdominal cramps |
| ❑ | ❑ | Undigested food in stools | ❑ | ❑ | Chronic laxative use | ❑ | ❑ | Nausea / Vomiting |
| ❑ | ❑ | Foul smelling stools | ❑ | ❑ | Pain with defecation | ❑ | ❑ | Hiccups |
| ❑ | ❑ | Black stools | ❑ | ❑ | Incomplete feeling of | ❑ | ❑ | Belching |
| ❑ | ❑ | Light colored stools | | | defecation | ❑ | ❑ | Bad breath |
| ❑ | ❑ | Other: _____ | | | | | | |

## Genito-Urinary

| PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Pain on urination | ❑ | ❑ | Unable to hold urine | ❑ | ❑ | Herpes |
| ❑ | ❑ | Urgency to urinate | ❑ | ❑ | Bedwetting | ❑ | ❑ | Current outbreak of herpes |
| ❑ | ❑ | Decrease in urine flow | ❑ | ❑ | Sperm in urine | ❑ | ❑ | Increased libido |
| ❑ | ❑ | Blood in urine | ❑ | ❑ | Urinary Tract Infections | ❑ | ❑ | Decreased libido |
| ❑ | ❑ | Frequent urination | ❑ | ❑ | Sore on genitals | ❑ | ❑ | Erectile Dysfunction |
| ❑ | ❑ | Nighttime urination | ❑ | ❑ | Itchiness on genitals | ❑ | ❑ | Premature ejaculation |
| ❑ | ❑ | Incomplete feeling after | ❑ | ❑ | STD _____ | ❑ | ❑ | Ejaculation during sleep |
| | | urination | ❑ | ❑ | Other: _____ | | | |

## Gynecological (Women only / If you've already had menopause, please describe your past menstruation)

Is there any possibility that you are pregnant? ❑ Yes ❑ No Date of last pap smear: _____

| PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Painful periods | ❑ | ❑ | Vaginal discharge | ❑ | ❑ | Mastitis |
| ❑ | ❑ | Irregular periods | | | Color _____ | ❑ | ❑ | Fibroids |
| ❑ | ❑ | Abnormal uterine bleeding | | | Odor _____ | ❑ | ❑ | Endometriosis |
| ❑ | ❑ | Infertility | ❑ | ❑ | Breast lumps / nodules | ❑ | ❑ | Yeast infection / vaginitis |
| ❑ | ❑ | Other: _____ | | | | | | |

Age of first period: _____ Number of days between periods: _____ Number of days of flow: _____

Menstruation Menstrual flow: ❑ Heavy ❑ Light ❑ Clots ❑ Painful ❑ Spotting between periods Color of flow: _____

Start date of last cycle: _____ PMS symptoms: _____

Menopause Age of menopause: _____ Menopausal symptoms: _____

Pregnancy # pregnancies: _____ # births: _____ # miscarriages: _____ # abortions: _____ # premature births: _____

## Musculoskeletal / Neurological

| PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION | PAST | CURRENT | CONDITION |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Neck tightness/pain | ❑ | ❑ | Knee pain | ❑ | ❑ | Hernia |
| ❑ | ❑ | Shoulder pain | ❑ | ❑ | Muscle weakness | ❑ | ❑ | Seizures |
| ❑ | ❑ | Hand/wrist pain | ❑ | ❑ | Muscle pain/soreness | ❑ | ❑ | Tremors |
| ❑ | ❑ | Back pain | ❑ | ❑ | Joint sprain | ❑ | ❑ | Numbness |
| ❑ | ❑ | Hip pain | ❑ | ❑ | Joint disorders | ❑ | ❑ | Tingling |
| ❑ | ❑ | Sciatica | ❑ | ❑ | Scoliosis | ❑ | ❑ | Paralysis |
| ❑ | ❑ | Other: _____ | | | | | | |