

Lisa Wagenseil L.Ac.
Acupuncture New Patient Intake Form

Demographics:

Name: _____ Date of Birth: _____ Gender: Male Female
Address: _____ City: _____ State: _____ Zip: _____
Phone Numbers: Home _____ Work _____ Cell _____
Email Address: _____
Occupation _____ Employer _____
Emergency Contact: Name _____ Phone _____
How did you hear about this clinic? _____

Reason for today's visit: _____

Yes, I have been treated by Acupuncture before. Date of last treatment: _____

Yes, I am currently under a Physician's care for: _____

Name of Physician: _____ Phone: _____

Yes, I am currently taking prescription drugs. Please list below:

Drug Name & Dosage	For What Purpose/Condition
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Yes, I am currently taking supplements and/or vitamins. Please list below:

Supplement/Vitamin Name & Amount	For What Purpose/Condition
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Yes, I have an infectious disease. Please describe: _____

Yes, I have allergies. Please indicate:

Foods – Describe _____

Medications – Describe _____

Bites/Stings – Describe _____

Seasonal – Describe _____

Animals – Describe _____

Other – Describe _____

Family Medical History (Please check if any of the following applies to any family members)

AIDS	Alcoholism	Allergies	High Blood Pressure
Asthma	Diabetes, Type I or II	Heart Disease	Cancer
Seizures	Stroke	Mental Illness	Other:_____

Describe:

Mother's Health: _____ Living/Deceased
Father's Health: _____ Living/Deceased
Siblings? _____ Health: _____ Living/Deceased
Grandparent's Health: _____ Living/Deceased

Personal Health History (Please check if any of the following apply)

AIDS	Diabetes	Hepatitis
Alcoholism	Emphysema	High Blood Pressure
Asthma	Epilepsy	Multiple Sclerosis
Allergies	Endocrine Disorder	Thyroid Disease
Arteriosclerosis	Gout	Childhood Fevers
Birth Trauma (yours)	Heart Disease	Childhood Illnesses

Major Surgeries (please list all with approx. dates): _____

Significant Trauma (auto accidents, falls, etc. Please list with approx. date of injury): _____

Current Symptoms (Please check if any of the following apply)

Headaches	Urination Difficulties	Constipation/Diarrhea
Vision Problems	Infertility	Skin Disorders
Jaw/Teeth Pain	Impotence	PMS
Ear Pain	Muscular Pain	Menstrual Disorders
Sinus Pain/Problems	Joint Dysfunction/Pain	Menopausal Problems
Throat Pain/Problems	High/Low Blood Pressure	Anxiety
Breathing Difficulties	Depression	Chest Pain
Chills	Overly Emotional	Excess Thirst
Fever	Fatigue	Lack of Thirst
Indigestion	Dizziness	Spontaneous Sweating
Insomnia	Weight Loss	Night Sweating
Nervousness	Weight Gain	Lack of Sweating
Other:	_____	

Life Style (Please check if any of the following apply)

Live Alone	Work 9-5	Exercise Seldom
Live with Spouse/Significant Other	Work 2 nd Shift	Exercise Occasionally
Live with Roommate(s)	Work 3rd Shift	Exercise Often
Live with Parents	Work Inconsistent Hours	Enjoy Hobby
Live with Children	Manage Own Business	Religious
Enjoy your Work	Unemployed	Spiritual Connection
Enjoy your Home	Student Full Time	Student Part-time
Enjoy your Social Life	Have Family Support	Have Financial Support

Diet and Personal Habits (Please check if any of the following apply)

Currently use Tobacco, # packs per Day? _____	Currently use alcohol, # drinks per week? _____
Former Tobacco Use, Year Quit? _____	Currently use recreational drugs
Exercise Regularly	Vegetarian
Vegan	Healthy Diet
Eat a lot of Fried Foods	Eat a lot of Dairy
Eat a lot of Sweets	Eat a lot of Red Meat
Normal weight for Height	Underweight
Very Overweight	<input type="checkbox"/> Overweight

Any additional information about yourself (Please write here)

Please check if you experience any of the following on a regular basis:

Head, Eyes, Ears, Nose, Throat

Glasses	Ear Ringing	Teeth Removed
Night Blindness	Hearing Loss	Numerous Cavities
Eye Strain	Earaches	Teeth Grinding
Eye Pain	Ringing in Ears	TMJ
Red Eyes	Headaches	Gum Problems
Itchy Eyes	Migraines	Lip Sores
Spots in Eyes	Concussions	Mouth Sores
Spots in Visions	Throat Drainage	Excessive Saliva
Blurred Vision	Throat Tickle	Facial Pain
Glaucoma	Sore Throat	Facial Numbness
Cataracts	Swollen Glands	Sinus Problem
Nosebleeds	Lump in Throat	Sinus Drainage
Heaviness of Head	Enlarged Thyroid	

Respiratory

Difficulty Breathing	Tight Chest	Pleurisy
Shortness of Breath	Asthma	Phlegm/Congestion
Chronic Cough	Wheezing	Rattling Sound with Breath
Acute Cough	Pneumonia	Can't Sleep Lying Down

Cardiovascular

Hypertension (High Blood Pressure)
Chest Pain
Palpitations
Slow Heart Rate

Blood Clots
Rapid Heart Rate
Edema (Swelling)
Pacemaker

Hypotension (Low Blood Pressure)
Fainting
Irregular Heart Rate

Gastrointestinal

Nausea
Vomiting
Acid
Regurgitation/Reflux
Gas/Flatulence
Hemorrhoids
Rectal Pain/Itching
Fissures
Bowel Movement
1X/Day
Bowel Movement
Greater than 1X/Day

Diarrhea
Constipation
Use Laxatives

Use Antacids
Hiccups
Bloating
Bad Breath
Vomiting Blood

Bowel Movement Less than 1X/Day

Dark Colored Stool
Light Colored Stool
Mucus in Stools

Blood in Stools
Use Fiber
Use Digestive Enzymes
Intestinal Pain
Poor Appetite

Genito-Urinary

Pain with Urination
Frequent Urination
Urgent Urination
Incomplete Urination

Increased Libido (Men)

Kidney Stones

Bed Wetting
Wake to Urinate
Frequent UTIs
Sexually Transmitted Disease
Decreased Libido (Men)

Impotence
Premature Ejaculation
Nocturnal Emissions
Blood in Urine

Dribbling

Musculo-Skeletal

Muscle Weakness

Muscle Cramps

Muscle Spasms
Joint Pain

Joint Instability

Chronic Pain (long-term pain)
Acute Pain (short-term pain)
Injuries
Muscle Atrophy

Falls

Limited Range of Motion
Arthritis

General Aches
Location of Pain_____

Neurological

Fainting/Syncope
Drowsiness
Tremor
Stroke/CVA/TIA

Dizziness
Loss of Balance
Convulsions
Seizures

Vertigo
Poor Memory
Paralysis
Numbness

Neurophysiological

Depression
Irritable
Easily Stressed
Easily Frustrated

Worry Easily – Anxious
Unresolved Grief
Frightened Easily
Numbness

Abuse Survivor
Receiving Counseling
Received Counseling
Poor Memory

Skin and Hair

Rashes
Hives
Ulcerations
Eczema
Fungal Infection

Psoriasis
Acne
Itching
Dandruff
Premature Graying

Hair Loss
Hair Changes
Hair Breaking
Thin Slow Growing Nails
Skin Changes

Vitality and Immune System

Frequent Colds

Frequent Flu
Less Ability to Adapt

Chronic Mental
Cloudiness
Low Energy
Lethargic

Slow Wound Healing

Tender/Achy All Over

Gynecology N/A

Pregnant
Could be Pregnant

Pregnancies # _____
Miscarries # _____

Abortions # _____

Pre-Mature Births # ____
Use Birth Control Pills
Use Birth Control, Other

Use No Contraceptives
Use Hormone
Replacement Therapy
Menopausal

Decreased Libido
Increased Libido

PMS
Pain Before
Menstruation
Pain During
Menstruation
Pain After Menstruation
Bone Density Changes
Fibrocystic Breasts

Breast Lumps
Breast Tenderness

Mastectomy

Hysterectomy
Excess Vaginal
Discharge
Vaginal Odor
Vaginal Sores

Vaginal Dryness

Vaginal Itching
Vaginal Pain
Spotting Between
Cycles
Blood Clots
Heavy Bleeding –
Weeks
Regular Self Breast
Exams

Peri-Menopausal Lumpectomy
--Age of Menarche? _____ Yrs/Old
--Age of Menopause? _____ Yrs/Old
--Date of Last PAP? _____
--Date of Last Mammogram? _____

Current Menses:

Length of Cycle _____ #Days per
Month

Duration of Flow? _____ #Days of Bleeding

****Please indicate any areas of pain ****

