Acu-Lounge | New Patient Intake Form | CONFIDENTIAL

Name	Today's Date:	
Date of Birth:	Age:	Gender:
Mailing Address: City: Zip:	Phone Number (Cell):	Phone (Work):
Email:	Occupation:	
Emergency Contact:	Emergency Contact Phone Number:	
How did you hear about us?	Have you been treated by Acupuncture or Chinese Medicine before? No: ☐ Yes: ☐ Month/Year: _____	

Main Concerns

Please list the concerns that brought you here today

1. _____
When did this start? _____

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/activity:	better	no change	worse

2. _____
When did this start? _____

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/activity:	better	no change	worse

3. _____
When did this start? _____

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/activity:	better	no change	worse

Health History

Please indicate any conditions you or your family has experienced:

P past **C** current **F** family

Write P if you have had it in the past, write C if you currently have it, and write F if anyone in your immediate family had/has it.

___ Alcoholism
___ Allergies: _____
___ Anorexia
___ Anemic
___ Anxiety
___ Asthma
___ Blood Clotting Disorder
___ Bulimia
___ Cancer: _____
___ Chemical Dependency
___ Compromised Immunity
___ Diabetes
___ Depression
___ Dizzy/Fainting
___ Epilepsy
___ High/low BP
___ High Cholesterol
___ HIV/AIDS
___ Menstrual Disorder
___ Mental Health Diagnosis: _____
___ Osteoporosis
___ Pacemaker
___ Pregnancy; # if children if applicable: _____
___ Respiratory Disease
___ Skin condition: _____
___ Stroke
___ Significant Stress/Trauma
___ Thyroid Disease

__ Other:

Habits

	Amount per day	If quit, Year?
Coffee / Tea		
Soda		
Tobacco		
Marijuana		
Drugs		
Other		

Please list any medications/supplements you are taking:

_____

_____

_____

Injuries & Surgeries

Please note what happened, which body area and when:

_____

_____

Exercise

Do you exercise regularly? _____

What do you do and how often? _____

Stress Level

1 2 3 4 5 6 7 8 9 10
Low Medium High

General Health

How is your energy level? 1 2 3 4 5 6 7 8 9 10
Very Low Very High

How is your body temperature? 1 2 3 4 5 6 7 8 9 10
Very Cold Very Hot

Do you sleep well at night? _____
How many hours do you sleep at night? _____

- ☐ trouble falling sleep
- ☐ wake up at night. Time: _____
- ☐ wake up early. Time: _____
- ☐ do not feel rested

How many bowel movements each week? ____

- ☐ well formed
- ☐ loose
- ☐ hard
- ☐ alternating loose/hard
- ☐ dry
- ☐ long and thin
- ☐ looks like small pellets
- ☐ blood in stools
- ☐ early morning diarrhea
- ☐ feel unfinished

How many times do you urinate per day? ____

- ☐ clear urine
- ☐ cloudy urine
- ☐ yellow/light yellow
- ☐ dark yellow
- ☐ painful
- ☐ urinate at night. How many times? ____

How is your digestion? _____

Please list any special dietary habits & allergies:
(eg. vegetarian, vegan, raw, etc and # of years)
_____

- ☐ no or less appetite
- ☐ hungry
- ☐ gas
- ☐ belching
- ☐ bloating
- ☐ heartburn
- ☐ stomach pain
- ☐ abdominal pain
- ☐ acid reflux
- ☐ slow digestion

How is your thirst?

- ☐ thirsty
- ☐ no or less thirst
- ☐ thirsty but can't quench thirst
- ☐ like warm drinks
- ☐ thirsty but no desire to drink
- ☐ like cold/ice drinks

Do you sweat?

- ☐ sweat easily
- ☐ don't usually sweat
- ☐ spontaneous sweat
- ☐ day/night sweat (please circle)

Which emotions do you experience on a daily basis?

- ☐ joy
- ☐ sadness/grief
- ☐ easily startled
- ☐ peace
- ☐ fear
- ☐ indifference
- ☐ anger
- ☐ anxiety
- ☐ excessive thinking
- ☐ depression
- ☐ guilt
- ☐ worry

How is your menstruation (if applicable)?

Date of last period: _____

- ☐ menopause
- ☐ regular cycle
- ☐ irregular cycle
- ☐ painful periods
- ☐ bleeding between periods
- ☐ excessive flow
- ☐ scanty flow

Please check box if you experience any of the following symptoms regularly:

- ☐ headaches
- ☐ migraines
- ☐ pain in ribcage
- ☐ frequent sighing
- ☐ stress
- ☐ heart palpitations
- ☐ moodiness
- ☐ pain that comes and goes
- ☐ grinding teeth
- ☐ cold hands and feet
- ☐ frequent colds
- ☐ sinus congestion
- ☐ sore throat
- ☐ aversion to wind or cold
- ☐ runny nose
- ☐ cough
- ☐ shortness of breath
- ☐ low immunity
- ☐ blurry vision
- ☐ spotters/floaters in the eyes
- ☐ eye dryness or pain
- ☐ dizziness
- ☐ poor memory
- ☐ inability to concentrate
- ☐ numbness
- ☐ dry skin/hair
- ☐ ligament/tendon problems
- ☐ brittle fingernail/toenails
- ☐ pale nails, lips, face
- ☐ low libido
- ☐ high libido
- ☐ sexual dysfunction
- ☐ hemorrhoids