

New Patient Intake

Full Name _____ Date of Birth _____ Today's Date _____

General Information

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ E-mail _____

Receive email communications? Yes No Receive text communications? Yes No

Occupation _____ Hours worked per week: _____

Emergency Contact _____ Relationship _____ Phone _____

Have you had Acupuncture or Oriental medicine before? Yes No Family Physician _____ Phone _____

What was your experience? Very good Good No change Married Partner Divorced Widowed Single

Are you presently under a doctor's care? Yes No Who and what for? _____

Are there any other therapies which you are involved in? Yes No Who and what for? _____

Insurance Information

Insurance Company _____ Group # _____

ID # _____ Co-Pay \$ _____

Deductible Amount _____ Phone _____

Primary Insured Name: _____ Referral Yes No

Focus

What is the primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities? Work Standing Sexually Other
 Sleep Emotional Recreation
 Walking Relationships Bending
 Sitting Social Life Stretching

What have you done about this? _____

Is this visit due to Auto Accident Workers Comp Employment Other Accident: _____ None of the 4 items listed in this section

Are you interested in: Pain Relief Holistic Health Stress Relief Other
 Preventative Care Stretching/Yoga Herbal Therapy
 Oriental Nutrition Maintenance Care

What are your health goals? _____

List any past or future surgeries: _____

List any significant trauma & when it occurred
(e.g. auto accident, falls, emotional, sexual, etc.): _____

List exercise and sport activities you
have been or are currently involved in: _____

Medical History

Do you have any allergies? Yes No If so, to what? _____

Do you take medication? Yes No If so, what types and how often? _____

Do you take supplements? Yes No If so, what types and how often? _____

Please indicate if you or any family members have or had any of the following conditions:

- | | | | | |
|---------------------------------------|--|---|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Drug reaction | <input type="checkbox"/> Mental breakdown | <input type="checkbox"/> Gonorrhea/Herpes | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Jaundice | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hypo/hyper thyroid |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Parasites | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Premature graying |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Obesity | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Cancer | |

Do you sleep well? Yes No

Do you dream? Yes No

Do you have a high point during the day? Yes No When? _____ Do you have a low point during the day? Yes No When? _____

What are your indulgences? _____

What are your hobbies? _____

Concerns

Date of last menstruation _____ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you ever been pregnant? Yes No Birth control? Yes No How long? _____

PMS Clotting Vaginal sores Vaginal pain Discharge

Other _____

Male Concerns

Testicle pain Penis pain Penis sores Discharge Premature ejaculation Nocturnal emission Impotence

Other _____

Signs/Symptoms

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Abdominal pain/distention | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Muscle cramps/pain | <input type="checkbox"/> Sinus pressure |
| <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Dark stools | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Skin fungal infection |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Hiccup | <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Spots in eyes |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Night sweat | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Dry throat/mouth | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Numbness | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain/cramps | <input type="checkbox"/> Odorous stools | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Irritable | <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Teeth/gum problems |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Peculiar tastes | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Breast lump/pain | <input type="checkbox"/> Eye pain/strain/tension | <input type="checkbox"/> Itchy skin | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Chest pains | Color of _____ | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Wake to urinate |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Rash | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Redness of eyes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas/belching | <input type="checkbox"/> Migraine | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Short temper | _____ |
| | <input type="checkbox"/> Headache | <input type="checkbox"/> Mucus in stools | <input type="checkbox"/> Shortness of breath | _____ |

Pain

Use the diagram and pain key to the right to indicate areas and type of pain. Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

- No Pain Moderate pain Severe pain Terrible pain

Sleeping

- No problem Disturbed Very disturbed Cannot sleep

Work - Can do:

- Usual work 50% of work 25% of work No work

Frequency of pain

- 25% of time 50% of time 75% of time 100% of time

Travel

- No problem Moderate pain on trips Severe pain

Recreation - Can do:

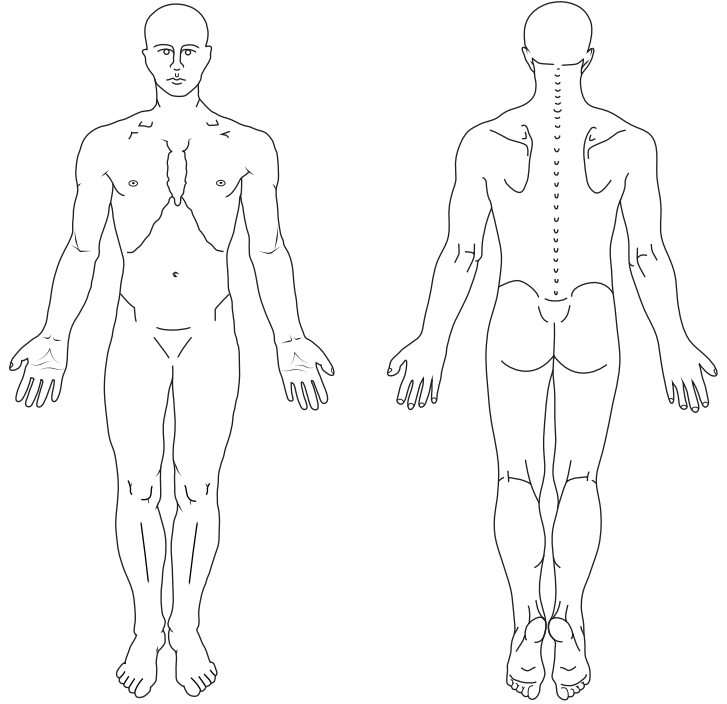
- All activities Some activities No activities

Walking

- Can walk fine Pain after 1/2 mile Cannot walk

Sitting

- No pain sitting Some pain while sitting Cannot sit



Pain Key

Ache ^ ^ ^ ^	Numbness = = = =	Pins & Needles 0 0 0 0	Burning X X X X	Stabbing / / / /
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Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)? not committed 1 2 3 4 5 6 7 8 9 10 very committed

I certify that I am the patient or legal guardian as indicated on this form. I have read and understand the information provided and certify it to be true and accurate to the best of my knowledge. Acupuncture is not meant to replace medical diagnosis or treatment. If symptoms are severe or presistant, you should always consult your physician. I agree to inform any staff of Divine Illumination Acupuncture, LLC of any and all changes to my health. If a non-acupuncture or unusual finding is encountered during any treatment, you will be referred to a licensed medical professional.

Patient or Legal Guardian Signature

Date

