

NEW PATIENT INTAKE FORM

Name _____ Date _____

Date of birth _____ Occupation _____

Email Address _____

Address _____ City _____ Zip _____

Home Phone Number _____

Cell Phone Number _____

Emergency Contact and Phone Number _____

Major Complaints

How long have you had this condition? _____

What makes it better? _____

What makes it worse? _____

Medications you are currently taking

List Surgeries/Operations you have had

Medical History (Do you have or ever had): Arthritis Asthma Anemia
Heart trouble Cancer High Blood Pressure
Kidney or Bladder Trouble

Family History (Has any member had any of the above)?

Yes No If yes, which member and what did they have?

Energy Level: _____ High (Time of Day) _____ Low
(Time of Day) _____

Stress None Moderate High

Sweating: Night Sweats Rarely Sweats Excessive

Circulation: Feelings of Hot Cold

What area? _____

Bleeds Easily Cold Limbs

Skin: Dry Itchy Acne Hair loss/thinning

Bruises easily

Other _____

Sleep Problems: Trouble falling asleep Trouble Staying Asleep

Restful Excessive Dreaming

Other _____

Head: Headaches (What area)? _____ Dizziness

Memory Loss Loss of Balance

Other _____

Ears: Poor Hearing Ringing in Ears

Eyes: Dry Eyes Blurry Vision

Nose: Frequent Nose Bleeds Sinus Trouble Frequent Colds

Throat: Sore Throat Jaw Problems Teeth Problems

Chest: Hard to Breathe Wheezing Shortness of Breath

Palpitations Coughing Phlegm Persistent Cough

Pain/Pressure in Chest

Blood Pressure: High Low

Bowels: Diarrhea Constipation Bloody Stools Hemorrhoids

Gas _____ Number of Bowel Movements per Day

Urine: Frequent Urination Burning Urination Water

Retention Incontinence Night time

Other _____

Musculoskeletal: Pain in: Neck Shoulder Between Shoulders

Arms/Hands Hip Knee Fingers Upper Back

Mid Back Lower Back Leg Cramps Painful Joints

Tingling in Feet Muscle Spasms/Cramps

Other _____

Neurological: Depressed Easily Angered

Frequent Crying Anxiety Mood Swings Poor Concentration Tremors

Seizures Numbness/Tingling

Females: Pregnant _____ First Day of Last Monthly Period

Menstrual Cycle: Irregular Clotting Heavy Bleeding Light/Scanty

Mood Changes Low or no Sex Drive Painful Breasts Hot Flashes
 Discharges: Yellow Thick White Itching
Males: Low Sex Drive Impotence Premature ejaculation
Appetite: Excessive appetite Poor Appetite Excessive thirst
Digestion: Stomach Gas Heartburn Belching
 Stomach pain Bitter taste in mouth Abdominal bloating
 Food allergies?
 If yes, to what? _____

NOTICE: If you are getting acupuncture for fertility please fill the section below. If not then please skip to the HIPPA section, read it and sign at the bottom.

JACKSONVILLE ACUPUNCTURE FERTILITY HISTORY

Age at which menses began _____

Are your periods painful? Yes No
 How many days does the pain last? ____

How many days do you normally bleed? ____

How heavy is the bleeding?
 Light Normal Heavy

What color is the blood?
 Light red Red Dark Red Purple Brown Black

Is there clotting? Yes No

Do you have premenstrual tension? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender premenstrually? Yes No

Are your menstrual cycles spaced irregularly?
 Yes No

How many days are there from one period to the next? _____

Do you bleed or spot between periods?
 Yes No

First day of last period _____

How many of pregnancies have you had? _____

How many children do you have? _____

How many abortions have you had? _____

How many miscarriages have you had? _____

How many times has a D & C been performed? _____

Have you ever had an abnormal pap smear?

Yes No

Have you ever had a cervical biopsy, operation, cauterization, or conization? Yes No

Do you get yeast infections regularly? Yes No

Do you have chronic vaginal discharge?

Yes No

Have you ever had pelvic inflammatory disease?

Yes No

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Do you take any other medications for gynecological conditions other than contraceptives?

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began?

Yes No

How? _____

Do you ovulate on your own?

Yes No

On what day of your cycle? _____

Do your breast get tender during ovulation?

Yes No

Do you get premenstrual back pain?

Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Have you ever had fertility treatments?

Yes No
If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? Yes No

When? _____

How long? _____

Have your fallopian tubes ever been evaluated medically? Yes No

What were the results? _____

Have you ever had any tubal operations?

Yes No

Have you ever had any hormone laboratory test performed? Yes No

If so, what were the results? _____

Has your partner had a fertility workup?

Yes No

What were the results? _____

Have you ever taken oral contraceptives?

Yes No

When? _____

How long? _____

How long have you been trying to conceive?

Have you had a diagnosis related to infertility?

Yes No

If so, what was it? _____

How is your sexual energy?

Low Normal High

Do you use vaginal lubricants? YesNo

Are you 20% over your ideal body weight?

Yes No

Are you 20% below your ideal body weight?

Yes No

Do you have a stressful occupation?

Yes No

Do you exercise regularly?

Yes No

Do you have excessive facial hair?

Yes No

Do you have excessively oily skin?

Yes No

Have you experienced loss of head hair?

Yes No

Have you noticed discharge from your nipples?

Yes No

Have you been exposed to any environmental toxins or hormones?

Yes No

Are you presently taking steroids?

Yes No

Do you eat animal products? Yes No

NOTICE: Please read the HIPPA section on the next page and sign at the bottom.

Effective: March 1, 2008

**Notice of Patient Privacy
Health Insurance Portability and Accountability Act
(HIPAA)**

Jacksonville Acupuncture Clinic is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization. You are provided the right to request and receive a copy of your medical information that we maintain, amending, correcting that information, obtaining an accounting or of disclosures of your medical information, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective date at the top right hand side of the page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions or concerns about the NOTICE or your medical information, please contact Jacksonville Acupuncture Clinic at (904) 296-0977. You may also send a written complaint to the US Department of Health and Human Services.

Patient Name

Date

Printed Name