

Natural Health Center for Acupuncture and Wellness

132 N Main Street
Oconomowoc Wisconsin 53066

Name: First _____ Middle _____ Last _____
Address _____ City, Zip _____
Phone: Daytime _____ Home _____ Cell _____
Email _____ Referred By _____
Birth Date _____ Marital Status: Married Single Divorced
Occupation _____ Employer _____
Insurance? No Yes Insurance Name _____
Policy Number _____
Emergency Contact: Name _____ Phone _____
Physician: Name _____ Phone _____

Please fill out all information as completely as you can on the following 2 pages. All information is kept private and is only used for your treatment and for billing services.

You may read and print out our Privacy Policy from our website at www.acupunctureeconomowoc.com/acupuncturePrivacy.asp

New Patient Intake Form

Today's Date _____ / _____ / _____

Have you had Acupuncture Before? Yes No

Herbal Medicine? Yes No

Reason for Visit Today _____

How long have you had this condition? _____ Is it getting worse? Yes No

Does it bother your Sleep Work Other (what?) _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Are you under the care of a physician now? Yes No If yes for what? _____

Who is your physician? _____ Physician's phone _____

Other concurrent therapies _____

Pharmaceuticals taken past 2 months _____

Other Supplements taken past 2 months _____

Family Medical History

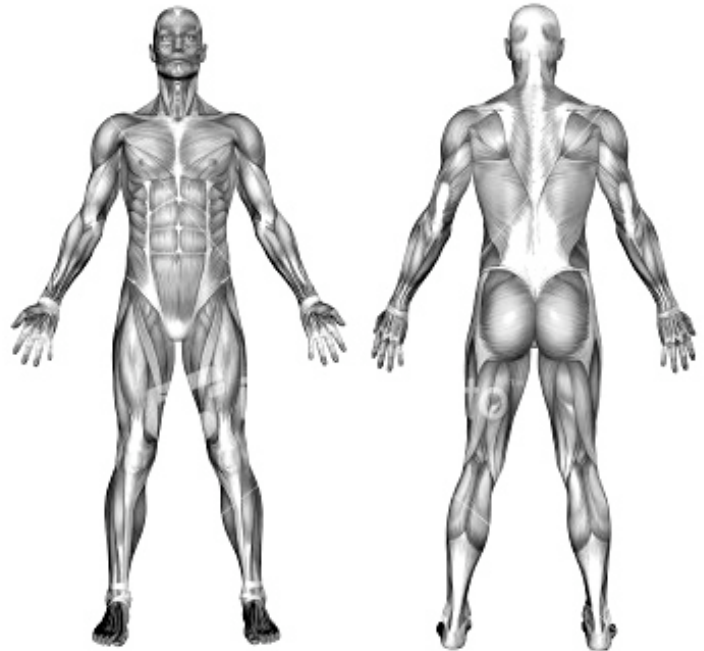
Allergies _____ Cancer _____

Diabetes _____ Seizures _____
 Heart disease _____ Stroke _____
 High blood pressure _____

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history)

- | | | |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Heart disease | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> STD | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Other (please specify) _____ | <input type="checkbox"/> Surgery | <input type="checkbox"/> Major Trauma |



Ache AAAAA	Numbness =====	Pins & Needles 0000000000	Burning XXXXX	Stabbing //////////
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Your Lifestyle

Alcohol Marijuana Stress
 Tobacco Drugs Occupational Hazards

Regular exercise
 Type _____ Frequency _____
 Type _____ Frequency _____

General Symptoms

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Chills | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Cold hands & feet | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Peculiar tastes (describe) |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> dream disturbed sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Sweat easily | _____ |
| <input type="checkbox"/> Strongly like hot drinks | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps | _____ |
| <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Fever | <input type="checkbox"/> Vertigo or dizziness | _____ |

Head, Eyes, Ears, Nose, Throat

- | | | | | |
|---|--|--|--|--------------------------------------|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Red Eyes | <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Enlarged thyroid | Other head or neck problems |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Nose bleeds | _____ |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> TMJ | Color of phlegm _____ | <input type="checkbox"/> Ringing in ears | _____ |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Facial Pain | | <input type="checkbox"/> Poor hearing | _____ |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Gum Problems | | <input type="checkbox"/> Earaches | _____ |

Respiratory

- | | | | |
|---|--|--------------------------------|---|
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma/wheezing | Wet or dry? _____ | <input type="checkbox"/> Pneumonia |
| | | Thick or thin? _____ | |

Cardiovascular

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat |

Gastrointestinal

- | | | | |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain or cramping | Bowel movements |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Itchy anus | |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Burning anus | Frequency _____ |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Black stools | <input type="checkbox"/> Rectal pain | Color _____ |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Hemorrhoid | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Mucous in Stool | <input type="checkbox"/> Anal Fissures | <input type="checkbox"/> Bad Breath |

Musculoskeletal

- | | | | | |
|---|--|-------------------------------------|--|---|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Limited use | _____ |

Skin and Hair

- | | | | | |
|--------------------------------------|------------------------------------|------------------------------------|--|--------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Change in hair/skin texture | Other hair/skin problems |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching | <input type="checkbox"/> Fungal infections | _____ |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne | <input type="checkbox"/> Hair loss | | _____ |

Neuropsychological

- | | | | | |
|-----------------------------------|--------------------------------------|--|---|-----------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered/attempted suicide | Other (specify) |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Easily Stressed | <input type="checkbox"/> Seeing a therapist | _____ |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | | | _____ |

Genito-Urinary

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased Libido | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Nocturnal emission |

Gynecology

- | | | | | |
|------------------------------------|--|--|---|---|
| Age Menses began _____ | Duration of flow _____ | <input type="checkbox"/> Vaginal discharge (color) _____ | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Date of last PAP _____ |
| Length of cycle (day 1 to 1) _____ | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> # pregnancies _____ | Date last period began _____ |
| | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal odor | <input type="checkbox"/> Live births _____ | _____ |
| | <input type="checkbox"/> PMS | <input type="checkbox"/> Clots | <input type="checkbox"/> Premature births _____ | _____ |
| | | | Age at Menopause _____ | |

Other _____

Stop Here

Pulse: _____ Tongue _____

Other: _____

Dx: _____

Points _____

Tx Plan: _____ / Week Based on medical necessity As prescribed by PTP As long as symptoms Maintenance

Modalities: Acupuncture E-Stim I/R Mech. Tract. Man Therapy Cupping Ther/exer

Short term goals: ↓Mms Spasm ↓ Inflammation ↑ROM ↓Pain

Long term goals: ↑Function ↑Strength ↑Balance ↑Stability

Herbs/Formulas: _____

Refer to Chiro Ortho Neuro Internist Opth Other _____