Natural Health Center for Acupuncture and Wellness

N56W39325 Wisconsin Ave Ste C
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.acupunctureoconomowoc.com/acupuncturePrivacy.asp

New Patient Intake Form

Today's Date_____/____/____

Have you had Acupuncture Before? O Yes O No Herbal Medicine? O Yes O No

Reason for Visit Today

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

Does it bother your O Sleep O Work O 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? O Yes O 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

O Allergies
O Cancer
O Diabetes
O Seizures
O Heart disease
O Stroke
O 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)

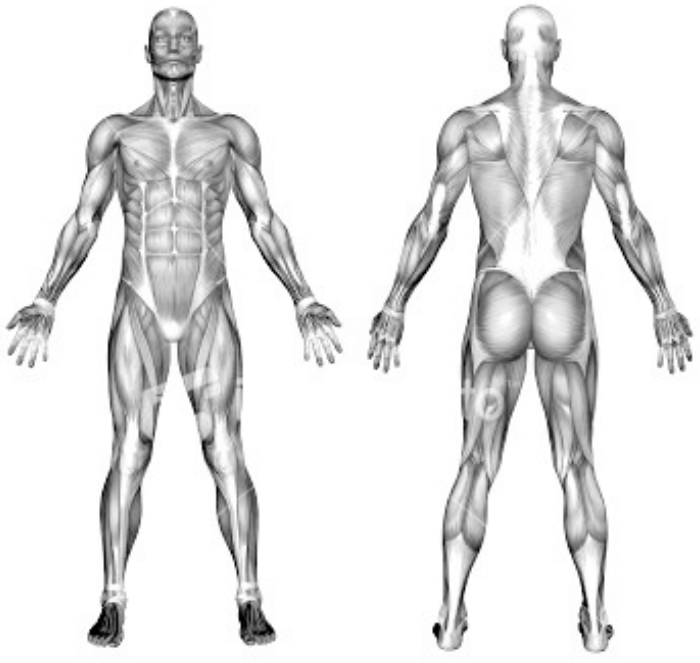
O AIDS/HIV
O Tuberculosis
O Measles
O Allergies
O Seizures
O Goiter
O Arteriosclerosis
O High blood pressure
O Chicken Pox
O Scarlet Fever
O Cancer
O Herpes
O Other (please specify)

O Diabetes
O Alcoholism
O Mumps
O Epilepsy
O Ulcers
O Pleurisy
O Heart disease
O Thyroid disorder
O Whooping cough
O Pneumonia
O Rheumatic fever
O STD
O Surgery

O Multiple Sclerosis
O Emphysema
O Typhoid Fever
O Pacemaker
O Appendicitis
O Stroke

O Gout
O Polio
O Asthma

O Hepatitis
O Major Trauma



Ache	Numbness	Pins & Needles	Burning	Stabbing
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Your Lifestyle

O Alcohol
O Tobacco
O Marijuana
O Drugs
O Stress
O Occupational Hazards

Regular exercise
Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms

O Poor appetite
O Heavy appetite
O Strongly like cold drinks
O Strongly like hot drinks
O Recent weight loss/gain

O Poor sleep
O Heavy sleep
O dream disturbed sleep
O Fatigue
O Lack of strength

O Bodily heaviness
O Cold hands & feet
O Poor circulation
O Shortness of breath
O Fever

O Chills
O Night Sweats
O Sweat easily
O Muscle cramps
O Vertigo or dizziness

O Bleed or bruise easily
O Peculiar tastes (describe)

Head, Eyes, Ears, Nose, Throat

o Glasses
o Eye strain
o Eye Pain
o Red Eyes
o Itchy Eyes
o Spots in eyes
o Poor vision
o Blurred vision

o Night blindness
o Glaucoma
o Cataracts
o Teeth Problems
o Grinding teeth
o TMJ
o Facial Pain
o Gum Problems

o Sores on lips or tongue
o Dry Mouth
o Excessive saliva
o Sinus problems
o Excessive phlegm
Color of phlegm
_____

o Recurrent sore throat
o Swollen glands
o Lumps in throat
o Enlarged thyroid
o Nose bleeds
o Ringing in ears
o Poor hearing
o Earaches

o Headaches
o Migraines
o Concussions
Other head or neck problems
_____
_____
_____
_____

Respiratory

o Difficulty breathing when lying down
o Shortness of breath

o Tight chest
o Asthma/wheezing

o Cough
Wet or dry?_____
Thick or thin?_____

o Coughing blood
o Pneumonia

Cardiovascular

o High blood pressure
o Blood clots

o Low blood pressure
o Fainting

o Chest pain
o Difficulty breathing

o Tachycardia
o Heart palpitations

o Phlebitis
o Irregular heartbeat

Gastrointestinal

o Nausea
o Vomiting
o Acid regurgitation
o Gas
o Hiccup
o Bloating

o Diarrhea
o Constipation
o Laxative use
o Black stools
o Bloody stools
o Mucous in Stool

o Intestinal pain or cramping
o Itchy anus
o Burning anus
o Rectal pain
o Hemorrhoid
o Anal Fissures

Bowel movements

Frequency _____
Color _____

o Bad Breath

Musculoskeletal

o Neck/shoulder pain
o Muscle pain

o Upper back pain
o Low back pain

o Joint pain
o Rib pain

o Limited range of motion
o Limited use

o Other (describe)
_____

Skin and Hair

o Rashes
o Hives
o Ulcerations

o Eczema
o Psoriasis
o Acne

o Dandruff
o Itching
o Hair loss

o Change in hair/skin texture
o Fungal infections

Other hair/skin problems
_____
_____

Neuropsychological

o Seizures
o Numbness
o Tics

o Poor memory
o Depression
o Anxiety

o Irritability
o Easily Stressed

o Considered/attempted suicide
o Seeing a therapist

Other (specify)
_____
_____

Genito-Urinary

o Pain on urination
o Frequent urination
o Urgent urination

o Blood in Urine
o Unable to hold urine
o Incomplete urination

o Venereal disease
o Bedwetting
o Wake to urinate

o Increased Libido
o Decreased Libido
o Kidney stone

o Impotence
o Premature ejaculation
o Nocturnal emission

Gynecology

Age Menses began
_____

Length of cycle (day 1 to 1)
_____

Duration of flow
_____

o Irregular periods
o Painful periods
oPMS

o Vaginal discharge (color)_____
o Vaginal sores
o Vaginal odor
o Clots

o Breast lumps
pregnancies_____
o Live births_____
o Premature births____.
Age at Menopause_____

o Date of last PAP
_____

Date last period began
_____

Other _____

Stop Here

Pulse:_____ Tongue_____

Other:_____

Dx: _____

Points_____

_____

Tx Plan: _____/ Week oBased on medical necessity oAs prescribed by PTP oAs long as symptoms oMaintenance

Modalities: oAcupuncture oE-Stim oI/R oMech. Tract. oMan Therapy oCupping oTher/exer

Short term goals: ◆Mms Spasm ◆ Inflammation 1'ROM ◆Pain

Long term goals: 1'Function 1'Strength 1'Balance 1'Stability

Herbs/Formulas:_____

Refer to o Chiro oOrtho o Neuro o Internist o Opth o Other_____