Creekside Acupuncture and Natural Medicine
New Patient Intake Form

Name:____________________________________ Age:______ Date of Birth:____________
Address:_______________________City:______________State:______Zip:_____________
Phone Numbers: Home______________Work______________Cell_________________
Email Address: ____
Occupation:____
Emergency Contact: Name________________________Phone_____________________
Primary Care Doctor:____
How did you hear about this clinic?____

Reason for today's visit:____
❑Yes, I have been treated by Acupuncture before. Date of last treatment:_______
❑Yes, I am currently under a Physician's care for:_________________________
Name of Physician:_________________________Phone:____________________

❑Yes, I am currently taking prescription drugs. Please list below:
____
____

❑Yes, I am currently taking supplements and/or vitamins. Please list below:
____
____

❑Yes, I have an infectious disease. Please describe:________________________

❑Yes, I have allergies. Please indicate:
- ❑Foods – Describe____
- ❑Medications – Describe____
- ❑Bites/Stings – Describe____
- ❑Seasonal – Describe____
- ❑Animals – Describe____
- ❑Other – Describe____

Personal Health History (Please check if any of the following apply)

❑AIDS
❑Alcoholism
❑Asthma
❑Allergies
❑Arteriosclerosis
❑Birth Trauma (yours)
❑Diabetes
❑Emphysema
❑Epilepsy
❑Endocrine Disorder
❑Gout
❑Heart Disease
❑Hepatitis
❑High Blood Pressure
❑Multiple Sclerosis
❑Thyroid Disease
❑Childhood Fevers
❑Childhood Illnesses

❑Major Surgeries (please list all with approx. dates):_____________________________________
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❑Significant Trauma (auto accidents, falls, etc. Please list with approx. date of injury):____________
____
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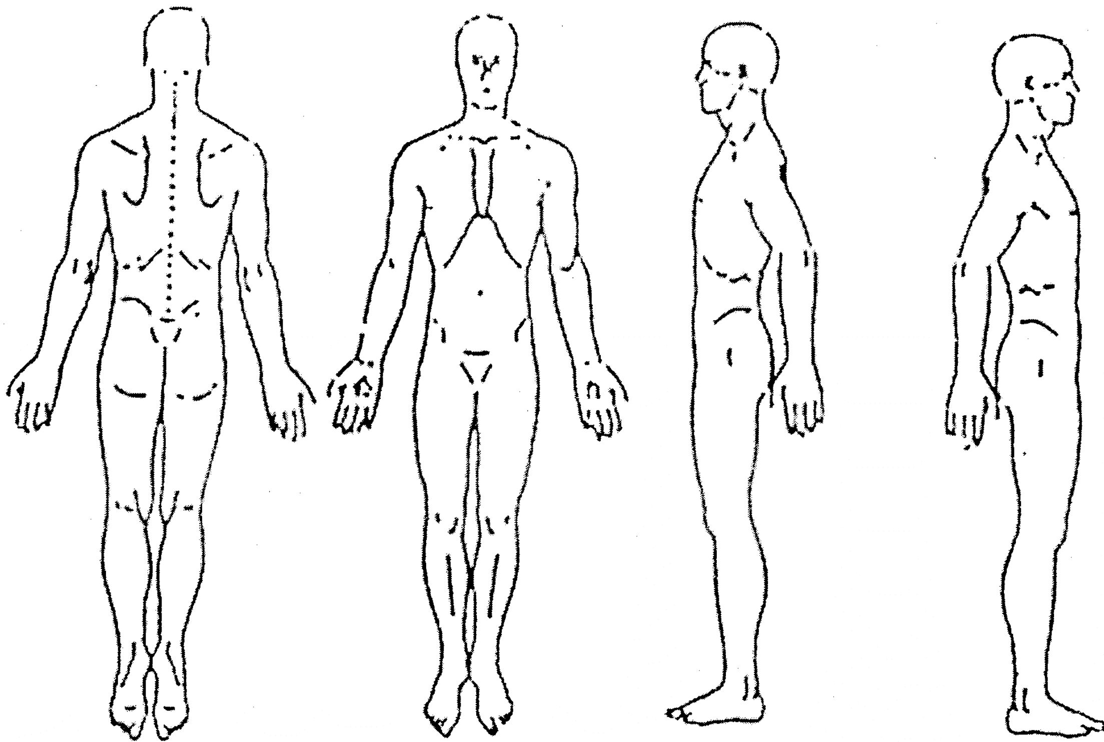
Current Symptoms (Please check if any of the following apply)

❑Headaches	❑Urination Difficulties	❑Constipation/Diarrhea
❑Vision Problems	❑Infertility	❑Skin Disorders
❑Jaw/Teeth Pain	❑Impotence	❑PMS
❑Ear Pain	❑Muscular Pain	❑Menstrual Disorders
❑Sinus Pain/Problems	❑Joint Dysfunction/Pain	❑Menopausal Problems
❑Throat Pain/Problems	❑High/Low Blood Pressure	❑Anxiety
❑Breathing Difficulties	❑Depression	❑Chest Pain
❑Chills	❑Overly Emotional	❑Excess Thirst
❑Fever	❑Fatigue	❑Lack of Thirst
❑Indigestion	❑Dizziness	❑Spontaneous Sweating
❑Insomnia	❑Weight Loss	❑Night Sweating
❑Nervousness	❑Weight Gain	❑Lack of Sweating

❑Other:____

****Please indicate any areas of pain on the diagram below****



Any additional information about yourself -

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Typical Daily Diet and Exercise

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Please check if you experience any of the following on a regular basis:

Head, Eyes, Ears, Nose, Throat

- ❑Glasses
- ❑Night Blindness
- ❑Eye Strain
- ❑Eye Pain
- ❑Red Eyes
- ❑Itchy Eyes
- ❑Spots in Eyes
- ❑Spots in Visions
- ❑Blurred Vision
- ❑Glaucoma
- ❑Cataracts
- ❑Nosebleeds
- ❑Heaviness of Head
- ❑Ear Ringing
- ❑Hearing Loss
- ❑Earaches
- ❑Ringing in Ears
- ❑Headaches
- ❑Migraines
- ❑Concussions
- ❑Throat Drainage
- ❑Throat Tickle
- ❑Sore Throat
- ❑Swollen Glands
- ❑Lump in Throat
- ❑Enlarged Thyroid
- ❑Teeth Removed
- ❑Numerous Cavities
- ❑Teeth Grinding
- ❑TMJ
- ❑Gum Problems
- ❑Lip Sores
- ❑Mouth Sores
- ❑Excessive Saliva
- ❑Facial Pain
- ❑Facial Numbness
- ❑Sinus Problem
- ❑Sinus Drainage

Respiratory

- ❑Difficulty Breathing
- ❑Shortness of Breath
- ❑Chronic Cough
- ❑Acute Cough
- ❑Tight Chest
- ❑Asthma
- ❑Wheezing
- ❑Pneumonia
- ❑Pleurisy
- ❑Phlegm/Congestion
- ❑Rattling Sound with Breath
- ❑Can't Sleep Lying Down

Cardiovascular

- ❑Hypertension (High Blood Pressure)
- ❑Chest Pain
- ❑Palpitations
- ❑Slow Heart Rate
- ❑Blood Clots
- ❑Rapid Heart Rate
- ❑Edema (Swelling)
- ❑Pacemaker
- ❑Hypotension (Low Blood Pressure)
- ❑Fainting
- ❑Irregular Heart Rate

Gastrointestinal

- ❑Nausea
- ❑Vomiting
- ❑Acid Regurgitation/Reflux
- ❑Gas/Flatulence
- ❑Hemorrhoids
- ❑Rectal Pain/Itching
- ❑Fissures
- ❑Bowel Movement 1X/Day
- ❑Bowel Movement Greater than 1X/Day
- ❑Diarrhea
- ❑Constipation
- ❑Use Laxatives
- ❑Use Antacids
- ❑Hiccups
- ❑Bloating
- ❑Bad Breath
- ❑Vomiting Blood
- ❑Bowel Movement Less than 1X/Day
- ❑Dark Colored Stool
- ❑Light Colored Stool
- ❑Mucus in Stools
- ❑Blood in Stools
- ❑Use Fiber
- ❑Use Digestive Enzymes
- ❑Intestinal Pain
- ❑Poor Appetite

Genito-Urinary

- ❑Pain with Urination
- ❑Frequent Urination
- ❑Urgent Urination
- ❑Incomplete Urination
- ❑Increased Libido
- ❑Kidney Stones
- ❑Bed Wetting
- ❑Wake to Urinate
- ❑Frequent UTIs
- ❑STD
- ❑Decreased Libido
- ❑Impotence
- ❑Premature Ejaculation
- ❑Nocturnal Emissions
- ❑Blood in Urine
- ❑Dribbling

Musculo-Skeletal

❑Muscle Weakness ❑Chronic Pain ❑Limited Range of Motion
❑Muscle Cramps ❑Acute Pain (short-term pain) ❑Arthritis
❑Muscle Spasms ❑Injuries ❑General Aches
❑Joint Pain ❑Muscle Atrophy
❑Joint Instability ❑Falls

Neurological

❑Fainting/Syncope ❑Dizziness ❑Vertigo
❑Drowsiness ❑Loss of Balance ❑Poor Memory
❑Tremor ❑Convulsions ❑Paralysis
❑Stroke/CVA/TIA ❑Seizures ❑Numbness

Neurophysiological

❑Depression ❑Worry Easily – Anxious ❑Abuse Survivor
❑Irritable ❑Unresolved Grief ❑Receiving Counseling
❑Easily Stressed ❑Frightened Easily ❑Received Counseling
❑Easily Frustrated ❑Numbness ❑Poor Memory

Skin and Hair

❑Rashes ❑Psoriasis ❑Hair Loss
❑Hives ❑Acne ❑Hair Changes
❑Ulcerations ❑Itching ❑Hair Breaking
❑Eczema ❑Dandruff ❑Thin Slow Growing Nails
❑Fungal Infection ❑Premature Graying ❑Skin Changes

Vitality and Immune System

❑Frequent Colds ❑Chronic Mental Cloudiness ❑Slow Wound Healing
❑Frequent Flu ❑Low Energy ❑Tender/Achy All Over
❑Less Ability to Adapt ❑Lethargic

Gynecology ❑N/A

❑Pregnant ❑Decreased Libido ❑Hysterectomy
❑Could be Pregnant ❑Increased Libido ❑Excess Vaginal Discharge
❑Pregnancies #______ ❑PMS ❑Vaginal Odor
❑Miscarries #_______ ❑Pain Before Menstruation ❑Vaginal Sores
❑Abortions #_______ ❑Pain During Menstruation ❑Vaginal Dryness
❑Pre-Mature Births #___ ❑Pain After Menstruation ❑Vaginal Itching
❑Use Birth Control Pills ❑Bone Density Changes ❑Vaginal Pain
❑Use Birth Control, Other ❑Fibrocystic Breasts ❑Spotting Between Cycles
❑Use No Contraceptives ❑Breast Lumps ❑Blood Clots
❑Use HRT ❑Breast Tenderness ❑Heavy Bleeding – Weeks
❑Menopausal ❑Mastectomy ❑Regular Self Breast Exams
❑Peri-Menopausal ❑Lumpectomy
Age of first period __________
Age of Menopause_________
Date of Last PAP ___________________
Date of Last Mammogram ____________

Current Menses:

Date of last period __________ Days between periods _______ Days of Bleeding ______