SEASIDE
FAMILY
ACUPUNCTURE

New Patient Intake Form

Date _____

Name _____ Date of birth _____

Address _____

_____

Primary phone _____ Secondary Phone _____

Email _____ Occupation _____

_____

What is your primary reason for coming today?

How did you hear about my practice?

When you get run down, how does your body respond? For example, you might tend to get a cold, tight shoulders, swollen glands, back pain, cold sores etc.

What kind of exercise do you do and how often?

What's your diet like? Are you vegetarian or vegan? Do you avoid any food types?

Are you currently undergoing any other treatment regimens or therapies?

Are you on any medications, including vitamins/herbs? Please list.

Please list any injuries, operations or major illnesses, whether as a child or adult (eg childhood asthma, whiplash at 22, glandular fever at 19, gall bladder removed at 35, knee surgery last year). These may be relevant to your current condition.

HEALTH HISTORY

Please indicate the year (if in the past) and mild or severe where appropriate.

Musculo-skeletal ☐ Headaches, migraines ☐ Joint stiffness/swelling ☐ Arthritis ☐ Broken/fractured bones ☐ Strains/sprains ☐ Lower back pain ☐ Shoulder stiffness/pain ☐ Neck stiffness/pain ☐ RSI ☐ Carpal Tunnel Syndrome ☐ Sciatica ☐ Osteoporosis ☐ Scoliosis ☐ Other_____	**Respiratory/ Skin** ☐ Smoker ☐ Allergies ☐ Sinus problems ☐ Asthma ☐ Emphysema ☐ Cough ☐ Susceptible to colds & flus ☐ Rashes ☐ Athlete's foot ☐ Warts ☐ Acne ☐ Other_____	**Nervous System/ Chronic Conditions** ☐ Numbness/tingling ☐ Chronic Fatigue Syndrome ☐ Chronic pain ☐ Lyme Disease ☐ Sleep disorders ☐ Paralysis ☐ Cerebral palsy ☐ Epilepsy ☐ Fibromyalgia ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Other_____
Digestive ☐ Indigestion ☐ Intestinal gas/bloating ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Irritable bowel syndrome ☐ Colitis ☐ Crohn's disease ☐ Ulcers ☐ Eating disorder ☐ Loss of appetite ☐ Other_____	**Circulatory** ☐ Heart condition ☐ Stroke ☐ Dizziness ☐ Shortness of breath ☐ Cold feet or hands ☐ Profuse sweating ☐ Swollen ankles, oedema ☐ Varicose veins ☐ Blood clots ☐ High/Low blood pressure ☐ Other_____	**Reproductive System** ☐ Currently Pregnant ☐ PMS ☐ Menopause ☐ Endometriosis ☐ Amenorrhea (No period) ☐ Ovarian Cysts ☐ Fertility concerns ☐ Last Menstrual Period: ☐Other_____
Other ☐ Diabetes ☐ Hepatitis A/B/C ☐ HIV/AIDS ☐ Cancer_____ ☐ Surgeries _____	**Other** ☐ Urinary Tract Infection ☐ Yeast Infection ☐ Kidney/Gall Bladder Stones ☐ STD_____	**Other** ☐ Anxiety ☐ Depression ☐ Thyroid Disorders ☐ Weight Loss/Weight Gain ☐ Hearing impaired ☐ Tinnitus (ringing in ears) ☐ Blurred Vision, floaters

Is this your first acupuncture or shiatsu? Have you had any notable reactions in the past?

Please indicate anything else that you think may be relevant (for example: family history of high blood pressure; current stressors that might be affecting your health etc.)

Thank you for taking time to complete this form.
Please feel free to raise anything further with me