Eva Stanley Acupuncture

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New Patient Intake Form

Patient Information

Date

Full Name
First | MI | Last

Gender
Male Female

Preferred Pronouns

Date of Birth

Address

City | State | Zip Code

Email

Cell

Home

Work

Martial Status
Single Married Divorced Widowed

# of Children & Ages

Employer

Employment Status
Select Option

Employer Address

City | State | Zip Code

How did you hear about us?

Whom may we thank for referring you?

Emergency Contact Information

Emergency Contact 1

Name

First Last

Address

City State Zip Code

Phone

Relationship to patient

Parent Significant Other Sibling Child Friend Other

Patient Condition

Primary Reason for Care

Secondary Reason for Care

Date Symptoms Started

What are you main treatment goals?

How often do you experience the symptoms?

Constant 100% Frequent 75% Intermittent 50% Occasional 25% Rare 10%

Are symtoms: ☐ Improving ☐ Progressively Worse ☐ Same

Describe any recent related accident or fall

What makes symptoms increase?

What makes symptoms decrease?

Type of pain:

☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throb ☐ Numbness ☐ Other

Where does the pain radiate to?

How bad is the pain? Indicate "0" no pain to "10" unbearable 0 1 2 3 4 5 6 7 8 9 10

Health & Medical History

What treatment have already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Acupuncture ☐ Chiropractic ☒ None

☐

If so, Name and Address of doctor(s) who have treated you for your condition

Please mark "C" if a current condition, "P" if a past condition and leave blank if not applicable.

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arm Pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Celiac Disease
- ☐ Chest Pain
- ☐ Chicken Pox
- ☐ Chronic Fatigue
- ☐ Cold Sores
- ☐ Concussions
- ☐ Cough
- ☐ Chrohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Gall Stones
- ☐ Goiter
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Irritable Bowel
- ☐ Infertility
- ☐ Jaw Pain
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Knee Pain
- ☐ Leg Pain
- ☐ Liver Disease
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Neck Pain
- ☐ Night Sweats
- ☐ Numbness/Tingling
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Psychiatric Care
- ☐ Pneumatic Fever
- ☐ Scarlet Fever
- ☐ Sciatica
- ☐ Seizures
- ☐ Shingles
- ☐ Shoulder Pain
- ☐ Sinus Congestion
- ☐ STDs
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcerative Colitis
- ☐ Ulcers
- ☐ Upper Back
- ☐ Urinary Tract Infection
- ☐ Vaginal Infection
- ☐ Whooping Cough

Others Not Listed _____

Allergies:

☐ Dust ☐ Mold ☐ Trees ☐ Weeds ☐ Grass ☐ Animal ☐ Perfume ☐ Smoke ☐ Foods (list on next page)

☐ Other

Description & Dates on the following:

List hospitalizations and/or surgeries you have had.

List recent infections (Cold, Flu, etc)

List any falls and/or injuries

List any fractures and/or dislocations

List current medications

List current vitamins or supplements

Please list your family medical history

Social and Occupational History

Diet

Food Cravings:

☐ Sweets ☐ Salt ☐ Sour ☐ Bitter ☐ Spicy

☐ Alcohol (type/drinks per week)
☐ Sugar (type/amount per day)
☐ Caffeine (type/drinks per day)
☐ Tobacco (type/amount per day)

Typical Breakfast

Mid-Morning Snack

Typical Lunch

Afternoon Snack

Typical Dinner

Typical Beverages

Favorite Foods

Food Allergies?

☐Yes ☐No

Please list food allergies

Female Only

Total Length of Cycle

Length of Menses

Menses:

☐Heavy ☐Moderate ☐Light ☐PMS ☐Mood Swings
☐Cramping ☐Breast Tenderness ☐Pregnant
☐Post Menopausal

Gastrointestinal

☐Excess Hunger ☐Poor Appetite ☐Nausea ☐Hemorrhoids
☐Diarrhea ☐Constipation ☐Heartburn ☐Gas ☐Bloating
☐Strong Smell

#Bowel Movements/Day

Sleep: hours per night

Quality of Sleep

☐Poor ☐Fair ☐Good ☐Trouble Falling Asleep ☐Staying Asleep
☐Insomnia

What time do you wake up?

How many times do you wake up?

Night Urination: How many times?

Do you sleep on your:

☐Back ☐Side ☐Stomach ☐All

Urination

☐Excess Urination ☐Frequent Urination ☐Painful Urination

Job Activities Include:

Physical Activity at Work

☐Sedentary ☐Light Manual Labor ☐Moderate Manual Labor ☐Heavy Manual Labor

How long do you speak on the telephone each day?

☐Traditional Phone ☐Headset

Do any of your work activities aggravate your present main compliants? Please describe.

Stress Level:

☐Mild ☐Medium ☐Severe

Reason