Four Winds Acupuncture Clinic & Integrative Therapies, PC

New Patient Intake

Identification

Name_____ Sex: ☐ M ☐ F Date_____

Address_____ City_____ State_____ Zip_____

Telephone: Home_____ Work_____ Cell_____

Date of Birth_____ Age_____ Email_____

☐ Single ☐Married ☐Partnered ☐Widowed ☐Separated/Divorced

Height_____ Weight _____ Occupation_____

Education_____

Emergency Contact _____ Relation_____

Emergency contact telephone: Home_____ Cell_____

Name of physician*_____ Phone number_____

Address_____ City_____ State_____ Zip_____

Name of counselor/psychologist*_____ Phone number_____

Address_____ City_____ State_____ Zip_____

Name of gynecologist*_____ Phone number_____

Address_____ City_____ State_____ Zip_____

**No contact will be made without your permission.*

Your signature_____

Special problems or symptoms (what brings you to our clinic today?)

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Family History

Please complete for each family member, as best you can, indicating any illnesses that they have ever had. Place an "X" or the date in appropriate box or boxes.

	Self (date)	Mother	Father	Sibling	Spouse/Partner	Children
Adopted						
Good health						
Cancer or tumors						
Diabetes						
Thyroid disorders						
Kidney disorders						
High blood pressure						
Heart disease						
Stroke						
Blood or bleeding disorders						
Anemia						
Seizures						
Allergies						
Alcohol or other drug use						
Depression or mental illness						
Hepatitis/other liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Asthma/breathing disorders						
Eczema/psoriasis/other skin disorders						
Deceased (age)						

Personal Lifestyle Habits

For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (pack per day) _____
Alcohol (drinks per day) _____ per week _____
Drug use (recreational)_____

Coffee (cups per day) _____
Tea (cups per day) _____
Water (glasses per day) _____

Exercise ☐Yes ☐No How often? _____

What kind of exercise? _____

Medical History

If you have every been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies). Use back side of paper if necessary.

Year	Operation/Illness	Hospital or Treatment Location

Medicines

Please list all medications, vitamins and/or food supplements you are currently taking.

Medications	Dosage	For what condition
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
Vitamins	**Dosage**	**For what condition**
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Food Supplements:	For what condition?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

CURRENT AND PAST CONDITIONS/SYMPTOMS/TRAUMAS

If you are currently experiencing any of the following, please mark it with a "C". If you have experienced any of the following in the past, please mark it with a "P". Mark "P-C" if you have experienced the condition both in the past and currently.

General
_____ Insomnia
_____ Dreams/nightmares
_____ Fatigue
_____ Poor memory
_____ Strongly like cold drinks
_____ Strongly like hot drinks
_____ Recent weight loss/gain
_____ Cold hands and feet
_____ Chills
_____ Fever
_____ Bad breath
_____ Fingernail/toenail fungus
_____ Other (describe)

Head & Neck
_____ Headaches
_____ Migraines
_____ Stiff neck
_____ Dizziness
_____ Fainting
_____ Vertigo
_____ Swollen glands
_____ Other (describe)
_____
_____
_____

_____ Dental exams?
Last dental visit
_____

Cardiovascular
_____ High blood pressure
_____ Low blood pressure
_____ Chest pain or tightness
_____ Palpitation
_____ Rapid heart beat
_____ Irregular heart beat
_____ Poor circulation
_____ Swollen ankles
_____ Phlebitis
_____ Anemia
_____ History of heart disease
_____ Night sweats
_____ Tendency to be cold
_____ Tendency to be warm
_____ Other (describe)

Gastrointestinal
_____ Nausea
_____ Indigestion
_____ Stomach pain
_____ Diarrhea
_____ Constipation
_____ Poor appetite
_____ Excessive hunger
_____ Vomiting
_____ Gas
_____ Hiccups
_____ Reflux
_____ Bloating
_____ Laxative use
_____ Bloody stool
_____ Other (describe)

Nose, Throat & Mouth
_____ Sinus infection
_____ Hay fever/allergies
_____ Frequent sore throats
_____ Difficulty swallowing
_____ Mouth & tongue ulcers
_____ Frequent colds
_____ Nosebleed
_____ Dry nose
_____ Nasal congestion
_____ Loss of voice
_____ Thirst
_____ Excessive phlegm
_____ TMJ
_____ Facial pain
_____ Gum problems
_____ Dry mouth
_____ Other (describe)

Skin
_____ Hives
_____ Rashes
_____ Eczema/psoriasis
_____ Night sweating
_____ Excessive sweating
_____ Dry skin
_____ Easily bruises
_____ Change is moles, lumps
_____ Itching
_____ Ringworm or other fungal infections
_____ Other (describe)

Eyes
How often checked:
_____

_____ Glasses/contact lenses
_____ Blurred vision
_____ Poor night vision
_____ Spots or floaters
_____ Eye inflammation
_____ Double vision
_____ Glaucoma
_____ Cataracts
_____ "Lazy" eye
_____ Other (describe)

Respiratory
_____ Difficulty breathing
_____ Difficulty breathing when reclining
_____ Wheezing
_____ Asthma
_____ Chronic cough
_____ Wet cough
_____ Dry cough
_____ Coughing up phlegm
_____ Coughing up blood
_____ Shortness of breath
_____ Tight chest
_____ Pneumonia
_____ Other (describe)

Musculoskeletal
_____ Joint pain/swelling
_____ Sore muscles
_____ Weak muscles
_____ Difficulty walking
_____ Limited range of motion
_____ Pain (describe)

_____ Other (describe)

Neurological
_____ Seizures
_____ Tremors
_____ Numbness or tingling
_____ Pain
_____ Paralysis
_____ Poor coordination
_____ Other (describe)

Mental/Emotional
_____ Depression
_____ Mood swings
_____ Irritability
_____ Difficulty relaxing
_____ Loneliness
_____ Sensitive
_____ Shyness
_____ Frequent crying
_____ Worries frequently
_____ Compulsive behaviors
_____ Difficulty focusing
_____ Foggy feeling
_____ Hopeless outlook
_____ Fearful
_____ Suicidal thoughts
_____ Lose temper
_____ Frustration
_____ Hyperactivity
_____ PTSD
_____ Other (describe)

Urinary
_____ Pain on urination
_____ Frequent urination
_____ Blood in urine
_____ Incontinence
_____ Incomplete urination
_____ Bedwetting
_____ Wake to urinate
_____ History of UTI
_____ Kidney issues (specify)

_____ Other (describe)

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Male Genital

_____ Impotence
_____ Premature ejaculation
_____ Nocturnal emission
_____ Pain/itching of genitalia
_____ Lumps in testicles
_____ Increased libido
_____ Decreased libido
_____ Breast checked
_____ Other (describe)

Gynecology (Women only)

_____ Currently pregnant
_____ # of pregnancies
_____ # of live births
_____ # of miscarriages
_____ # of abortions
_____ Perimenopause
_____ Menopause
_____ Irregular periods
_____ Menstrual cramps
_____ Excessive blood flow
_____ Menstrual blood clots
_____ Breast tenderness
_____ PMS
_____ Abnormal pap smear
_____ Vaginal infections
_____ Vaginal pain/itching
_____ Uterine fibroids
_____ Endometriosis
_____ Breast lumps/cysts
_____ Increased libido
_____ Decreased libido
_____ Other (describe)

Infectious Screening

Please circle: Self and/or partner

_____ HIV risks: self or partner

_____ TB: Self or household

_____ Hepatitis risk: Self or partner

_____ History of STD: Self or partner
(Specify): _____
_____
_____
_____
_____

_____ Other (describe)

Trauma (list)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Other information you wish to share:

We accept cash, personal checks, credit cards (MC, Visa, American Express, Discover), FSA and HAS debit cards. Please note there is a 4% convenience fee for using credit and debit cards.

We require 24-hour notification for cancelation of appointment. A fee of $60 will be assessed for all no-shows and all cancelations made with less than 24-hour notification. Future appointments will not be made until account is brought current and this fee is paid in full or payment arrangements are made.

Please initial the following:

I understand that fee is due at time of service: _____

I understand that there is a 4% convenience fee for using credit and debit cards: _____

I understand that there is a $60 fee for all no-shows and appointments canceled with less than 24-hours notice and that future appointments will not be made until this fee is paid in full: _____

I understand that there is a $50 service fee for all returned checks: _____

Patient signature _____ Date _____

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