New Patient Intake

Pine Street Acupuncture
Betty Shuford, LAc

Patient Name ______________________ **Date** __________

General Information

Address ______ City ______ State ______

Home Phone ______ Occupation ______ Zip ______

Work Phone ______ Mobile Phone ______ Date of Birth ______

Email Address ______

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:

Emails ☐ Yes ☐ No
Texts ☐ Yes ☐ No

Emergency Contact ______ Relationship ______ Phone ______

Have you had Acupuncture or Oriental medicine before? ☐ Yes ☐ No

Family Physician ______ Phone ______

What was your experience? ☐ Very good ☐ Good ☐ No change

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

Are you presently under a doctor's care? ☐ Yes ☐ No Who and what for? ______

Are there any other therapies which you are involved in? ☐ Yes ☐ No Who and what for? ______

Cancellation Policy

Please kindly give 24 hours notice if you need to reschedule or cancel your appointment.
Missed appointments may be charged a fee.

This is a confidential questionnaire that will help us determine the optimal treatment plan specific to your needs. If you have any questions or concerns please do not hesitate to ask.

Focus

What is the primary reason for seeking care at our office? ______

What was the initial cause? ______

When did it begin? ______

What makes it worse? ______

What makes it better? ______

How does this problem interfere with your daily activities?

☐ Work ☐ Sleep ☐ Walking ☐ Sitting
☐ Standing ☐ Emotional ☐ Relationships ☐ Social Life
☐ Sexually ☐ Recreation ☐ Bending ☐ Stretching
☐ Other ______

What have you done about this? ______

Are you interested in:

☐ Pain Relief ☐ Preventative Care ☐ Oriental Nutrition
☐ Holistic Health ☐ Stretching/Yoga ☐ Maintenance Care
☐ Stress Relief ☐ Herbal Therapy
☐ Other ______

What are your health goals? ______

List any past or future surgeries: ______

List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, etc.): ______

List exercise and sport activities you have been or are currently involved in: ______

Medical History

Do you have any allergies? ☐ Yes ☐ No If so, to what? ______________________

Do you take medication? ☐ Yes ☐ No If so, what types and how often? ______________________

Do you take supplements? ☐ Yes ☐ No If so, what types and how often? ______________________

Please indicate if you or any family members have or had any of the following conditions:

☐ Pneumonia	☐ Drug reaction	☐ Mental breakdown	☐ Gonorrhea/Herpes	☐ Mental illness
☐ Tuberculosis	☐ Heart attack	☐ Jaundice	☐ HIV/AIDS	☐ Hypo/hyper thyroid
☐ Hepatitis	☐ Blood transfusion	☐ Parasites	☐ High/low blood pressure	☐ Premature graying
☐ Diabetes	☐ Anemia	☐ Measles	☐ Heart disease	☐ Seizures
☐ Epilepsy	☐ Arthritis	☐ Mumps	☐ Gout	☐ Multiple Sclerosis
☐ Kidney Stone	☐ Obesity	☐ Syphilis	☐ Cancer	

Do you sleep well? ☐ Yes ☐ No Do you dream? ☐ Yes ☐ No

Do you have a high point during the day? ☐ Yes ☐ No When? ________ Do you have a low point during the day? ☐ Yes ☐ No When? ________

What are your indulgences? ______________________

What are your hobbies/pleasures? ______________________

Female Concerns

Date of last menstruation ______________ Is your cycle regular? ☐ Yes ☐ No Is your cycle painful? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No Birth control? ☐ Yes ☐ No How long? ______________

☐ PMS ☐ Clotting ☐ Vaginal sores ☐ Vaginal pain ☐ Discharge Other ______________

Male Concerns

☐ Testicle pain ☐ Penis pain ☐ Penis sores ☐ Discharge ☐ Premature ejaculation ☐ Nocturnal emission ☐ Impotence

Other ______________

Signs/Symptoms

☐ Abdominal pain/distention	☐ Coughing blood	☐ Hemorrhoids	☐ Muscle cramps/pain	☐ Sinus pressure
	☐ Dark stools	☐ Heart palpitations	☐ Nasal congestion	☐ Skin fungal infection
☐ Abuse survivor	☐ Decreased libido	☐ Hiccup	☐ Neck/shoulder pain	☐ Spots in eyes
☐ Acid regurgitation	☐ Depression	☐ High blood pressure	☐ Night sweat	☐ Sweat easily
☐ Acne	☐ Dizziness/vertigo	☐ Increased libido	☐ Nose bleeds	☐ Sore throat
☐ Asthma	☐ Dry throat/mouth	☐ Indigestion	☐ Numbness	☐ Sudden energy drop
☐ Bad breath	☐ Diarrhea	☐ Intestinal pain/cramps	☐ Odorous stools	☐ Swollen glands
☐ Blood in stools	☐ Ear aches	☐ Irritable	☐ Pain upon urination	☐ Teeth/gum problems
☐ Blood in urine	☐ Enlarged thyroid	☐ Itchy eyes	☐ Peculiar tastes	☐ Ulcerations
☐ Blurry vision	☐ Eye pain/strain/tension	☐ Itchy skin	☐ Poor appetite	☐ Upper back pain
☐ Breast lump/pain	☐ Excessive phlegm	☐ Joint pain	☐ Poor circulation	☐ Urgent urination
☐ Bruise easily	Color of ________	☐ Kidney stones	☐ Poor memory	☐ Vomiting
☐ Chest pains	☐ Excessive saliva	☐ Laxative use	☐ Poor sleep	☐ Wake to urinate
☐ Chills	☐ Fatigue	☐ Limited range of motion	☐ Psoriasis	☐ Weight loss/gain
☐ Cold hands/feet	☐ Fever	☐ Loss of hair	☐ Rash	☐ Wheezing
☐ Concussion	☐ Frequent urination	☐ Low back pain	☐ Redness of eyes	☐ Other: ________
☐ Confusion	☐ Gas/belching	☐ Migraine	☐ Seizures	________
☐ Constipation	☐ Grinding teeth	☐ Mouth sores	☐ Short temper	________
☐ Cough	☐ Headache	☐ Mucus in stools	☐ Shortness of breath	________

Pain

Use the diagram and pain key to the right to indicate areas and type of pain.
Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

☐ No Pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work - Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation - Can do:

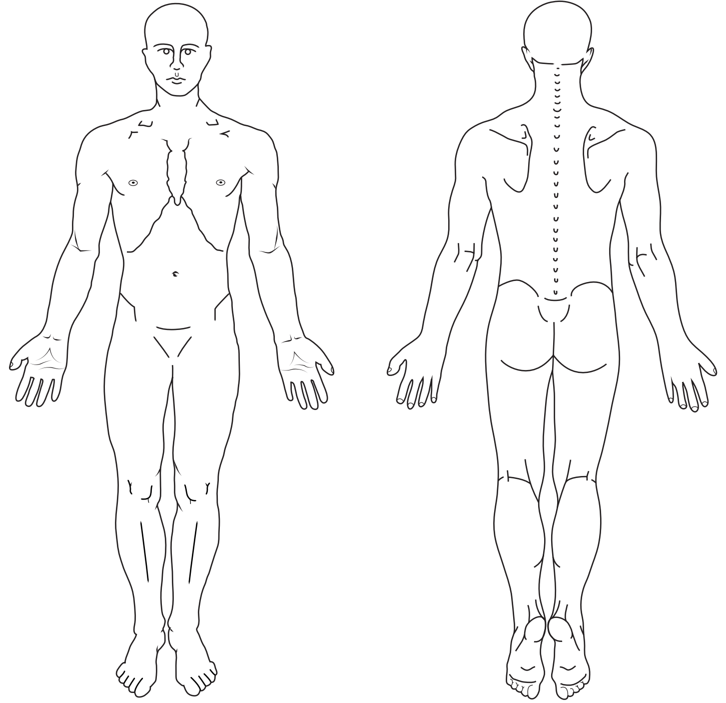
☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after 1/2 mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit



Pain Key

Ache	Numbness	Pins & Needles	Burning	Stabbing
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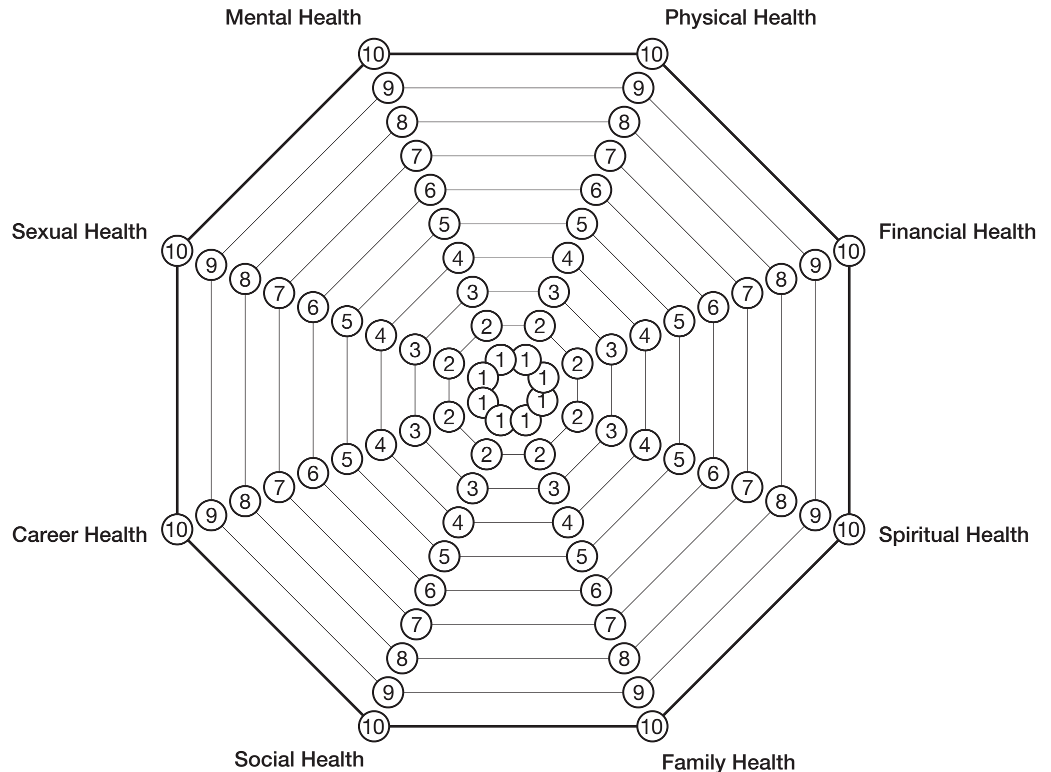
Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the “10” circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed