
# New Patient Form

Name: _____

Address: _____

_____

Phone: _____

Email: _____

Preferred method of contact: ☐ phone ☐ text ☐ email

Date of Birth: ____ / ____ / _____

Emergency Contact Name: _____

Phone: _____

Please list any medication, herbs or supplements you are taking:

Have you had acupuncture before? ☐ yes ☐ no

Primary reason for today's visit:

Secondary reason/concern:

## Please list any allergies:

## General Concerns:

□Weight gain □Weight loss □Edema □Excess thirst □Lack of thirst □Hair loss

Crave: □sweet □salty □sour □spicy foods

## Sleep

□Restful □Dream-disturbed □Nightmares □Insomnia

□Difficult falling asleep □staying asleep

How many hours do you sleep each night: _____

## Digestion/Gastrointestinal

□Belching □Gas □Bad breath □Bloating □Nausea □Vomit □Diarrhea □Loose stools

□Constipation □Undigested food in stool □Heart burn □Ulcers □Indigestion

□Excess hunger □Low appetite □No appetite

□Abdominal pain (when is it worse: □After eating □Before eating)

□Rectal Pain □Hemorrhoids □Rectal Bleeding: □Red □Brown □Black □Mucus in stool

How often do you have a bowel movement: _____

Stool is: □Dry □Hard □Loose □Pebble-like □Urgent □Watery □Other_____

## Head & Neck

Headaches (where)_____ How often: _____

Triggers: _____

□Dizziness □Vertigo □Blurred vision □Eye pain □Floaters □Memory loss

□Poor coordination □Seizures □Tingling □Numbness □Tremors (where)_____

## Temperature

□Feel cold easily □Cold feet (time of day) _____ □Cold hands(time of day)_____

□Chills □Feel hot easily □Hot flashes (time of day) _____

□Burning sensation in □palms □feet □chest

## Sweating

□Sweat easily without much activity □Hardly ever sweat □Night sweat □Profuse sweating

□Sweating of hands and feet

## Ear/Nose/Throat/Mouth

□Sinus congestion □Runny nose □Sneezing □Frequent colds □Sore throat □Infections

□Nose bleeds □Ringing in the ears: (sound) □Low □High □Blocked ear □Ear pain

□Loss of hearing □Bleeding Gums □Grinding teeth

## Chest/Respiration

□Shortness of Breath □Wheezing □Dry cough: □Day □Night □Persistent

□Productive cough: (phlegm) □Thin □Thick Color:_____

□Chest pain □Rib-side pain □Palpitations

## Urination

□Frequent urination: □Day □Night □Burning urination □Blood in the urine □Difficult urination

□Dribbling □Urgent □Incontinence □Frequent urinary tract infections

## Emotions

□Nervous □Depressed □Anxious □Easily angered □Easily irritated □Moody □Manic

□Crying easily □Fearful □Grieving □Other _____

## Lifestyle

Do you: □Smoke Tobacco □Smoke Marijuana

□Drink coffee (cups/day): _____ □Tea (cups/day): _____ □Drink alcohol (servings/day): _____

□Exercise (type/frequency):

## Male Health

□testicular pain □difficulty forming erection □difficulty sustaining erection

□difficult starting urination □low libido □prostate cancer □STD/STI

## Female Health

Currently pregnant: □Yes □No □Unsure history of STD/STI: □Yes □No

Date of last menstrual period_____ Menses lasts _____days

How many days between first date of this cycle and last cycle _____

Color: □Pale red □Bright red □Dark □Brown Consistency: □Thick □Watery

Clotting: □Yes □No □Cramps (better with) □Heat □Exercise □Rest

□Breast tenderness □Acne □Mood changes □Food cravings □Bearing down sensation

□Low Back pain □Spotting between periods

□Menopause □Hot flashes □Vaginal dryness Libido: □Low □High □Normal

If you have been pregnant in the past:

Pregnancies: ____,_____ (#, most recent year)

Miscarriages: ____,_____ (#, most recent date) How far along were you? _____ weeks

Abortions: ____,_____ (#, most recent date) □Medical □Personal □Decline to state

### Please only fill this part out if trying to conceive:

I last used birth control □Never □On this date _____ □What kind? _____

I have been 'trying' for _____ years/months

Rounds of attempted IUI _____ when? _____

Rounds of attempted IVF _____ do you have embryos already frozen? _____ #? _____

Do you track your ovulation? □Yes □No What day of your cycle do you ovulate on? _____

Any known fertility or OB/Gyn history of your mother or sisters?

Has your partner had their sperm checked? □Yes, findings_____ □No □Using donor sperm