Calandra
ACUPUNCTURE

New Patient Intake Form

Personal Information

Name _____Date_____

Address_____City_____State_____Zip_____

Occupation_____ Referred by _____

I prefer to be contacted by: Phone (_____)_____ Email_____

Marital Status: Married Single Divorced Widowed Partnered Number of children_____

Sex: Male Female Trans MTF FTM Weight_____ Height _____ Birthdate_____ Age_____

Emergency Contact: _____Relation _____Phone_____

Have you received acupuncture therapy before? Y N With whom? _____When_____

There are times when it is necessary for there to be communication between your acupuncturist and physician in order to discuss the best treatment and method of care. It is important that patient, physician, and acupuncturist work together. Physicians will not be contacted without written signature and consent.

Who is your primary care physician? _____ Phone_____

Are you under the care of any other doctors? Who? Contact info

Name_____ Phone_____

Name_____Phone_____

May I contact your physicians on your behalf? Y N Singature_____Date_____

I agree to administer payment at the time of treatment in the form of cash or check Y N Initials _____

I have received a copy of, read, reviewed, understand and agree to the 24 hour cancellation policy Initials_____

Signature _____ Date_____

Calandra
ACUPUNCTURE

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	relative	Approx. Date	Illness	You	relative	Approx. Date
Diabetes	☐	☐	_____	Heart Disease	☐	☐	_____ _
Asthma	☐	☐	_____	Lung Disease	☐	☐	_____
Cancer	☐	☐	_____	Arthritis	☐	☐	_____
Emotional Disorder	☐	☐	_____	Allergies	☐	☐	_____
Hepatitis	☐	☐	_____	High Blood Pressure	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Infectious Disease	☐	☐	_____
Seizures	☐	☐	_____				

Childhood diseases/ yr: ☐ Measles ☐ Mumps ☐ Chicken Pox

Sexually Transmitted Disease: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes Date _____

Check the Box if any of the following statements are true:

☐ I have a pacemaker/ joint replacements _____ ☐ I am taking Coumadin/Warfarin

☐ I have a stent or shunt Where _____ ☐ I am taking Lithium (Eskalith, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount		Yes	No	Amount
Coffee/black tea	☐	☐	_____	Tobacco	☐	☐	_____	Water Intake	☐	☐	_____
Non-medical/drugs	☐	☐	_____	Alcohol	☐	☐	_____	Soda	☐	☐	_____

Please list all medication, vitamins, supplements and over the counter drugs.

_____ Dose_____ Prescribed by_____Date_____

_____ Dose_____ Prescribed by_____Date_____

_____ Dose_____ Prescribed by_____Date_____

_____ Dose_____ Prescribed by_____Date_____

_____ Dose_____ Prescribed by_____Date_____

What are the main health problems for which you are seeking treatment?

_____

_____

What other forms of treatment have you sought?

_____

_____

_____

List any other health problems you now have.

_____

_____

_____

List any known allergies, food sensitivities or food craving that you have.

_____

_____

_____

List any accidents, surgeries or hospitalizations (include date).

_____

_____

_____

Lab results: (please include copies)

_____

_____

Clinical Notes

To be completed by practitioner

Calandra
ACUPUNCTURE

OB/ Gyn History

Age of 1st period (menarche)_____ Are you pregnant? Yes N # of pregnancies_____

Age of last period (menopause)_____# of live births_____# of abortions _____ # miscarriages _____

Date of last: Gynecologic exam _____Pap smear_____Mammogram _____ Bone density scan _____

Results_____

Number of days between periods _____ Number of days of flow _____ Color of flow_____

Clots? Yes No Color_____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ +days _____

Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID PCOS
Other_____

Location of pain: Low abdomen Lower back Thighs Other _____

Nature of pain (please indicate before, during or after menses) Other symptoms related to menses:

Cramping _____ Stabbing _____ Discharge Vaginal dryness Headache

Burning _____ Aching _____ Nausea Constipation Diarrhea

Dull _____ Bloating _____ Swollen breasts Mood swings Ravenous appetite

Consistent _____ Intermittent_____ Poor Hot flashes Night sweats

Bearing down sensation_____ Increased libido Decreased libido Insomnia

Calandra
ACUPUNCTURE

Urogenital History

Date of last prostate check up _____ PSA results _____ Manual prostate exam results_____

Lab results_____

Frequency of urination: Daytime _____ nighttime _____ Color of urine: ☐ clear ☐ murky odor:_____

Symptoms related to prostate

☐ prostate problems ☐ delayed stream ☐ post void dribbling ☐ incontinence ☐ retention of urine

☐ erectile dysfunction (ED) ☐ increased libido ☐ decreased libido ☐ premature ejaculation ☐ impotence

☐ back pain ☐ groin pain ☐ testicular pain ☐ decreased force of stream ☐ BPH/ enlarged prostate

☐ other_____

Calandra
ACUPUNCTURE

Symptom Survey

Please "check" the symptoms or conditions you experience <u>frequently</u>

__ excessive appetite
__ loose stool/diarrhea
__ digestive problems, indigestion
__ vomiting
__ belching, burping
__ heartburn/reflux
__ stomach bloating
__ obsession in work, relationships, etc.
__ lack of appetite

__ insomnia
__ palpitations
__ cold hands and feet
__ nightmares
__ mentally restless
__ laughing for no reason
__ chest pains
__ poor memory
__ sadness

__ cough
__ shortness of breath
__ decreased sense of smell
__ nasal problems
__ skin problems
__ claustrophobia
__ colitis/diverticulitis
__ constipation
__ blood in stool
__ hemorrhoids
__ recent use of antibiotics

__ low back pain
__ knee problems
__ hearing impairment
__ ear ringing
__ kidney stones
__ decreased sex drive
__ hair loss
__ urinary problems
__easily bruised
__ dental problems
__ nighttime urination

__ eye problems
__ jaundice
__ difficulty digesting oily foods
__ gall stones
__ light-colored stool
__ soft or brittle nails
__ easily angered
__ difficulty in making decisions
__ high cholesterol
__ bitter taste

__ fatigue __edema __asthma __allergies __dizziness __ get sick easily __headaches

__ I usually feel warm __ I usually feel chilled