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 Signature____________________________Date________

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

I would like to be updated on news, events, & classes for Calandra Acupuncture and Miessence Initials ________

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

Signature ____ Date________________________________

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

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 ______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

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____

Symptom Survey

Please “check” the symptoms or conditions you experience frequently

__ excessive appetite	__ insomnia	__ cough	__ low back pain	__ eye problems
__ loose stool/diarrhea	__ palpitations	__ shortness of breath	__ knee problems	__ jaundice
__ digestive problems, indigestion	__ cold hands and feet	__ decreased sense of smell	__ hearing impairment	__ difficulty digesting oily foods
__ vomiting	__ nightmares	__ nasal problems	__ ear ringing	__ gall stones
__ belching, burping	__ mentally restless	__ skin problems	__ kidney stones	__ light-colored stool
__ heartburn/reflux	__ laughing for no reason	__ claustrophobia	__ decreased sex drive	__ soft/brittle nails
__ stomach bloating	__ chest pains	__ colitis/diverticulitis	__ hair loss	__ easily angered
__ obsession in work, relationships, etc.	__ poor memory	__ constipation	__ urinary problems	__ difficulty in making decisions
		__ blood in stool	__easily bruised	
__ lack of appetite	__ sadness			
		__ hemorrhoids	__ dental problems	__ high cholesterol
		__ recent use of antibiotics	__ nighttime urination	__ bitter taste

__ fatigue __edema __asthma __allergies __dizziness __ get sick easily __headaches

__ I usually feel warm __ I usually feel chilled