

# Harlem Village Community Acupuncture & Healing Center

*"rooted in the Spirit & Soul"*

Date: \_\_\_\_\_

New Patient Intake Form  
ALL RECORDS ARE KEPT CONFIDENTIAL

## Personal Information

Name: \_\_\_\_\_ Sex: M / F / Trans \_\_\_ MTF \_\_\_ FTM

Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Birth Place & Time: \_\_\_\_\_

Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell#: \_\_\_\_\_

E-mail: \_\_\_\_\_ Preferred Contact: Home# / Work# / Cell# / E-mail (circle one)

Emergency Contact (Name & Phone#): \_\_\_\_\_

Primary Care Physician (Name & Phone#): \_\_\_\_\_

List other Health Care Practitioners treating you & for what: \_\_\_\_\_

Have you received acupuncture before? Y / N If yes, where, when, & for what: \_\_\_\_\_

Have you received qigong therapy, essential oil therapy, tuina (Chinese massage), Chinese herbs, Chinese dietary therapy, or any other alternative therapy before? Yes / No

If yes, which modality: \_\_\_\_\_

Have you received any form of body work before? If yes, what type? \_\_\_\_\_

## Medical History

Please check if you or a blood relative currently has or have experience any of the following:

Illness	You	Blood Relative
Diabetes Mellitus		
AIDS/HIV		
Herpes (oral/genital)		
HPV		
Gonorrhea		
Syphilis		
Chlamydia		
Depression		
Stress		
Anxiety		
High Blood Pressure		
High Cholesterol		
Ulcers		

Illness	You	Blood Relative
Stroke		
Chest Pain		
Heart Disease		
Cancer		
Tuberculosis		
Glaucoma		
Cancer		
Hepatitis B or C		
Seizures		
Thyroid Hypo or Hyper		
Asthma		
Rheumatic Fever		
Infectious Diseases		

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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Please list any other medical issue you or your blood relative has had that wasn't listed.

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Please list all medications you are currently taking including name, dosage, & duration.

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Do you have a pacemaker? Y / N                      Do you have any metal parts in your body? Y / N

Are you taking Coumadin, Warfarin, or any other anticoagulant? Y / N

Are you taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)? Y / N

## Women - Gynecology

Age of first period (menarche) \_\_\_\_\_ Age of last period (menopause) \_\_\_\_\_

Number of days between periods \_\_\_\_\_ Number of days of flow \_\_\_\_\_

Color of flow \_\_\_\_\_ Clots? Y / N      Color \_\_\_\_\_ Size \_\_\_\_\_

Discharge? Y / N      When \_\_\_\_\_      Color \_\_\_\_\_      Odor? Y / N      Texture \_\_\_\_\_

Are you pregnant? Y / N      # of live births \_\_\_\_\_      # of abortions \_\_\_\_\_      # of miscarriages \_\_\_\_\_

Date of last Gyno exam \_\_\_\_\_      Pap Smear \_\_\_\_\_      Mammogram \_\_\_\_\_      Bone density scan \_\_\_\_\_

Results of exams: \_\_\_\_\_

Please check any other symptoms that you experience related to your menses.

(Indicate when you experience it; 'B' for before, 'D' for during, or 'A' for after your menses)

Lower back pain \_\_\_\_\_      Vaginal dryness \_\_\_\_\_      Hot flashes \_\_\_\_\_

Decreased

Bloating \_\_\_\_\_      libido \_\_\_\_\_      Mood swings \_\_\_\_\_

Swollen

Nausea \_\_\_\_\_      Increased libido \_\_\_\_\_      breasts \_\_\_\_\_

Poor appetite \_\_\_\_\_      Cramping \_\_\_\_\_      Headache \_\_\_\_\_

Increased

appetite \_\_\_\_\_      Constipation \_\_\_\_\_      Night sweats \_\_\_\_\_

Food cravings \_\_\_\_\_      Diarrhea \_\_\_\_\_      Insomnia \_\_\_\_\_

Method of contraception \_\_\_\_\_      History of sexual abuse? Y / N

Name: \_\_\_\_\_      Date: \_\_\_\_\_

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Do you have any issues w/ sexual intercourse? Y / N \_\_\_\_\_

## Men

Date of last prostate exam \_\_\_\_\_ Results \_\_\_\_\_

Urinary frequency: Day \_\_\_\_\_ Night \_\_\_\_\_ Color: clear / yellow / murky / bloody

Masturbation /day \_\_\_\_\_ Sex w/ ejaculation/week \_\_\_\_\_ History of sexual abuse? Y / N

Do you have any issues w/ sexual intercourse? Y / N \_\_\_\_\_

Do you experience any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Delayed stream     | <input type="checkbox"/> Impotence                       | <input type="checkbox"/> Groin pain         |
| <input type="checkbox"/> Weak stream        | <input type="checkbox"/> Decreased libido                | <input type="checkbox"/> Back pain          |
| <input type="checkbox"/> Dribbling          | <input type="checkbox"/> Increased libido                | <input type="checkbox"/> Rectal dysfunction |
| <input type="checkbox"/> Incontinence       | <input type="checkbox"/> Premature ejaculation           | <input type="checkbox"/> Genital itching    |
| <input type="checkbox"/> Retention of urine | <input type="checkbox"/> Difficulty maintaining erection | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Prostate issues    | <input type="checkbox"/> Testicular pain                 | _____                                       |

## General Symptoms

Please mark the symptoms that you experience. (✓) = sometimes experience. (+) = often experience.

- |                                 |                                  |                                  |
|---------------------------------|----------------------------------|----------------------------------|
| ____ Lack of appetite           | ____ Insomnia                    | ____ Facial pain                 |
| ____ Excessive appetite         | ____ Nightmares/vivid dreams     | ____ Abdominal pain              |
| ____ Weight loss/gain           | ____ Wakes @ night; time _____   | ____ Sciatica                    |
| ____ Loose stools/diarrhea      | ____ Difficulty waking           | ____ Headaches                   |
| ____ Constipation               | ____ Heart palpitations          | ____ Limb pain; where _____      |
| ____ Digestive problems         | ____ Shortness of breath         | ____ Back pain; where _____      |
| ____ Vomiting                   | ____ Chest pains                 | ____ Knee problems               |
| ____ Difficulty swallowing      | ____ High cholesterol            | ____ Pain/cold in genital area   |
| ____ Belching/burping           | ____ High/low blood pressure     | ____ Cold hands & feet           |
| ____ Gas/flatulence             | ____ Tendency to faint easily    | ____ Skin problems               |
| ____ Heart burn/acid reflux     | ____ Fatigue                     | ____ Jaundice                    |
| ____ Food retention/bloating    | ____ Easily bruised              | ____ Gall stones                 |
| ____ Diff. digesting oily foods | ____ Catch colds easily          | ____ Kidney stones               |
| ____ Blood in stool             | ____ Sensitive to weather change | ____ Urinary problems            |
| ____ Black tarry stool          | ____ Persistent cough            | ____ Edema                       |
| ____ Hemorrhoids                | ____ Bronchitis                  | ____ Yeast infections or UTI's   |
| ____ Colitis/diverticulitis     | ____ Asthma                      | ____ Gout                        |
| ____ Foul breath/halitosis      | ____ Allergies/hay fever         | ____ Tend to become obsessive    |
| ____ Gum/teeth problems         | ____ Recent use of antibiotics   | ____ Mentally restless           |
| ____ Hearing impairment         | ____ Muscle twitches/spasms      | ____ Laughing for no reason      |
| ____ Ringing in the ears        | ____ Dizziness                   | ____ Difficulty making decisions |
| ____ Eye issues                 | ____ Excessive hair loss         | ____ Easily angered/agitated     |
| ____ Near/far sighted           | ____ Scalp/hair issues           | ____ Very anxious/nervous        |
| ____ Soft or brittle nails      | ____ Decreased sex drive         | ____ Prone to depression         |

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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List any accidents, surgeries, traumas, or hospitalizations including event & date.

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## Life Style

Do/did you smoke? \_\_\_cigarettes \_\_\_pipe \_\_\_cigars \_\_\_marijuana \_\_\_other\_\_\_\_\_

How many years\_\_\_\_\_ How much\_\_\_\_\_ Month/years quit\_\_\_\_\_

Do you drink alcohol? Y / N Do you use street drugs? Y / N Do you take unprescribed medications? Y / N Do you use unregulated substances, i.e. sniff glue etc.? Y / N

Please indicate what type, how much, and how often\_\_\_\_\_

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Do you drink coffee? Y / N tea? Y / N What kind\_\_\_\_\_ How many cups/day?\_\_\_\_\_

Do you drink plain water (w/ no substances added)? Y / N How many cups/day?\_\_\_\_\_

Do you exercise? Y / N Type\_\_\_\_\_ Frequency\_\_\_\_\_

# hours of sleep/night\_\_\_\_\_ Time you go to bed\_\_\_\_\_ Time you wake up\_\_\_\_\_

Describe your typical diet.

Breakfast\_\_\_\_\_

Lunch\_\_\_\_\_

Dinner\_\_\_\_\_

Dietary restrictions and/or allergies \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Food cravings\_\_\_\_\_

Supplements/vitamins\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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How do you feel about these areas of your life:

	Great	Good	Fair	Poor	Bad	Comments
Significant other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Childhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Chief Complaint

What is your chief complaint(s)? (reason for visit) Please be detailed. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all previous or current treatments for this condition, including medication. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any additional information that was not asked on this form that you feel is important.

\_\_\_\_\_

\_\_\_\_\_

Sign indicating that you, the patient have completed this form to the best of your knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_