



Marian Blum
ACUPUNCTURE

NEW CLIENT INTAKE

Name _____ Today's Date _____ Birthdate _____

Street address (incl. zip) _____

Mailing address, if different _____

PHONES: Home _____ Work _____ Cell _____

Email _____

Occupation _____ Employer _____ phone _____

Workplace address _____

If you are married/partnered, spouse's name _____ day phone _____

Her/his employer and address _____

Your primary care physician (MD, DO, ND) _____ phone _____

List other health practitioners you see and what you see them for _____

Medicines, including herbs and vitamins you currently take (use back if needed)	for what reason	dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The main reason for your visit today is _____

Did your symptoms begin while at work or because of work? Y N

List surgeries, major injuries or traumas with year of occurrence _____

Women before menopause: are you using contraception? Y N Are you nursing? Y N

Do you have any concerns about receiving acupuncture treatment? Y N

Please check any symptoms that apply to you by writing a "C" for current symptoms and a "P" for past.

HEAD
 Headaches _____
 Loss of memory _____
 Dizziness _____
 Fainting _____
 Itchy eyes _____
 Nose or sinus condition _____
 Nosebleeds _____
 Loss of hearing _____

Ringing in ears _____
 Loss of taste or smell _____
 Facial paralysis _____
 Lip or mouth sores _____
 Sore or dry throat _____

CHEST
 Palpitations _____
 Cough _____

Shortness of breath _____
 Pain or constriction in chest _____
 Sighing a lot _____

MUSCULOSKELETAL
 Joints _____ which? _____
 Neck _____
 Shoulder R L
 Arm R L

Hand R L
Upper or Mid Back ____
Low Back, hips or pelvis ____
Legs R L
Feet R L

DIGESTION

Bloating ____
Nausea or vomiting ____
Excessive gas ____
Constipation ____
Diarrhea ____
Hemorrhoids or fissure ____
Blood or mucus from rectum ____
Black stools ____

UROGENITAL

Pain with urination ____
Urinary difficulty ____
Inability to hold urine ____
Blood in urine ____
Kidney condition ____
Hernia ____
Sexually transmitted disease ____

Sexual difficulties ____
Lack of libido ____

GENERAL

Sweating at night ____
Sweating too easily ____
Fatigue ____
Insomnia ____
Loss or gain of weight ____
Skin condition ____
Hair loss ____
Blood clots ____
Bleeding tendency ____
Bruise easily ____

EMOTIONAL

Irritability or frustration ____
Anger ____
Anxious or nervous ____
Sadness ____
Worry or over-thinking ____
Lack of emotion ____
Other _____

FOR WOMEN ONLY

Do you menstruate? ____
1st day of last period ____/____/____
Pain associated with period ____
PMS ____
Other symptoms associated with period _____
Irregular periods ____
Excessive bleeding ____
Last PAP smear ____/____/____
Abnormal PAP smear ____
when? ____
pregnancies ____ births ____
Hot flashes ____
Vaginal dryness ____
Discomfort of breasts ____
Lumps in breasts ____

FOR MEN ONLY

Prostate condition ____
Last prostate exam ____/____/____

Circle "me" if a condition applies to you now or in the past. Circle "F" if there's a family history.

I have allergies to _____

Asthma me F
Autoimmune disease me
Which? _____
History of cancer of
Me _____
F _____

High cholesterol me F
Diabetes me F
Epilepsy or seizures me F
Fainting me
Heart disease me F
Hepatitis B or C
High blood pressure me F
Joint replacement _____

Osteoporosis me F
Pacemaker me F
Periodontal disease me F
Stroke me F
Tuberculosis me
Bleeding disorder me F
Other Chronic condition _____

LIFESTYLE AND DIET

Aerobic exercise
_____hrs/week
Strength-building exercise
_____hrs/week
Meditation, guided imagery
or prayer _____/week
Yoga, taiji or other medita-
tive movement ____/week
Sitting _____hrs/week

Work stress (1-10) _____
General stress (1-10) _____
Occupational hazards _____
Exposure to toxics _____
Alcohol _____serv/week
Tobacco _____/week
Coffee _____serv/week
Soft drinks _____serv/week
Red meat _____serv/week

Chicken _____serv/week
Fish _____serv/week
Dairy _____serv/week
Eggs _____serv/week
Whole grains
_____serv/week
Beans _____serv/week
Fruits _____serv/week
Vegetables ____serv/week

On a Scale of 1-10 How interested are you in guidance on lifestyle changes that may benefit your health? _____ (1 - not at all interested, 10 - very interested)

The information I have supplied on this form is complete and accurate to the best of my knowledge.

Patient's signature (parent, if patient is a minor)

date