New Patient Information Form

Patient Name ____
Last First

Contact Info

Address	City	State	Zip
Cell phone	Home phone	Work phone	(circle contact preference)
Email			
DOB	Age	Height	Weight
Sex: M F	Marital Status: S M W		
Occupation			
Emergency Contact:	Name	Phone	
How did you hear about Tap Into Acupuncture?			

Do any of the following pertain to you:

___hepatitis ___HIV ___high blood pressure ___seizures ___pacemaker

___blood thinning medications _____pregnancy ____none of the above

Health Concerns:

Indicate your top 3 health concerns and how long you have been experiencing them:

Health Concern How Long

1. ____
2. ____
3. ____

What other forms of treatment have you tried? ______________________________

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Prescription Medications		
Medication	***Reason***	***How long***

Vitamins, supplements and over the counter		
Medication	***Reason***	***How long***

Surgeries and hospitalizations		
Procedure	***Reason***	***Date***

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Do you experience any of the following:								
Earth	**now**	**past**	***Wood***	**now**	**past**	***Fire***	**now**	**Past**
Excessive appetite			Jaundice			Insomnia		
Diarrhea			Acid reflux/ heartburn			Heart palpitations		
Digestive problems			Gallstones			Chest pain		
Gas / bloating			Ringing in ears			Poor memory		
Lack of appetite			Brittle hair or nails					
Fatigue			High cholesterol					
Sweets cravings			Easily frustrated/ angered					
Hemorrhoids			Depression					
Low blood pressure			Difficulty making decisions					
Worry thoughts								
Metal	**now**	**past**	***Water***	**now**	**past**	***Blood & Dampness***	**now**	**Past**
Cough			Low back pain			Arthritis		
Shortness of Breath			Knee pain			Nausea		
Decreased sense of smell			Hearing impairment			Sluggishness		
Diverticulitis			Hair loss			Dark circles under eyes		
Constipation			Urinary problems					
Grief								
Claustrophobia								

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For Women	
Date of last menstrual cycle ___________ Age of first menstrual cycle ___________ How long is your cycle __________ How many days does your period last _______ Number of pregnancies _______ Miscarriages ______ Abortion __________	Are your cycles: ☐ regular ☐ irregular Is your menstrual flow: ☐ heavy ☐ normal ☐ light
Do you experience any of these during period: ☐ Low back pain ☐ Blood clots ☐ Nausea ☐ Bloating ☐ Diarrhea ☐ Constipation	☐ Insomnia ☐ Moodiness ☐ Fatigue ☐ Breast pain or soreness ☐ Headache ☐ Increased appetite ☐ Decreased appetite
Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic breasts ☐ Endometriosis	☐ Ovarian cysts ☐ Polycystic ovary syndrome ☐ Pelvic inflammatory disorder
Do you experience: ☐ Vaginal dryness ☐ Profuse vaginal discharge	☐ Yeast infections ☐ Urinary tract infections
Menopause	
Date of last period ________________	
Do you experience any of the following: ☐ Hot flashes ___day ___night _____both ☐ Sleep disturbances	☐ Moodiness ☐ Vaginal Dryness

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Lifestyle	
Type of diet ☐ Vegetarian ☐ Standard American diet ☐ Gluten free	☐ Vegan ☐ Raw ☐ Other ________________
How many hours of sleep each night ________	From when to when _____________________
Do you experience: ☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Interrupted sleep	☐ Nightmares ☐ Vivid dreams ☐ Wake up not well rested/groggy
How many bowel movements per day ______	per week _______
Are your bowl movements: ☐ Well formed ☐ Loose	☐ Easy to pass ☐ Difficult to pass
Rate your energy level scale 1-10 ________	Rate your stress level scale 1-10 ________
I usually feel: ☐ Hot ☐ Cold	What temp do you prefer your drinks: ☐ Warm ☐ Room temp ☐ Cold
Do you have any emotional difficulties: ☐ Anxiety ☐ Panic attacks	☐ Depression ☐ Mood swings

____

Patient Signature Date

____

Joan Spitz, L.Ac. Date