Masters Acupuncture

504 1st Avenue West Columbia Falls, MT 59912
406-212-8364 mastersacupuncturepllc.com

New Patient Intake Form

Today's Date _____

Name_____ Date of Birth _____ Age _____
Address _____
City_____ State _____ Zip Code _____
Home Phone_____ Work_____ Cell_____
Email Address _____
Emergency Contact _____ Phone _____
Reason For Visit today _____
Have you had acupuncture before? Yes_____ No_____ Chinese Herbal Medicine? Yes_____ No _____
How long have you had this condition? _____ Is it getting worse _____
Does it bother your Sleep _____ Work _____ Other (specify) _____
What seems to be the initial cause? _____
What seems to make it better?_____
What seems to make it worse?_____
Are you under the care of a physician? Yes_____ No _____ If yes, for what? _____
Physician's name _____Physician's Phone _____
Other concurrent therapies _____

Family Medical History

☐ Allergies (List) _____ _____
☐ Arteriosclerosis
☐ Asthma
☐ Alcoholism
☐ Cancer (type) _____
☐ Depression
☐ Diabetes
☐ Heart disease
☐ High blood pressure
☐ Seizures
☐ Stroke

Your Past Medical History

(Check any of the following conditions yon currently have, or have had in the past. Please also check if yon feel any of the following are a significant part of your medical history.)

☐ AIDs/HIV
☐ Alcoholism
☐ Allergies
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Birth trauma(your own birth)
☐ Cancer
☐ Chicken pox
☐ Diabetes (Type:_____)
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart disease
☐ Hepatitis (Type:_____)
☐ Herpes (Type:_____)
☐ High blood pressure
☐ Measles
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker(Date:_____)
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever D Scarlet
☐ fever
☐ Seizures
☐ Stroke
☐ Surgery (list) _____ _____
☐ Thyroid disorders
☐ Major trauma
☐ (Car, fall, etc--list) _____ _____ _____
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal disease
☐ Whooping cough
☐ Other (Specify) _____ _____ _____ _____ _____ _____

Your Lifestyle

☐ Alcohol ☐ Marijuana ☐ Stress ☐ Regular Exercise
☐ Tobacco ☐ Drugs ☐ Occupational hazards Type_____ Frequency _____
Type_____ Frequency _____

General Symptoms

☐ Poor appetite
☐ Heavy appetite
☐ Strongly like cold drinks
☐ Strongly like hot drinks
☐ Recent weight loss/gain
☐ Peculiar taste
☐ Poor sleep
☐ Heavy sleep
☐ Dream-disturbed sleep
☐ Fatigue
☐ Lack of strength
☐ Bleed or bruise easily
☐ Bodily heaviness
☐ Cold hands or feet
☐ Poor circulation
☐ Shortness of breath
☐ Fever
☐ Chills
☐ Night sweats
☐ Sweat easily
☐ Muscle cramps
☐ Vertigo or dizziness

Head, Eyes, Ears, Nose, Throat

☐ Glasses
☐ Eye strain
☐ Eye pain
☐ Red eyes
☐ Itchy eyes
☐ Spots in eyes
☐ Poor vision
☐ Blurred vision
☐ Night blindness
☐ Myopia or Presbopia
☐ Glaucoma
☐ Cataracts
☐ Teeth problems
☐ Grinding teeth
☐ TMJ
☐ Facial pain
☐ Recurrent sore throat
☐ Swollen glands
☐ Lumps in throat
☐ Enlarged thyroid
☐ Nosebleeds
☐ Ringing in ears (High or Low?)
☐ Poor hearing
☐ Earaches
☐ Gum problems
☐ Sores on lips or
☐ tongue Drymouth
☐ Excessive saliva
☐ Sinus problems
☐ Excessive phlegm
☐ Headaches
☐ Migraines
☐ Concussions
☐ Other back or neck problems
_____
_____
_____
_____

Respiratory

☐ Difficulty breathing when lying down
☐ Shortness of breath
☐ Tight chest
☐ Asthma/wheezing
☐ Difficult inhalation? exhalation?
☐ Cough, Wet orDry?_____
☐ Thick or thin?_____
☐ Coughing up blood
☐ Pneumonia

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Tachycardia ☐ Phlebitis
☐ Blood clots ☐ Fainting ☐ Difficulty breathing ☐ Heart palpitations ☐ Irregular heartbeat

Gastrointestinal

☐ Nausea
☐ Vomiting
☐ Acid regurgitation
☐ Gas
☐ Hiccup
☐ Bloating
☐ Bad breath
☐ Diarrhea
☐ Constipation
☐ Black stools
☐ Bloody stools
☐ Mucous in stools
☐ Hemorrhoid
☐ Itchy anus
☐ Intestinal pain or cramping
☐ Burning anus
☐ Rectal pain
☐ Anal fissures
☐ Laxative use
What kind?_____
How often?_____

Bowel movements:
Frequency _____
Color _____
Texture/form _____
Odor_____

Musculoskeletal

☐ Neck/shoulder pain
☐ Muscle pain
☐ Upper back pain
☐ Low back pain
☐ Joint pain
☐ Rib pain
☐ Limited range of motion
☐ Limited use
☐ Other (Describe)
_____
_____

Skin and Hair

☐ Rashes
☐ Hives
☐ Ulcerations
☐ Eczema
☐ Psoriasis
☐ Acne
☐ Dandruff
☐ Itching
☐ Hair Loss
☐ Change in hair/skin texture
☐ Fungal infections

Other hair or skin problems
_____
_____

Neuropsychological

☐ Seizures
☐ Numbness
☐ Tics
☐ Poor memory
☐ Depression
☐ Anxiety
☐ Irritability
☐ Easily stressed
☐ Abuse survivor
☐ Cinsidered/attempted suicide
☐ Seeing a therapist
☐ Other (Specify)
_____
_____

Genitourinary

☐ Pain on urination	☐ Blood in urine	☐ Venereal disease	☐ Increased libido	☐ Impotence
☐ Frequent urination	☐ Unable to hold urine	☐ Bedwetting	☐ Decreased libido	☐ Premature ejaculation
☐ Urgent urination	☐ Incomplete urination	☐ Wake to urinate	☐ Kidney stone	☐ Nocturnal emission

Gynecology

☐ Age menses began _____	☐ Duration of flow _____	☐ Vaginal discharge (color} _____	☐ Breast lumps	Date of last PAP_____
☐ Length os cycle (day 1 to day 1) _____	☐ Irregular periods	☐ Vaginal sores	# Pregnancies _____	
	☐ Painful periods	☐ Vaginal odor	# Live births _____	
	☐ PMS	☐ Clots	# Premature births____	Start date of last period_____
			Age at menopause ____	

Other

_____

_____

_____

_____

_____

_____