Two Pines Acupuncture & Integrative Medicine
New Patient Intake Form

Full Name		Sex ☐ F ☐ M ☐ Other _____ Date	
Date of Birth	Age	Occupation	
Main Phone #		Other Phone #	
E-mail Address		Allow Email Contact by TPAIM ☐ Yes ☐ No	
Address: Street		City	State Zip
Marital Status: Single Partner Married Divorced Widowed			
Emergency Contact Name & Phone:			
Primary Care Physician			
Have you ever used acupuncture for your health care? For what reason?			
How did you find out about our clinic?			

PRIMARY REASON FOR SEEKING CARE: _____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

_____

What kind of treatment have you tried? _____

What makes this problem worse? _____

What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____

Remarks and additional information: _____

_____

SECONDARY REASON FOR SEEKING CARE: _____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

_____

What kind of treatment have you tried? _____

What makes this problem worse? _____

What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____

Remarks and additional information: _____

ANY OTHER ADDITIONAL HEALTH CONCERNS: _____

_____

CHILDHOOD ILLNESSES (Please circle any you have had):

Chicken Pox Measles Mumps Rheumatic Fever Rubella Diphtheria

IMMUNIZATIONS (Please circle any you have had):

Tetanus Hepatitis B Polio Pertussis Measles/Mumps/Rubella

Diphtheria Pneumonia Shingles Influenza Covid Other:_____

List any MEDICATIONS (prescribed and over-the-counter), VITAMINS, and SUPPLEMENTS you are currently taking (include dosage) : _____

_____

_____

List any ALLERGIES or SENSITIVITIES to drugs, medications, foods, and/or environmental (please include reaction):

_____

_____

Do you have any infectious diseases? Y N Please Identify: _____

Do you have any reason to believe you may be pregnant? Y N How far along? _____

MEDICAL HISTORY: (Please check all that apply)

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer			Seizures			Heart Disease		
Diabetes			Mental Illness			High Cholesterol		
Hepatitis			Emotional Disorder			Heart Attack		
Hyper/Hypo Thyroid Disease			Sexually Transmitted Disease			High or Low Blood Pressure (circle)		
Arthritis			Alcoholism			Pneumonia		
Gout			Depression or Anxiety			Asthma		
Digestive Disorders			HIV/AIDS			Tuberculosis		
Anemia			Breathing Disorder			Other:		

SURGERIES & HOSPITALIZATIONS:

Reason: **When:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SIGNIFICANT TRAUMAS & DATES OCCURED: (auto accidents, sports injuries, emotional, sexual, etc.)

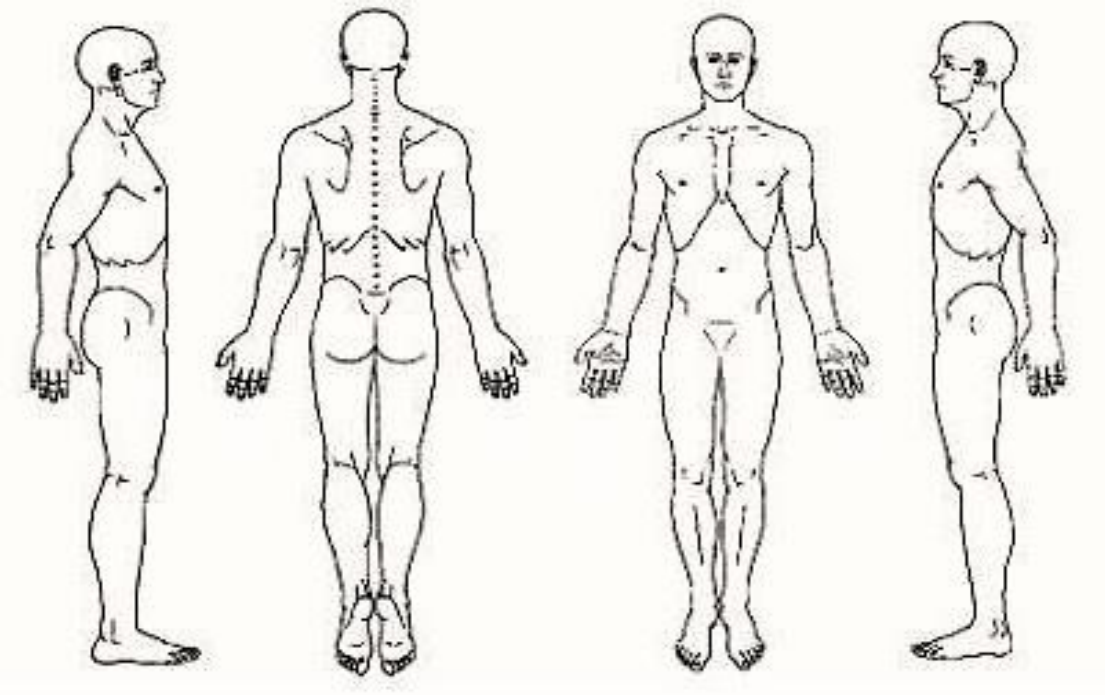
_____

_____

_____

INDICATE PAINFUL OR DISTRESSED AREAS:

Pain Key: Ache ^ ^ ^ ^ Numbness = = = = Pins & Needles 0 0 0 0 Burning X X X X Stabbing / / / /



PLEASE CHECK ALL THAT APPLY:

Pain Intensity:	☐ No Pain	☐ Moderate Pain	☐ Severe Pain	☐ Terrible Pain
Sleeping:	☐ No problem	☐ Disturbed	☐ Very Disturbed	☐ Cannot Sleep
Work (Can do):	☐ Usual Work	☐ 50% of Work	☐ 25% of Work	☐ No Work
Frequency of Pain:	☐ 25% of Time	☐ 50% of Time	☐ 75% of Time	☐ All the time
Recreation:	☐ All Activities	☐ Some Activities	☐ No Activities	
Sitting:	☐ No Pain While Sitting	☐ Some Pain While Sitting		☐ Cannot Sit
Walking:	☐ Can Walk Fine	☐ Pain after _____ Minutes		☐ Cannot Walk

Please CIRCLE if you CURRENTLY have any of the following diseases or conditions.

Please CHECK if you have had any of the following diseases or conditions in the PAST.

General: ☐ Poor appetite ☐ Poor sleep ☐ Fatigue ☐ Fevers ☐ Chills

☐ Night sweats ☐ Sweat easily ☐ Chronic Infections ☐ Cravings ☐ Change in appetite

☐ Poor balance ☐ Bruise easily ☐ Localized weakness ☐ Weight loss ☐ Weight gain

☐ Poor healing ☐ Typically feel hot ☐ Typically feel cold ☐ Bleed easily ☐ Cold hands/feet

☐ Peculiar tastes ☐ Desire hot food ☐ Desire cold food ☐ Strong thirst (cold or hot drinks)

☐ Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

Skin & hair: ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema

☐ Pimples ☐ Acne ☐ Dandruff ☐ Dry skin ☐ Recent moles ☐ Loss of hair

☐ Psoriasis ☐ Change in hair or skin texture ☐ Other _____

Musculoskeletal: ☐ Joint disorders ☐ Muscle weakness ☐ Pain/soreness in the muscles ☐ Hernia

☐ Muscle spasms ☐ Difficulty walking ☐ Swelling of hands/feet ☐ Spinal curvature ☐ Joint Pain ☐ Neck pain

☐ Muscle cramps ☐ Low back pain ☐ Mid back pain ☐ Upper back pain ☐ Ankle pain ☐ Shoulder pain

☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Other _____

Head, eyes, ears, nose, & throat: ☐ Headache ☐ Concussions ☐ Migraines ☐ Glasses/lens

☐ Eye strain ☐ Eye pain ☐ Dry eyes ☐ Night blindness ☐ Poor vision ☐ Cataracts

☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Spots in front of eyes

☐ Sinus problems ☐ Nose bleeding ☐ Sore throat ☐ Grinding teeth ☐ Teeth problems ☐ Facial pain

☐ Jaw clicks ☐ Sores on lips/tongue ☐ Difficulty swallowing ☐ Other _____

Cardiovascular: ☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Palpitation ☐ Fainting

☐ Murmur ☐ Irregular heartbeat ☐ Swelling of feet ☐ Varicose veins ☐ Other _____

Respiratory: ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty breathing

☐ Bronchitis ☐ Shortness of breath ☐ Chest pain ☐ Production of phlegm – What color? _____

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas

☐ Belching ☐ Black stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath ☐ Rectal pain

☐ Hemorrhoids ☐ Abdominal pain ☐ Heartburn ☐ Parasites ☐ Chronic laxative use

☐ Ulcers ☐ Liver disease ☐ Gallbladder problems ☐ Incontinence ☐ Abdominal cramps

Bowel movements: Frequency _____/day Color _____ Odor _____ Texture/ Form _____

Neuro-psychological: ☐ Loss of balance ☐ Lack of coordination ☐ Concussion

☐ Tremors ☐ Vertigo/Dizziness ☐ Numbness ☐ Tingling ☐ Paralysis

☐ Depression ☐ Anxiety ☐ Stress ☐ Irritable ☐ Bi-polar

☐ Mood Swings ☐ Obsessive Behavior ☐ Panic Attacks ☐ Nervousness ☐ Personality Disorder

Please CIRCLE if you CURRENTLY have any of the following diseases or conditions.

Please CHECK if you have had any of the following diseases or conditions in the PAST.

Endocrine:	☐ Hyperthyroid	☐ Hypothyroid	☐ Hypoglycemic	☐ Diabetes
Genito-urinary:	☐ Painful urination	☐ Frequent urination	☐ Blood in urine	☐ Urgency to urinate
☐ Kidney stones	☐ Unable to hold urine	☐ Dribbling	☐ Pause of flow	☐ Frequent urinary tract infection
☐ Genital pain	☐ Genital itching	☐ Genital rashes	☐ STD	☐ Other: _____
Male:	☐ Prostate problems	☐ Discharge	☐ Erectile dysfunction	☐ Ejaculation problems
	☐ Frequent seminal emission	☐ Fertility problems	☐ Painful/swollen testicles	☐ Other_____
Female:	☐ Fibroids	☐ Pelvic infection	☐ Endometriosis	☐ Vaginal/genital discharge
☐ Ovarian cysts	☐ Irregular periods	☐ Clots	☐ Breast Lumps	☐ Bleeding between cycles
☐ Pain/cramps prior/during periods		☐ Breast tenderness	☐ Hot flashes	☐ Moodiness related to periods
☐ Fertility Problems		☐ Light flow	☐ Heavy flow	☐ Frequent vaginal infections
_____ Number of pregnancies		_____ Number of births	_____ Miscarriages	_____ Abortions
_____ Premature births		_____ C-section	_____ Difficult delivery	

First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____ days

Do you practice birth control ? ☐ Yes ☐ No. If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

OCCUPATION: _____ Do you usually work ☐ indoors ☐ outdoors?

Occupational stress (chemical, physical, psychological, etc): _____

How do you feel about your work? _____

PERSONAL: Height_____ Weight now_____ Weight maximum _____Year _____

HABITS: Do you smoke? ☐ Yes ☐ No What? _____ # per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes: _____

Do you exercise regularly ☐ Yes ☐ No Please describe your exercise program: _____

_____

How many hours do you sleep in general? _____ What time do you go to bed? _____ Wake rested? Y N

Quality of sleep: _____

TV/Internet Habits & hours/day: _____

Spiritual practice: _____

DIET: How much **Water** do you drink? _____cups/day **Coffee** _____ cups/day **Tea** _____ cups/day

Soda _____cups/day

What kind of alcoholic beverages do you usually drink, if any? _____

Average number of alcoholic drinks/week? _____ Do you eat a lot of spicy food? □ Yes □ No

Do you follow a specific diet? □ Yes □ No If yes, please describe: _____

Remarks and additional information (e.g. diet) _____

Please describe your average daily diet (Please be as specific as possible):

Morning _____

Afternoon _____

Evening _____

Snacks _____

Are there any other health issues you want to discuss with us?

I have completed this form correctly to the best of my knowledge.

Signature: _____ □ Adult Patient □ Parent or Guardian □ Spouse

Date: _____