83 South Street, Suite 204, Freehold, NJ 07728 | (732)-780-6320 | www.RehabilityNJ.com

Acupuncture New Patient Intake

Patient Name: _____ **Date:** _____

Reason for visit: _____ **How long have you had this condition?** _____

What seemed to be the initial cause? _____ **Is it getting worse?** Y□ N□

What makes it better? _____ **What makes it worse?** _____

Activities or movements that are painful to perform: Sitting □ Standing □ Walking □ Bending □ Lying down □

Does it interfere with your: Work □ Sleep □ Daily routine □ Recreation □

Are there other problems you would like to address? _____

Are you pregnant? Y □ N □ **Due Date:** _____ **Exercise:** None □ Moderate □ Daily □ Heavy □

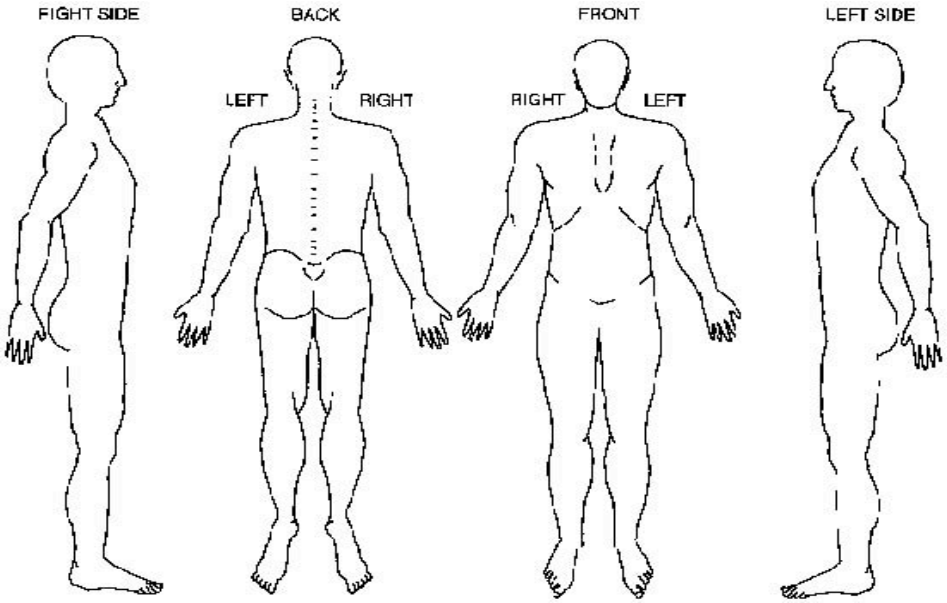
Have you had Acupuncture before? Y □ N □ **Chinese Herbal Medicine?** Y □ N □

Habits: Smoking: Packs/Day _____ Alcohol: Drinks/Week _____

Coffee/Caffeinated Drinks: Cups/Day _____ High Stress Level: Reason _____

Please complete the following diagram by using the letters below to indicate the area and type of pain you are experiencing:

P. Pain **T. Tingling** **B. Burning** **N. Numbness** **S. Stiffness**



Medications: _____ **Allergies**: _____ **Vitamins/Herbs/Minerals**: _____

_____ _____ _____

_____ _____ _____

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Please place a mark in the box to indicate if you have had any of the following:

Medical History

□ Poor appetite	□ Poor Sleep	□ Heavy appetite	□ Heavy Sleep	□ Cold hands or feet
□ Night Sweats	□ Sweat easily	□ Dream-disturbed sleep	□ Fatigue	□ Shortness of breath
□ Recent weight loss/gain	□ Lack of strength	□ Recurrent Fevers	□ Vertigo/dizziness	□ Bleed or bruise easily
□ Eye pain	□ Red eyes	□ Itchy eyes	□ Spots in eyes	□ Poor vision
□ Blurred vision	□ Recurrent sore throat	□ Grinding teeth	□ TMJ	□ Facial pain
□ Gum problems	□ Sores on lips/tongue	□ Dry mouth	□ Sinus problems	□ Nose bleeds
□ Enlarged thyroid	□ Ringing in ears	□ Earaches	□ Headaches	□ Migraines
□ Seasonal allergies	□ Asthma/wheeze	□ Pneumonia	□ Difficulty breathing while lying down	
□ Cough: Wet or Dry? _____		□ Nausea	□ Vomiting	□ Acid regurgitation
□ Gas	□ Hiccup	□ Bloating	□ Bad breath	□ Diarrhea
□ Bowel movements:	Frequency: _____	Texture/form: _____	Color: _____	Odor: _____
□ Constipation	□ Intestinal pain/cramping	□ Arthritis	□ Neck/Shoulder pain	□ Muscle tension
□ Upper back pain	□ Low back pain	□ Joint Pain	□ Limited range of motion	□ Rashes
□ Hives	□ Eczema	□ Psoriasis	□ Acne	□ Dandruff
□ Itching	□ Hair loss	□ Fungal infections	□ Seizures	□ Numbness
□ Tics	□ Poor memory	□ Anxiety	□ Depression	□ Irritability
□ Easily stressed	□ Abuse survivor	□ Seeing a therapist	□ Pain on urination	□ Frequent urination
□ Urgent urination	□ Wake to urinate	□ Increased libido	□ Decreased libido	□ Kidney Stone
□ Impotence	□ Irregular periods	□ Painful periods	□ PMS	□ Vaginal discharge
□ Vaginal sores	□ Clots	□ Breast lumps	□ Age menses began: _____	
□ Age at menopause:_____	□ Length of cycle: _____		□ Date of last period: _____	
□ #Pregnancies: _____	□ # Live births: _____		□ Date of last PAP: _____	

□ Other:_____

Family Medical History

□ Heart Disease □ Stroke □ Diabetes □ Cancer: Type: _____

□ Other:_____

Do you have any blood borne illness? □ Hepatitis □ HIV □ AIDS □ Lyme disease □ Other: _____

Please list any major surgeries, traumas, or significant hospitalizations:

_____

_____

I certify that the information provided is current and complete to the best of my knowledge.

Patient Signature: _____ Date: _____