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New Patient Information Form for All Patients
Including Cosmetic Treatments

DATE: _____

PATIENT INFORMATION

Name: _____

Gender: _____

Age: _____ Date of Birth: ___/___/_____ Social Security # _____-____-_____

Home Address: _____

Home Phone: _____Cell: Work Phone: _____

Email: _____

Emergency Contact: _____Relationship to Patient:_____

Emergency Contact Phone number: _____

Primary Care Physician (PCP): _____PCP Phone: _____

Date of last medical examination: _____

Who referred you? _____ May we thank them for the referra? Yes __ No ___

Occupation: _____

I. EXPERIENCE WITH ACUPUNCTURE, GUA SHA OR CUPPING

- Have you received Acupuncture before? YES NO
- Have you received Gua Sha before? YES NO
- Have you received Cupping before? YES NO

• If yes, for what conditions and what were the outcomes?

_____
_____

II. MEDICATIONS, SUPPLEMENTS AND HERBS

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are **CURRENTLY** taking:

Name of medication, supplement or herb	Taking this for what condition or purpose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

III. DESCRIPTION OF MAJOR COMPLAINTS

In order of priority What are your complaints?	**Complaint 1**	**Complaint 2**	**Complaint 3**
How long have you had this condition?			
Was the onset gradual or sudden?			
Was there a significant event that lead to this condition? Please answer Yes or No.			
Have you seen a physician or other primary care provider for this complaint? If yes, what diagnosis did you receive?			
Please check other therapies you receive(d) to manage each complaint? Which is helping or has helped?	**Physical Therapy ___ Chiropractic___ Massage ___ Other _____**	**Physical Therapy ___ Chiropractic___ Massage ___ Other _____**	**Physical Therapy ___ Chiropractic___ Massage ___ Other _____**
Rate the intensity of the *PHYSICAL & EMOTIONAL DISCOMFORT* associated with each complaint (None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)	**PHYSICAL _____ EMOTIONAL _____**	**PHYSICAL _____ EMOTIONAL _____**	**PHYSICAL _____ EMOTIONAL _____**
What relieves the symptoms of these complaints (e.g. heat, cold, pressure, movement, rest, etc)?	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**
What makes the symptoms of your complaint worse?	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**	**Heat _____ Cold _____ Pressure _____ Movement _____ Rest _____ Other _____**

IV. COSMETIC PROCEDURES AND PACEMAKER IMPLANTS

Do you have a pacemaker or any type of implant? Yes ____ No _____
What type and when was this implanted _____

Have you had any kind of cosmetic surgery or cosmetic implants or cosmetic injections of any substance?
Yes _____ No ____
When and in what type
_____
_____

Do you have High Blood Pressure? Yes _____ No_____ If yes, are taking medication? Yes _____ No _____

Are you taking Blood Thinning Medication? Yes_____ No_____

Do you have a Bleeding Disorder or Prolonged Bleeding Time? Yes _____ No_____

Do you bruise easily or have a history of broken facial capillaries? Yes _____ No_____

Do you have skin allergies or conditions? Yes _____ No_____

Do you have sensitive skin or redden easily? Yes _____ No_____

Is your skin excessively dry or oily? Yes _____ No_____ Is your skin thin? Yes _____ No_____

Do you have acne? Yes _____ No_____ Facial Scarring? Yes _____ No_____

Do you have rosacea? Yes _____ No_____

V. PERSONAL MEDICAL HISTORY

A. BIRTH: Describe anything significant/traumatic about your birth:
_____
_____

B. VACCINATION HISTORY: Any unusual reaction?
_____

C. ILLNESSES & SURGERIES
Any surgery, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____

AGE: _____

AGE: _____

AGE: _____

AGE: _____

AGE: _____

D. FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER_____
FATHER _____
SIBLINGS _____
MATERNAL GRANDPARENTS _____
PATERNAL GRANDPARENTS _____

E.. FOR WOMEN ONLY

(Please explain in the space provided if you have any of the following symptoms)

When was your last menses? _____

Are you perimenopausal (less than one year since your last menses Yes OR No

List any symptoms that you may be having _____

_____

Are you already in menopause or postmenopausal (more than one year since your last menses)? Yes OR No

List any symptoms that you may be having _____

_____

<u>Your menses:</u>

Menopause: Approximate date of last menses _____

Amenorrhea (absence of menstrual bleeding) _____

Irregular menstruation _____

How often do you get your menses? _____

How many days does your menses last? _____

What is the flow like (for example, scanty, moderate, starts & stops, etc.) _____

What color is the blood? _____

Are there clots? If yes, what color are they? _____

Do you have bleeding at other times during the month? _____

Do you get PMS? If so what are the symptoms

_____

Pain with menses (dysmenorrhea) Yes OR No If yes, when do you get this pain and what does it feel like?

_____

<u>Other issues:</u>

Changes in hair distribution _____

Fertility concerns _____

Bone Density Decline _____

Vitamin D Insufficiency or Deficiency _____ What was your last Vitamin D Score _____

Abnormal vaginal bleeding _____

Pain during or after sexual relations _____

Pelvic pain _____

Sexual dysfunction _____

Unusual discharge _____

Are you pregnant OR trying to become pregnant?

YES NO (Circle one)

Have you ever been pregnant? YES NO (Circle one)

If yes, how many pregnancies: _____

 # Births _____# Miscarriages _____

F. FOR MEN ONLY

Fertility concerns _____

Prostate problems _____

Sexual dysfunction _____

Unusual discharge _____

OTHER (Please list) _____

VI. LIFESTYLE

A. Do you smoke tobacco? YES NO (circle one) If yes, please describe amount and frequency of use. _____What impact do you believe smoking has on your complaints? _____

B. Do you drink alcohol? YES NO If yes, please describe how much and under what circumstances you drink. _____ What impact do you believe alcohol consumption has on your complaints? _____

C. Do you use recreational drugs and/or prescription medications that your physician does not know about? YES NO _____
What impact do you believe this has on your complaints? _____

VII. Diet & Nutrition

A . Briefly describe your eating habits and appetite, including any dietary restrictions or diet regimen. Number of meals and snacks per day?
_____
_____
_____

I have answered these questions truthfully and to the best of my knowledge.

Signature _____ Date:_____

Revised 4/29/2015