NYC Energy Medicine

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Patient Intake Form

Name _____ Date _____
(Last) (First)
Date of Birth ____/____/_____ Age ____ Place of Birth _____
Gender: F __ M __ Marital Status: Single __ Married __ Others ____

Occupation _____ Height _____ Weight _____

Address _____ _____ _____ _____
(Street) (City) (State) (Zip Code)
Tel: (Home) _____ (Work) _____ (Cell) _____

Email _____

Emergency Contact: Name _____ Phone _____

Have you received acupuncture before? Yes __ No __

If yes, When? _____ For? _____With Whom? _____

How did you hear about our clinic? _____

Main complaints: (in order of importance)

Complaints	1.	2.	3.
Medical diagnosis?			
How Long			
Causes			
Detailed Description			
What makes it better			
What makes it worse			

Other Medical History: (check the following that apply)

○Hepatitis B	○Hepatitis C	○HIV
○High blood pressure	○Low blood pressure	○Heart disease
○Epilepsy	○Anemia	○Fainting
○Venereal diseases	○Tuberculosis	○Parasites
○Cancer and what type		

Last physical Date _____ Results _____

Injury _____

Hospitalization_____

Others _____

Family history _____

Do you get chiropractic, physical therapy or massage treatment? If so, which one?

Medications & supplements you are taking currently:

Medication	Dosage	Since when	Notes

Allergies:

_____

Symptom Questionnaire: (please check all that apply):

Overall energy level 1 2 3 4 5 6 7 8 9 10 (low to high)

0=never 1=rarely 2=occasionally 3=frequently 4=always

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0 1 2 3 4 pain here or there	0 1 2 3 4 sweat easily
0 1 2 3 4 feels cold generally	0 1 2 3 4 feels hot generally
0 1 2 3 4 clear urine	0 1 2 3 4 dark yellow urine
0 1 2 3 4 poor memory	0 1 2 3 4 thirst
0 1 2 3 4 poor balance	0 1 2 3 4 hot flash
0 1 2 3 4 dizziness	0 1 2 3 4 night sweats
0 1 2 3 4 foggy thinking	0 1 2 3 4 heat in palms or soles
0 1 2 3 4 lack of coordination	0 1 2 3 4 enlarged lymph nodes

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0 1 2 3 4 rapid heart beat	0 1 2 3 4 chest pain
0 1 2 3 4 irregular heart beat	0 1 2 3 4 disturbing dreams
0 1 2 3 4 insomnia	0 1 2 3 4 restlessness
0 1 2 3 4 anxiety	0 1 2 3 4 manic
0 1 2 3 4 depression	0 1 2 3 4 sores on tip of tongue

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0 1 2 3 4 spontaneous sweat	0 1 2 3 4 allergies
0 1 2 3 4 catch cold easily	0 1 2 3 4 nasal discharge
0 1 2 3 4 shortness of breath	0 1 2 3 4 sinus congestion
0 1 2 3 4 feel worse after exercise	0 1 2 3 4 cough
0 1 2 3 4 aversion to wind/cold	0 1 2 3 4 asthma
0 1 2 3 4 general weakness	0 1 2 3 4 dry skin/nose/throat

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0 1 2 3 4 low appetite	0 1 2 3 4 ravenous appetite
0 1 2 3 4 loose stools	0 1 2 3 4 constipation
0 1 2 3 4 belching/vomiting	0 1 2 3 4 heartburn/acid reflex
0 1 2 3 4 fatigue after eating	0 1 2 3 4 dry mouth/thirst
0 1 2 3 4 abdominal bloating/gas	0 1 2 3 4 gum bleeding/swelling
0 1 2 3 4 bruise easily	0 1 2 3 4 bad breath/mouth sores

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0 1 2 3 4 chest tightness	0 1 2 3 4 anger easily
0 1 2 3 4 neck/shoulder tension	0 1 2 3 4 irritable
0 1 2 3 4 hypochondriac pain	0 1 2 3 4 headaches
0 1 2 3 4 alternating diarrhea/constipation	0 1 2 3 4 dizziness
0 1 2 3 4 symptoms worse with stress	0 1 2 3 4 ear ringing
0 1 2 3 4 poor vision	0 1 2 3 4 phlegm in throat
0 1 2 3 4 numb extremities	0 1 2 3 4 red eyes/dry eyes
0 1 2 3 4 tremor/muscle twitches	0 1 2 3 4 bitter taste

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0 1 2 3 4 weak knees	0 1 2 3 4 knee pain
0 1 2 3 4 low back pain	0 1 2 3 4 loss of hair
0 1 2 3 4 frequent urination	0 1 2 3 4 dribbling urination
0 1 2 3 4 early morning diarrhea	0 1 2 3 4 edema
0 1 2 3 4 low sex drive	0 1 2 3 4 high sex drive

Men only: (check the following that apply)

○Prostate problems ○Erectile dysfunction ○Premature ejaculation
○Frequent seminal emission ○Infertility ○Painful/swollen testicles

Women only: (check the following that apply)

○Frequent vaginal infections ○Vaginal discharge ○Endometriosis
○Fibroids ○Ovarian cysts ○Fertility problems
○Breast lumps ○Breast tenderness
○Pain/cramps prior/during periods ○Moodiness related to periods

Are you pregnant now? Yes__ No__ Have you been pregnant before? Yes__ No__
Number of live births ____ Miscarriage ____ Abortion ____
Age of first period ___ First date of last period _____Duration of periods __days, cycle __days
Do you practice birth control? Yes__ No__ If yes, what type and how long? _____

General Information:

Habits: Please check the boxes to the amount of activity listed.

	Heavy	Moderate	Light	None
Water	○	○	○	○
Alcohol	○	○	○	○
Tobacco	○	○	○	○
Coffee	○	○	○	○
Tea	○	○	○	○
Sugar	○	○	○	○
Salt	○	○	○	○
Spicy foods	○	○	○	○
Marijuana	○	○	○	○
Other drugs	○	○	○	○

Stress level: 1 2 3 4 5 6 7 8 9 10 (low to high)
Sources of stress: work family relationship others
How many hours do you sleep in general? ____ Time to sleep? _____ Time to get up_____

What do you do for relaxation? _____

What do you do for exercise? _____ How often? _____

Are you a vegetarian? Yes__ No__ Yes, but not so strict__
Please describe your average daily diet:

Morning _____

Afternoon _____

Evening _____

Snacks _____

Did you experience weight gain? How much? _____ Weight loss? _____

Any other health issues you want to discuss? _____

Signature: _____ Date: _____
○Adult patient ○Parent or guardian