KRISTIN MISIK, LAc

NEW PATIENT INTAKE FORM

NAME _____ TODAY'S DATE ____ / ____ / ____

ADDRESS _____ APT # ____ CITY, STATE, ZIP _____

PHONE (H) _____ (W) _____ (C) _____

EMAIL _____ SS# _____

☐ MALE ☐ FEMALE AGE ____ DATE OF BIRTH ____ / ____ / ____ HEIGHT ____ WEIGHT ____

INSURANCE CO _____ ID# _____

EMERGENCY CONTACT _____ PHONE _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ PARTNERED/LIVE-IN ☐ WIDOWED ☐ DIVORCED

OCCUPATION _____ EMPLOYER _____

CHIEF COMPLAINT _____

HOW LONG HAVE YOU HAD THIS CONDITION? _____

WHAT SEEMS TO BE THE INITIAL CAUSE? _____

WHAT SEEMS TO MAKE IT BETTER? _____ WORSE? _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? _____

WHO IS YOUR PHYSICIAN? _____ PHONE # _____

HAVE YOU HAD ACUPUNCTURE BEFORE? ☐ YES ☐ NO CHINESE HERBAL MEDICINE? ☐ YES ☐ NO

FAMILY MEDICAL HISTORY

	MOTHER	FATHER	SIBLING	GRANDPARENT
ALLERGIES	☐	☐	☐	☐
ARTERIOSCLEROSIS	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐
ALCOHOLISM	☐	☐	☐	☐
CANCER	☐	☐	☐	☐
TYPES _____				
DIABETES	☐	☐	☐	☐
HIGH CHOLESTEROL	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐
OBESITY	☐	☐	☐	☐
SEIZURES	☐	☐	☐	☐
STROKE	☐	☐	☐	☐

YOUR PAST MEDICAL HISTORY

☐ AIDS/HIV	☐ Diabetes	☐ Hepatitis B	☐ Pleurisy	☐ Thyroid disorder
☐ Alcoholism	☐ Emphysema	☐ Hepatitis C	☐ Pneumonia	☐ Tuberculosis
☐ Allergies	☐ Epilepsy	☐ Herpes	☐ Polio	☐ Ulcers
☐ Appendicitis	☐ Goiter	☐ High Blood Pressure	☐ Rheumatic Fever	☐ Whooping cough
☐ Arteriosclerosis	☐ Gout	☐ Lupus	☐ Scarlet Fever	
☐ Asthma	☐ Heart Disease	☐ MS	☐ Seizures	
☐ Cancer	☐ Hepatitis A	☐ Pacemaker	☐ Stroke	

Surgery (list) _____ Major Trauma (MVA, fall, etc) _____

DIET & LIFESTYLE

APPETITE ☐ good ☐ poor ☐ irregular ☐ voracious

THIRST ☐ excess ☐ moderate ☐ little #GLASSES WATER/DAY _____

PREFER DRINKS TO BE ☐ Hot ☐ Cold ☐ room temp

☐ COFFEE ☐ TEA ☐ SODA ☐ SALT FOOD ☐ SWEETS/CANDY

☐ PACKAGE FOODS ☐ ARTIFICIAL SWEETENER ☐ ALCOHOLIC DRINKS/ WEEK _____

☐ MARIJUANA ☐ DRUGS (NON RX)

☐ SMOKE CIGARETTES HOW MANY YEARS? _____ PACKS/WEEK _____

PHARMACEUTICALS TAKEN IN THE PAST 2 MONTHS: _____

VITAMINS/SUPPLEMENTS TAKEN IN THE PAST 2 MONTHS: _____

☐ REGULAR EXERCISE HOW MANY TIMES/WEEK? _____ HOW LONG? _____ (MINUTES)

☐ CARDIO ☐ STRENGTH ☐ YOGA ☐ PILATES

FOR THE FOLLOWING SYMPTOMS, CHECK BOX IF YOU REGULARLY EXPERIENCE THEM:

GENERAL SYMPTOMS

☐ difficulty falling asleep	☐ awakening too early	☐ lack of strength	☐ chills	☐ muscle cramps
☐ restless sleep	☐ awakening un-rested	☐ poor circulation	☐ hot flashes	☐ vertigo/dizziness
☐ dream-disturbed sleep	☐ night sweats	☐ bodily heaviness	☐ bleed/bruise easily	☐ cold hands/feet
☐ awakening in the night	☐ poor energy	☐ sweat easily		

HEAD, EYES, EARS, NOSE, THROAT

☐ headaches	☐ spots in vision	☐ teeth problems	☐ dry mouth	☐ nose bleeds
☐ migraines	☐ poor vision	☐ grinding teeth	☐ excessive saliva	☐ difficulty hearing
☐ eye strain	☐ blurry vision	☐ gum problems	☐ sinus problems	☐ earaches
☐ eye pain	☐ night blindness	☐ loose teeth	☐ recurrent sore throat	☐ ringing in the ears
☐ red eyes	☐ glaucoma	☐ tongue ulcers	☐ swollen glands	☐ high pitch
☐ itchy eyes	☐ cataracts	☐ canker sores	☐ difficulty swallowing	☐ low pitch

RESPIRATORY

- ☐ difficulty inhaling
- ☐ tight chest
- ☐ cough
- ☐ difficulty exhaling
- ☐ asthma/wheezing
- ☐ wet or ☐ dry
- color of phlegm _____
- ☐ shortness of breath
- ☐ pneumonia
- ☐ thick or ☐ thin

CARDIOVASCULAR

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ racing heart
- ☐ palpitations
- ☐ blood clots
- ☐ fainting
- ☐ chest pain
- ☐ irregular heartbeat

GASTROINTESTINAL

- ☐ nausea
- ☐ vomiting
- ☐ acid reflux
- ☐ gas
- ☐ hiccups
- ☐ diarrhea
- ☐ constipation
- ☐ bloating
- ☐ bloody stools
- ☐ mucous in stools
- ☐ intestinal pain/cramping
- ☐ itchy anus
- ☐ rectal pain
- ☐ hemorrhoid

frequency of bowel movements _____

MUSCULOSKELETAL

- ☐ neck pain
- ☐ limited use
- (CIRCLE RIGHT OR LEFT)
- ☐ shoulder pain R / L
- ☐ wrist pain R / L
- ☐ low back pain
- ☐ limited range
- ☐ elbow pain R / L
- ☐ knee pain R / L
- ☐ ankle pain R / L
- ☐ upper back pain
- ☐ hip pain R / L

NEUROPSYCHOLOGICAL

- ☐ seizures
- ☐ poor memory
- ☐ irritability
- ☐ numbness
- ☐ depression
- ☐ excessive worry
- ☐ tics
- ☐ anxiety
- ☐ easily stressed

GENITO-URINARY

- ☐ painful urination
- ☐ frequent urination
- ☐ urgent urination
- ☐ blood in urine
- ☐ unable to hold urine
- ☐ dribbling urination
- ☐ bedwetting
- ☐ awaken to urinate
- ☐ increased libido
- ☐ decreased libido
- ☐ kidney stones
- ☐ impotence

GYNECOLOGY

AGE MENSTRUATION BEGAN _____ LENGTH OF CYCLE _____ DURATION OF FLOW _____

COLOR OF BLOOD ☐ bright red ☐ dark red ☐ purple ☐ brown/rust ☐ pale red

CONSISTENCY OF BLOOD ☐ thick ☐ thin ☐ watery

- ☐ scant
- ☐ profuse
- ☐ mid-cycle bleeding
- ☐ irregular periods
- ☐ clots
- ☐ pain at ovulation
- ☐ breast tenderness
- ☐ painful periods
- ☐ vaginal sores
- ☐ ovarian cysts
- ☐ breast lumps
- ☐ PMS
- ☐ vaginal odor
- ☐ fibroids
- ☐ fibrocystic breasts
- ☐ vaginal discharge: color _____
- ☐ # of pregnancies _____
- ☐ # of live births _____