Inner Compass Acupuncture & Integrative Health

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New Patient Intake Form

Please take the time to fill out this questionnaire. The information you provide will assist us in formulating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary phone:_____ Secondary phone: _____

Email: _____ Preferred method of contact: ☐ phone ☐ email

Date of birth: _____ Current age: _____ Height: _____ Weight: _____

Relationship status: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____

Emergency contact: _____ Phone: _____

How did you hear about us? _____ Have you had acupuncture before? ☐ Y ☐ N

If yes, when? _____ By whom? _____ What for?_____

Do you want access to the patient online portal? ☐ Y ☐ N Receive our online newsletter? ☐ Y ☐ N

HEALTH INFORMATION

Main complaint: _____

Other complaints: _____

How long have you had this problem? _____

What makes your symptoms improve? _____

What makes your symptoms worse? _____

Have you received a medical diagnosis? ☐ Y ☑ N If yes, please list: _____

MEDICAL HISTORY

Please check any of the following that have ever affected you.

☐ Addiction	☐ Candida	☐ Gallstones	☐ Hypotension	☐ Rheumatism
☐ AIDS/HIV	☐ Chronic fatigue	☐ Glaucoma	☐ Kidney stones	☐ Seizures
☐ Alcoholism	☐ Colitis/bowel disease	☐ Goiter	☐ Malaria	☐ Stroke
☐ Anemia	☐ Diabetes	☐ Gout	☐ Meningitis	☐ STD
☐ Arteriosclerosis	☐ Digestive disorders	☐ Heart disease	☐ Mononucleosis	☐ Thyroid problems
☐ Arthritis	☐ Eating disorder	☐ Hernia	☐ Multiple sclerosis	☐ Tonsillitis
☐ Asthma	☐ Emotional imbalance	☐ Hepatitis	☐ Nephritis	☐ Tuberculosis
☐ Breast lumps	☐ Emphysema	☐ Herpes	☐ Neuralgia	☐ Ulcers
☐ Bursitis	☐ Epilepsy	☐ High cholesterol	☐ Paralysis	☐ Urinary problems
☐ Cancer	☐ Fibromyalgia	☐ Hypertension	☐ Prostate problems	☐ Whopping cough

Other: _____

Surgeries, Hospitalizations, and Significant traumas (car accidents, loss of loved ones, etc.):

Date	Event

Medications taken in the last 3 months, including over-the counter medications:

Medication	Dosage	Reason	How long

Please list any vitamins, supplements, or herbal medicines you are currently taking (with dosage):

_____

_____

_____

Please list any allergies or adverse reactions, especially to food or drugs:

_____

_____

_____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following diseases or conditions? Check all that apply.

☐	Addiction	☐	Arthritis	☐	Heart disease	☐	Mental health
☐	Allergies	☐	Asthma	☐	Hypertension	☐	Obesity
☐	Anemia	☐	Cancer	☐	Kidney disease	☐	Seizures
☐	Arteriosclerosis	☐	Diabetes	☐	Liver disease	☐	Stroke

Other: _____

Is your biological mother still alive? ☑ Y ☐ N ☐ N/A If so, what is her age? _____

Is your biological father still alive? ☐ Y ☐ N ☐ N/A If so, what is his age? _____

PERSONAL & SOCIAL HISTORY

How many hours per night do you sleep? _____ When do you usually go to bed? _____ Wake rested? ☐ Y ☐ N

Do you exercise regularly? ☐ Y ☐ N What kind and how much? _____

What are your hobbies/things you enjoy doing in your free time? _____

_____

Energy level: ☐ up and down ☐ low ☐ normal ☐ excess ☐ low after eating

Mental/Emotional: ☐ happy ☐ easily irritable ☐ difficulty making decisions ☐ angry ☐ cry easily

☐ stressed ☐ hurry to do things ☐ depression ☐ anxiety ☐ restlessness

Please indicate use and frequency of the following:

Cigarettes: ☐ Y ☐ N How many per day? _____ When did you start? _____

Alcohol: ☐ Y ☐ N Type and amount per week? _____

Recreational drugs: ☐ Y ☐ N Type and amount per week? _____ Since when? _____

Coffee: ☐ Y ☐ N Amount _____ Soda: ☐ Y ☐ N Amount _____

Water: ☐ Y ☐ N Amount _____

Please describe your daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you crave any particular foods or flavors? _____

How do you feel about the following areas of you life?

	GREAT	GOOD	FAIR	POOR	BAD	COMMENTS
Significant other	☐	☐	☐	☐	☐	
Family	☐	☐	☐	☐	☐	
Diet	☐	☐	☐	☐	☐	
Sex	☐	☐	☐	☐	☐	
Self	☐	☐	☐	☐	☐	
Work	☐	☐	☐	☐	☐	
Spirituality	☐	☐	☐	☐	☐	

SYMPTOM SURVEY

Please check any of the following that apply to you now or in the past.

GENERAL

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Shortness of breath	☐	☐	Poor appetite	☐	☐	Allergies
☐	☐	Poor coordination	☐	☐	Excess appetite	☐	☐	Fever
☐	☐	Vertigo/dizziness	☐	☐	Strong thirst	☐	☐	Chills
☐	☐	Bleed/bruise easily	☐	☐	Fatigue	☐	☐	Heavy body
☐	☐	Hot/cold intolerance	☐	☐	Poor sleeping	☐	☐	Weight loss
☐	☐	Nervousness/irritability	☐	☐	Night sweats	☐	☐	Weight gain
☐	☐	Sudden energy drop	☐	☐	Sweat easily	☐	☐	Tremors

☐	☐	Localized weakness	☐	☐	Swollen glands	☐	☐	Mood changes
☐	☐	Frequent infection	☐	☐	Cold hands/feet	☐	☐	Cravings

Other: _____

PSYCHOLOGICAL

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Loss of control	☐	☐	Irritability	☐	☐	Depression
☐	☐	Anxiety	☐	☐	Bad temper	☐	☐	Panic attacks
☐	☐	Suicidal thoughts	☐	☐	Suicidal attempt	☐	☐	Easily stressed
☐	☐	Seeing a therapist	☐	☐	Extreme fear	☐	☐	Extreme grief

Other: _____

SKIN AND HAIR

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Rashes	☐	☐	Dry skin	☐	☐	Itching
☐	☐	Eczema	☐	☐	Acne	☐	☐	Psoriasis
☐	☐	Hives	☐	☐	Moles	☐	☐	Dandruff
☐	☐	Tumors/lumps	☐	☐	Ulceration	☐	☐	Slow wound healing

Other: _____

HEAD, EYES, EARS, NOSE, AND THROAT

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Dizziness	☐	☐	Color blindness	☐	☐	Corrective lenses
☐	☐	Headache	☐	☐	Vision changes	☐	☐	Poor hearing
☐	☐	Migraine	☐	☐	Cataracts	☐	☐	Ear pain
☐	☐	Concussion	☐	☐	Glaucoma	☐	☐	Sinus problems
☐	☐	Facial pain	☐	☐	Spots in vision	☐	☐	Runny nose
☐	☐	Sore throat	☐	☐	Night blindness	☐	☐	Sneezing
☐	☐	Sores on lips/tongue	☐	☐	Blurry vision	☐	☐	Congestion
☐	☐	Grinding teeth	☐	☐	Eye pain	☐	☐	Loss of smell
☐	☐	Jaw clicks	☐	☐	Dry eyes	☐	☐	Nosebleeds
☐	☐	Gum problems	☐	☐	Red eyes	☐	☐	Peculiar smells
☐	☐	Excessive saliva	☐	☐	Itchy eyes	☐	☐	Peculiar tastes

Other: _____

CARDIOVASCULAR

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	High blood pressure	☐	☐	Swelling of hands	☐	☐	Fainting

☐	☐	Low blood pressure	☐	☐	Swelling of ankles	☐	☐	Blood clots
☐	☐	Irregular heartbeat	☐	☐	Cold hands/feet	☐	☐	Palpitations
☐	☐	High cholesterol	☐	☐	Heart murmur	☐	☐	Chest pain
☐	☐	Poor circulation	☐	☐	Heart valve issues	☐	☐	Heart attack
☐	☐	Varicose veins	☐	☐	Stroke	☐	☐	Clotting disorder

Other: _____

RESPIRATORY

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Shortness of breath	☐	☐	Shallow breathing	☐	☐	Sleep apnea
☐	☐	Pain in deep breathing	☐	☐	Bronchitis	☐	☐	Asthma
☐	☐	Tightness of chest	☐	☐	Emphysema	☐	☐	Wheezing
☐	☐	Difficulty breathing	☐	☐	Frequent colds/flu	☐	☐	Pneumonia
☐	☐	Excessive phlegm	☐	☐	Coughing blood	☐	☐	Cough

Other: _____

GASTROINTESTINAL

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Burning of anus	☐	☐	Constipation	☐	☐	Hemorrhoids
☐	☐	Chronic laxative use	☐	☐	Diarrhea	☐	☐	Gas/bloating
☐	☐	Pain with defecation	☐	☐	Blood in stool	☐	☐	Indigestion
☐	☐	Incomplete defecation	☐	☐	Food in stool	☐	☐	Belching
☐	☐	Light colored stools	☐	☐	Black stool	☐	☐	Nausea
☐	☐	Foul smelling stools	☐	☐	Rectal pain	☐	☐	Vomiting
☐	☐	Abdominal pain	☐	☐	Bad breath	☐	☐	Hiccups
☐	☐	Hiatal hernia	☐	☐	Lack of appetite	☐	☐	Acid reflux

Other: _____

GENITO-URINARY

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Pain on urination	☐	☐	Kidney stones	☐	☐	Herpes
☐	☐	Urgency to urinate	☐	☐	Increased libido	☐	☐	Bedwetting
☐	☐	Unable to hold urine	☐	☐	Decreased libido	☐	☐	STDs
☐	☐	Decreased urine flow	☐	☐	Frequent UTIs	☐	☐	Genital itching
☐	☐	Incomplete urination	☐	☐	Sores on genitals	☐	☐	Blood in urine
☐	☐	Nighttime urination	☐	☐	Malodorous urine	☐	☐	Cloudy urine

Other: _____

MALE REPRODUCTIVE (Men only)

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Prostate problems	☐	☐	Penile discharge	☐	☐	Impotence
☐	☐	Sexual dysfunction	☐	☐	Testicular lumps	☐	☐	Testicular pain

Other: _____

Have you had a prostate exam? ___ Y ___ N If yes, when? _____ results? _____

GYNECOLOGICAL (Women only, if you have gone through menopause, please describe your past menstruation)

Is there a possibility you're pregnant? ___ Y ___ N Date of last pap smear? _____

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Painful periods	☐	☐	Irregular periods	☐	☐	Mastitis
☐	☐	Vaginal discharge	☐	☐	Uterine bleeding	☐	☐	Fibroids
☐	☐	Infertility	☐	☐	Breast lumps	☐	☐	Endometriosis
☐	☐	Yeast infection	☐	☐	Vaginitis	☐	☐	Endometriosis
☐	☐		☐	☐	PMS	☐	☐	PID

Age of first period: _____ Number of days between periods: _____ Number of days of flow: _____

Menstruation: Flow: ☐ Heavy ☐ Light ☐ Clots ☐ Painful ☐ Spotting between periods

Color of flow: _____ Start date of last cycle: _____

PMS Symptoms: _____

Menopause: Age of menopause: _____ Menopausal symptoms: _____

Pregnancy: # of pregnancies: _____ # of births: _____ # of miscarriages: _____ # of abortions: _____

# of premature births _____

MUSCULOSKELETAL/NEUROLOGICAL

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Neck tightness/pain	☐	☐	Knee pain	☐	☐	Hernia
☐	☐	Shoulder pain	☐	☐	Muscle weakness	☐	☐	Seizures
☐	☐	Hand/wrist pain	☐	☐	Muscle pain	☐	☐	Tremors
☐	☐	Back pain	☐	☐	Joint sprain	☐	☐	Numbness
☐	☐	Hip pain	☐	☐	Joint disorders	☐	☐	Tingling
☐	☐	Sciatica	☐	☐	Scoliosis	☐	☐	Paralysis

Other: _____

Please feel free to list/describe any other issues you would like to discuss.

_____

_____

_____

_____

_____

_____

The information on this form is correct and accurate to the best of my knowledge.

Signature: _____ Date: _____

Please save this document and return it to your practitioner via e-mail.
Kate: kate@innercompassacupuncture
Lamya: lamya@innercompassacupuncture

Thank you and we look forward to working with you in achieving health and wellbeing!