

ZEPHYR ACUPUNCTURE AND BODYWORK

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New Patient Intake Form

Name:

Today's Date:

Address:

Phone:

Can I leave a message at this number?:

Email Address:

Would you like to receive newsletters?

Emergency Contact:

Phone:

Birthdate:

Age:

Height:

Weight:

Primary Physician:

Referred By:

Main Concerns:

Onset:

Other Concurrent Therapies:

Occupation:

Past Medical History(include date)

Significant Illnesses: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Hepatitis
___ Rheumatic Fever ___ Thyroid Disease ___ Seizures ___ Other

Surgeries: _____

*Significant Traumas(auto accidents, falls,
etc.):* _____

*Birth History(prolonged labor, forceps delivery,
etc.):* _____

*Allergies(drugs, chemicals,
foods):* _____

Medicines taken in the last two months(include vitamins, OTC drugs/herbs, etc.)

Occupational Stresses(chemical,physical,psychological, etc.)

Exercise:

Habits: ___ Cigarettes ___ Coffee ___ Tea ___ Cola ___ Alcohol ___ Drugs ___ Sugar
___ Salt Other _____

Family Medical History: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Stroke
___ Heart Disease ___ Asthma ___ Seizures ___ Allergies ___ Alcoholism
Other _____

Average Daily Diet

Morning

Afternoon

Evening

Please describe your sleeping habits _____

Please describe your relationship to breathing _____

PLEASE CIRCLE AND DESCRIBE ANY OF THE SYMPTOMS THAT APPLY TO YOU

HEAD

Headaches	Head injury	Migraines	Dizziness
Earaches	Impaired Hearing	Vertigo	ringing
Congestion	Frequent colds	Allergies	Other

Description _____

CARDIOVASCULAR

High BP	Low BP	Chest Pain	Palpitations
Dizziness	Swollen hands/feet	Cold hands/feet	Fainting
Blood Clots	Irregular Heartbeat	Varicosities	Other

Description _____

RESPIRATORY

Cough	Coughing Blood	Asthma	Bronchitis
Pneumonia	Difficulty Breathing	Tight Chest	Other

Production of Phlegm(color)
Description _____

GASTROINTESTINAL

Nausea	Vomiting	Diarrhea	Gas
Belching	Bloating	Bad breath	Rectal Pain
Constipation	Bloody stools	Hemorrhoids	Pain or cramps
Diarrhea	Sensitive Abdomen	Other	
Bowel movements	Frequency	Color	Odor
Laxative use	Times/week	Type	Texture/form

Description _____

GENITO-URINARY

Pain on urination	Frequent urination	Blood in urine	Urgency to urinate
Unable to hold urine	Kidney stones	STD	Impotency

Other
Wake up to urinate Times/night
Description _____

PERSPIRATION/THIRST

Often Thirsty	No Thirst	Difficult to drink water	
Preference-	Hot beverages	Cold beverages	Ice
Sweat easily	Difficult to Sweat	Sweat at Night	
Often Cold	Often Hot		

Description _____

PREGNANCY AND GYNECOLOGY

Number of pregnancies	Age of first menses	Flow	Vaginal Discharge
Number of births	Period length	Last PAP	Breast lumps
Premature births	Last menses	Menopause	Clots
Miscarriages	Spotting	Vaginal sores/pain	
Pain with intercourse	Other		

Birth control type and duration
Changes in body prior to menstruation
Description _____

NEUROPSYCHOLOGICAL

Seizures	Areas of numbness	Poor memory	Concussion
Depression	Anxiety/Panic	Bad Temper	Easily Stressed
Treated for emotional problems		Attempted Suicide	
Other neurological or emotional problems			

Description _____

MUSCULOSKELETAL(please mark and describe on the chart below)

Neck Pain	Muscle Pain	Back Pain(where)
Joint Pain(where)	Other joint or bone problems	



