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	Texture/form
Laxative use	Times/week	Type		

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