Bouchard Wellness
Acupuncture And Oriental Medicine

NEW PATIENT INTAKE FORM

Today's Date:_____

Last Name:_____ First Name:_____

Home Address:_____

Home Phone:_____Work Phone:_____Cell/Text Phone (for appt reminder):_____

E-Mail Address:_____

Date of Birth:_____Age:_____Height:_____Weight:_____

Relationship Status:_____Occupation:_____

Employer's Name & Address:_____

Personal Physician's Name and phone number:_____

Did your Primary Care Physician refer you to us? Yes No

Date of Last Physical Examination:_____/____/_____

Please list any other providers you have seen for this condition:_____

May we communicate with your physicians about your case and treatment? Yes No

Emergency Contact Information

Contact Name:_____Relationship with patient:_____

Contact Phone Numbers: (1)_____ (2)_____

Who can we thank for referring you to us?_____

Have you ever had acupuncture treatment before? (circle one): Y N

Chief Complaint

Main complaint:_____

When did this condition start?_____

How did the condition start?_____

How often?_____ Radiation elsewhere:_____

Have you received a medical diagnosis? Yes No If yes, please list:_____

Pain Level:____ Recently the condition has: Improved Worsened Stayed the Same

What makes your symptoms improve?_____

What makes your symptoms aggravate?_____

Have you received treatment for this condition? Yes No If yes, any improvement? Yes No

MEDICAL HISTORY

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

Addiction	Candida	Goiter	Malaria	Sinus problems
Aids/HIV	Chronic fatigue	Gout	Meningitis	Stroke
Alcoholism	Clotting disorder	Heart disease	Mental disease	STD
Allergies	Colitis /Bowel disease	Hernia	Mononucleosis	Hypothyroidism
Anemia	Diabetes	Hepatitis A,B,C	Multiple sclerosis	Hyperthyroidism
Arterosclerosis	Digestive disorders	Herpes I or II	Nephritis	Other thyroid problems
Arthritis	Eating disorder	High cholesterol	Neuralgia	Tonsilitis
Asthma	Emotional imbalance	High triglycerides	Paralysis	Ulcers
Autoimmune Disorders	Emphysema	Hypertension	Prostate problems	Urinary problems
Bell's Palsy	Epilepsy	Hypotension	Rheumatic fever	Whooping cough
Breast lumps	Fibromyalgia	Kidney disease	Rheumatism	
Busritis	Gallstones	Kidney stones	Seizures	
Cancer	Glaucoma	Liver disease	Shingles	

Other: _____

Please list surgeries, hospitalizations, significant traumas (including emotional ones), implants, botox injection:

Date	Event

Other:_____

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

Medication	Dosage	Reason	How long

Other: _____

Please list any vitamins, supplements or herbal medicines you are currently taking:

Vitamin, supplement, etc	Dosage	Reason	How long

Other:_____

Please list all known **allergies** to food, animals, chemicals, drugs, seasons, metals etc):_____

_____

Please list any **toxin exposure:**_____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following conditions?

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

PERSONAL AND SOCIAL HISTORY

Sleep

Number of hours per night:_____	Wakes up_____times per night	Wake up_____times to urinate
At what time usually in bed:_____	Difficulty falling asleep	Difficulty staying asleep
Restless sleep	Profuse dreaming	Nightmares
Easily awakened	Not rested on waking	Sleep apnea

Energy

Sudden energy drop Time of day:_____	Wired/ungrounded feeling	Blood pressure high/low	Dizziness/lightheadness/ vertigo
Energy drop after eating	Dependence on caffeine	Heart palpitations	Headaches:_____/week
Fatigue	Body/limbs feel heavy	Shortness of breath	Hard to concentrate
Exhaustion	Body/limbs feel weak	Bleed/bruise easily	Poor memory/coordination

Emotions

Angry	Worried	Joyful	Fearful	Mood swings
Irritable	Obsessive thinking	Grieving	Timid/shy	Crying easily
Anxious	Sadness	Depressed	Indecisive	Stressed

Habits

Do you exercise regularly? Yes No	What type?
Are there hobbies you enjoy doing? Yes No	List:
Do you consume alcohol? Yes No	Type and amount per week:
Do you smoke? Yes No	Type and amount per week:
Do you consume recreational drugs? Yes No	Type and amount per week:
Do you drink coffee? Yes No	Amount per week:
Do you drink tea? Yes no	Amount per week:
Do you drink soda? Yes No	Amount per week:
Do you drink water? Yes No	Amount per week:

Weight

Recent gain. How much?_____lbs	Recent loss. How much?_____lbs	On what time period?_____weeks

Daily food choices

Please describe your typical meal content:

	Food choices
Morning	
Afternoon	
Evening	
Cravings?	

Satisfaction level

How do you feel about the following area of your life?

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

SYMPTOM SURVEY

Temperature

How warm/cold do you feel (not in degrees) relative to other people?

Cold hands or feet	Thirst with no desire to drink	Night sweats	Hot hands/feet
Chills	Absence of thirst	Unusual sweats When_____am/pm Where on body_____	Hot flashes
Cold "in the bones"	Excessive thirst	Fever	Hot in the afternoon
Areas of numbness	Thirst for cold **or** hot drinks	Areas of numbness	Hot at night

Moisture

How does your overall body moisture feel?

Dry skin/hair/nails	Dry lips	Edema/swelling location_____	Hives
Dry eyes	Dry throat	Rashes/Eczema_____	Oily skin/hair
Dry nose/nosebleeds	Dry mouth	Itching_____	Weight gain/loss

Skin and Hair

Tumor/lumps	Acne	Ulceration	Psoriasis
Hair loss	Moles	Early grey hair	Dandruff
Slow wound healing	Easy infection	Pimples	

Head, Ear, Nose and Throat

Headache	Blurry vision	Sore throat	Poor hearing
Migraine	Color blindness	Sores on lips/tongue	Ear pain
Concussion	Night blindness	Gum problems	Ringing in the ears
Skull pain	Cataracts	Excessive saliva	Excess earwax
Facial pain	Glaucoma	Difficulty swallowing	Ear fullness
Poor balance	Spots in visual field/Halo	Sinus problems	Mouth sores
Dizziness/vertigo	Eye pain	Phlegm. Color:_____	Cough
Light sensitivity	Dry eyes	Runny nose	Dental problems
Swollen eyelids	Red eyes	Sneezing	TMJ
Tear easily	Itchy eyes	Loss of smell	Feels lump in throat
Eye twitch	Corrective lenses	Peculiar smells	Jaw clicks

Cardiovascular system

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

Respiratory system

Shortness of breath	Difficulty inhaling	Emphysema	Dry cough
Pain in deep breathing	Difficulty exhaling	Frequent colds/flu	Asthma
Tightness in chest	Shallow breathing	Coughing blood	Wheezing
Excessive phlegm	Bronchitis	Persistent cough	Pneumonia
Sigh a lot	Cough with phlegm		

Gastrointestinal system

Poor appetite	Bowel movement per week____	Dry stool	Rectal pain
Excessive appetite	Normal shape stool	Stool difficult to pass	Hemmorhoids
Bitter taste in mouth	Loose stool Diarrhea	Pain in defecation	Burning of anus
Bad breath	Watery diarrhea	Incomplete defecation	Chronic laxative use
Hiccups	Constipation	Light colored stool	Irritable Bowel Syndrome
Acid reflux/heartburn	Alternative diarrhea/constipation	Foul smelling stools	
Belching	Indigestion	Black stool	Loss of taste
Nausea	Abdominal pain	Food in stool	Tired after bowel movement
Vomiting	Gas/bloating	Blood in stool	Hiatal hernia

Genito-urinary system

Fluid in = Fluid out? Y N	Frequent urination	Malodorous urine
Decrease in flow/dribbling	Nighttime urination	Bedwetting
Difficulty starting/stopping	Incontinence	Sores on genitals
Urgency to urinate	Cloudy urine	STDs
Unable to hold urine	Blood in urine	Genital itching
Pain/burning on urination	Kidney stones	Herpes
Incomplete void	Frequent UTIs	Change in libido: Higher Lower

Male reproductive system

Prostate diseases	Penile discharge	Fibroids/cysts
Erectile dysfunction	Testicular lumps	Hernia
Premature ejaculation	Genital pain	Infertility
Increased sex drive	Reduced sex drive	

Gynecological system

Are you pregnant? Yes No	Increased sex drive	Decreased sex drive	**Hormonal imbalance**
Age at first mense:_____	Heavy periods	Cramps before/during	Age at last menses:_____
Length of full cycle____days	Light periods	Fatigue with menses	Year changes began:____
Length of mense_____days	Painful periods	Digestive changes w/menses	Hot flashes:___times/day
Last menses start date___/___	Irregular periods	Vaginal discharge. Color:___	Night sweats:__times/day
# of pregnancies____	Clots	Yeast infection	Vaginal dryness
# of births____ Premature____	Breast tenderness	Endometriosis	Loss of sex drive
# of abortions/miscarriages___	Mood changes	PCOS	Other:_____
Birth control? Yes No	Midcycle spotting	PID	
Infertility	Low ovarian reserve	Fibroids	

Gynecological surgeries and operations

Ovaries:_____	Vagina:_____	Breasts:_____
Uterus:_____	Fallopian tubes:_____	Other:_____

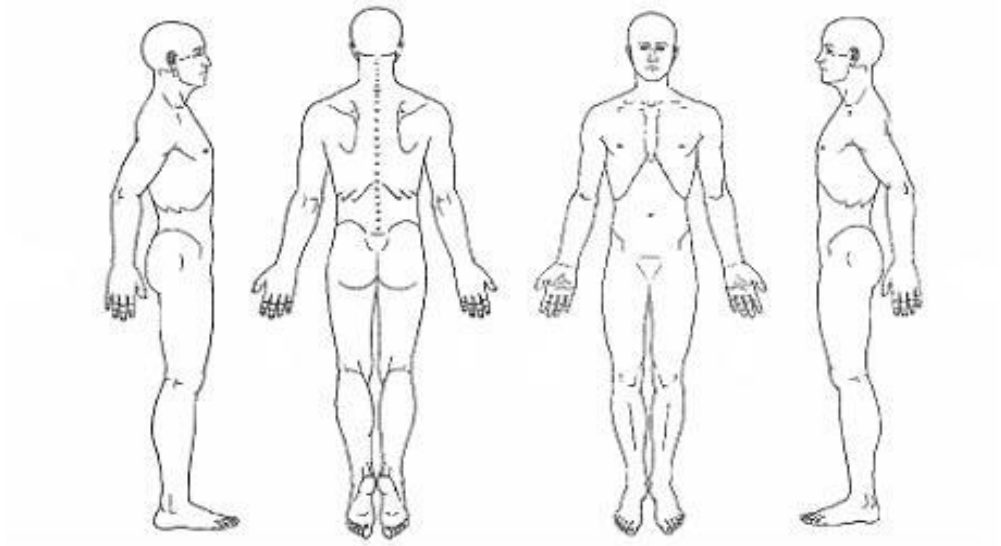
Gynecological examinations

Date of last mammogram:___/___	Breast self exam: Yes No	Ovulation symptoms:_____
Date of last PAP smear:____?____	Excess body hair: Yes No	_____

Musculoskeletal system

Neck tightness/pain	Knee pain	Sciatica	Shooting/sharp pain
Shoulder pain	Leg pain	Scoliosis	Numbness
Elbow pain	Ankle/foot pain	Joint sprain	Tingling
Wrist/hand pain	Plantar fasciitis	Joint disorder	Arthritis
Hip pain	Muscle pain	Hernia	Paralysis
Thigh pain	Muscle weakness	Seizures	Metal implants
Buttock pain	Muscle cramp	Tremors	Coldness

Indicate the location, intensity, frequency and nature of the symptoms on the drawing:



I affirm that the information provided by me in this form is true and correct.

_____	_____	____/____/____
Name (printed)	Name (signature)	Date

_____

Relation to patient (if representative)

Thank you for your time and effort! We look forward to providing you with the best possible care. If there is anything else you would like to add at this time, please do so on the back of this page or on another sheet of paper.