New Patient Intake Form Today's date _____/_____/_____

Name:_____ Date of Birth:___/___/_____
Address:_____
City:_____State:_____Zip:_____
Email Address:_____
Home:_____Work:_____Cell/Pager:_____

□ Male □ Female Height:_____Weight:_____Marital Status:_____Age:_____
Occupation:_____Hobbies:_____

Emergency Contact Person and Phone #: _____

Referred by:_____
Reason for visit:_____
How long have you had this condition:_____
Is it getting worse?_____Does it bother your: □ Sleep □ Work □ Other (what?)_____
What seemed to be the initial cause?_____
What makes it feel better?_____
What makes it feel worse?_____

Are you under the care of a physician now? □ Yes □ No If yes, for what? _____
Who is your physician?_____Physician's Phone#:_____
Other concurrent therapies?_____
Have you had a massage before? _____ If so, how long ago? _____
Are you sensitive to touch or pressure in any area?_____ If so, where? _____
Is it difficult to lay down in any certain position? _____
Are you pregnant or think you are pregnant? _____ If so, how far along? _____
Do you wear contacts? _____ Do you wear dentures? _____

Family Medical History

□ Allergies	□ Arteriosclerosis	□ Cancer	□ Diabetes	□ Seizures
_____	□ Asthma	_____	□ Heart Disease	□ Stroke
_____	□ Alcoholism	_____	□ High Blood Pressure	

Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past.)

□ AIDs / HIV	□ Emphysema	□ Multiple Sclerosis	□ Surgery	□ Tuberculosis
□ Alcoholism	□ Epilepsy	□ Mumps / Measles	_____	□ Typhoid Fever
□ Allergies _____	□ Goiter	□ Pacemaker	_____	□ Ulcers
□ Appendicitis	□ Gout	□ Parkinson's Disease	_____	□ Venereal Disease
□ Arteriosclerosis	□ Heart Disease	□ Pleurisy	□ Thyroid Disorder	□ Whooping Cough
□ Arthritis	□ Hepatitis	□ Pneumonia	□ Major Trauma	□ Other (Specify)
□ Asthma	□ Herpes	□ Polio	(Car, Fall, Broken Bone)	_____
□ Body Piercing(s)	□ High / Low Blood Pressure	□ Rheumatic Fever		
□ Cancer	□ Hyper / Hypoglycemia	□ Scarlet Fever	_____	_____
□ Chicken Pox	□ Hyper / Hypothyroidism	□ Seizures	_____	_____
□ Diabetes	□ Irritable Bowel Syndrome	□ Stroke	_____	_____

Medicine and Vitamins

Pharmaceuticals taken in last 2 months:_____

Vitamins/supplements taken in last 2 months:_____

Your Lifestyle

□ Alcohol	□ Marijuana	□ Stress/Tension	Regular Exercise	
□ Tobacco	□ Drugs	_____	Type _____	Frequency _____
□ Occupational hazards		_____	Type _____	Frequency _____

General Symptoms

□ Poor Sleep	□ Bodily Heaviness	□ Chills	□ Bleed or Bruise easily
□ Heavy Sleep	□ Cold hands or feet	□ Sweat easily	□ Recent weight loss/gain
□ Poor Circulation	□ Muscle cramps	□ Vertigo/Dizziness	□ Fever
□ Fatigue	□ Shortness of Breath	□ Difficult breathing	□ Lack of strength

Cardiovascular

□ High blood pressure	□ Low blood pressure	□ Chest pain	□ Tachycardia	□ Phlebitis
□ Blood clots	□ Fainting	□ Varicose veins	□ Heart palpitations	□ Irregular heartbeat

Head, Eyes, Ears, Nose, and Throat

□ Glasses
□ Eye strain
□ Eye pain
□ Red eyes
□ Itchy eyes
□ Spots in eyes
□ Poor vision
□ Blurred vision

□ Night Blindness
□ Glaucoma
□ Cataracts
□ Teeth problems / Dentures
□ Grinding teeth
□ TMJ
□ Facial pain
□ Gum problems

□ Sores on lips or tongue
□ Dry mouth
□ Excessive Saliva
□ Sinus problems
□ Excessive phlegm
□ Color of phlegm
_____

□ Chronic sore throat
□ Swollen glands
□ Lumps in throat
□ Enlarged thyroid
□ Nose bleeds
□ Ringing in ears
□ Poor hearing
□ Earaches

□ Headaches
□ Migraines
□ Concussions
□ Other head and neck problems
_____
_____
_____

Musculoskeletal

□ Neck/shoulder pain/soreness
□ Muscle pain/soreness
□ Osteoporosis

□ Upper back pain/soreness
□ Low back pain/soreness
□ Injury to bones

□ Joint pain/swelling
□ Rib pain/soreness
□ Injury to joints

□ Limited range of motion or use
□ Broken bones

Other (describe)
_____
_____

Skin and Hair

□ Rashes
□ Hives
□ Ulcerations

□ Eczema
□ Psoriasis
□ Acne

□ Dandruff
□ Itching
□ Hair loss

□ Change in hair or skin texture
□ Fungal Infections

Other hair or skin problems _____
_____

Neuropsychological

□ Seizures
□ Numbness
□ Tics

□ Poor memory
□ Depression
□ Anxiety

□ Irritability
□ Easily stressed
□ Abuse survivor

□ Considered or attempted suicide
□ Seeing a therapist

Other (specify)
_____
_____

Other _____
_____

Note: The remaining questions are only needed if administering Tui Na or Shiatsu

Have you had Tui Na massage before?_____Shiatsu before?_____How long ago?_____
Have you had Cupping, Moxabustion, or Guasha before? _____
If yes, which ones?_____How long ago?_____

Your Diet

Appetite □ Low □ High

□ Coffee
□ Soft Drinks

□ Artificial Sweetener

□ Sugar
□ Salty Food

General Symptoms

□ Night Sweats
□ Strongly like cold drinks
□ Strongly like hot drinks

□ Peculiar Taste (describe)
_____
_____

□ Lack of strength
□ Dream-disturbed Sleep
□ Shortness of Breath

□ Hot Flashes
□ Worry easily
□ Malar Flush to face

Respiratory

□ Difficulty breathing when lying down
□ Tight chest
□ Wheezing
□ Cough
Wet or Dry?_____
Thick or thin?_____
Color of phlegm _____
□ Coughing blood

Gastrointestinal

□ Nausea
□ Vomiting
□ Acid regurgitation
□ Gas
□ Hiccup
□ Bloating

□ Diarrhea
□ Constipation
□ Laxative use
□ Black stools
□ Bloody stools
□ Mucus in stools

□ Intestinal pain or cramping
□ Itchy anus
□ Burning Anus
□ Hemorrhoid
□ Rectal pain

□ Bowel movements:
Frequency _____Texture/form _____
Color _____ Odor _____
□ Bad breath
□ Anal fissures

Urinary/Genital

□ Pain on urination
□ Frequent urination
□ Urgent urination

□ Blood in urine
□ Unable to hold urine
□ Incomplete urination

□ Venereal disease
□ Bedwetting
□ Wake to urinate

□ Increased libido
□ Decreased libido
□ Kidney stone

□ Impotence
□ Premature ejaculation
□ Nocturnal emission

Gynecology

□ Age menses began
_____
Length of cycle (day 1 to day 1)
_____

□ Duration of flow
_____
□ Irregular periods
□ Painful periods
□ PMS

□ Vaginal discharge (color) _____
□ Vaginal sores
□ Vaginal odor
□ Clots

□ Breast lumps
Pregnancies _____
Live births _____
Premature births ___
Age of Menopause

□ Date of last PAP
_____
□ Date last period
_____

Other _____
_____