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?_____
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? _____
Do you have any allergies to anything?_____
Any Conditions/Diseases?_____
Any Traumas?_____ When?_____
_____ _____
Any Surgeries?_____ When?_____
_____ _____

Have you had a massage before? _____ How long ago? _____
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?_____

Medicine and Vitamins

Pharmaceuticals taken in last 2 months:_____

Vitamins/supplements taken in last 2 months:_____

General Signs and Symptoms – Past or Present

□ Acne
□ AIDs / HIV
□ Alcoholism
□ Arthritis
□ Asthma
□ Bleed or Bruise Easily
□ Body Piercing(s)
□ Broken Bones
_____
□ Cancer
□ Chicken Pox
□ Chills
□ Chronic Sore Throat
□ Cold Hands and/or Feet
□ Concussions
□ Diabetes
□ Difficult Breathing
□ Dream-disturbed Sleep

□ Earaches
□ Emphysema
□ Epilepsy / Seizures
□ Eye Strain
□ Fatigue
□ Fever – Rheumatic / Scarlet
□ Fungal Infections
□ Gout
□ Grinding teeth / TMJ
□ Headaches / Migraines
□ Heart Disease
□ Heart Palpitations
□ Heavy Sleep
□ Hepatitis
□ High / Low Blood Pressure
□ Hives / Rashes
□ Hot Flashes
□ Hyper / Hypoglycemia

□ Injury to Bones / Joints
□ Irregular Heartbeat
□ Irritable Bowel Syndrome
□ Itching / Eczema
□ Joint Pain/Swelling
□ Lack of Strength
□ Low Back Pain/Soreness
□ Lumps in Throat
□ Muscular Limited Range of Motion or Use
_____
□ Muscle Pain/Soreness/Cramps
_____
□ Neck/shoulder Pain/Soreness
_____
□ Numbness
_____
□ Osteoporosis

□ Pacemaker
□ Pneumonia
□ Poor Circulation
□ Poor Hearing
□ Poor Sleep
□ Poor Vision
□ Psoriasis
□ Rib Pain/Soreness
□ Ringing in Ears
□ Shortness of Breath
□ Strokes / Seizures
□ Tuberculosis
□ Ulcers
□ Upper Back Pain/Soreness
□ Varicose veins
□ Venereal Disease
□ Vertigo/Dizziness Easily
□ Worry

Other _____
_____
_____