

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

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Earaches | <input type="checkbox"/> Injury to Bones / Joints | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> AIDs / HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Itching / Eczema | <input type="checkbox"/> Poor Hearing |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Joint Pain/Swelling | <input type="checkbox"/> Poor Sleep |
| <input type="checkbox"/> Bleed or Bruise Easily | <input type="checkbox"/> Fever – Rheumatic / Scarlet | <input type="checkbox"/> Lack of Strength | <input type="checkbox"/> Poor Vision |
| <input type="checkbox"/> Body Piercing(s) | <input type="checkbox"/> Fungal Infections | <input type="checkbox"/> Low Back Pain/Soreness | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Gout | <input type="checkbox"/> Lumps in Throat | <input type="checkbox"/> Rib Pain/Soreness |
| | <input type="checkbox"/> Grinding teeth / TMJ | <input type="checkbox"/> Muscular Limited Range of Motion or Use | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches / Migraines | | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Muscle Pain/Soreness/Cramps | <input type="checkbox"/> Strokes / Seizures |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Heart Palpitations | | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Sore Throat | <input type="checkbox"/> Heavy Sleep | | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold Hands and/or Feet | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neck/shoulder Pain/Soreness | <input type="checkbox"/> Upper Back Pain/Soreness |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> High / Low Blood Pressure | | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives / Rashes | <input type="checkbox"/> Numbness | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Difficult Breathing | <input type="checkbox"/> Hot Flashes | | <input type="checkbox"/> Vertigo/Dizziness Easily |
| <input type="checkbox"/> Dream-disturbed Sleep | <input type="checkbox"/> Hyper / Hypoglycemia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Worry |

Other _____
