Moxa Medicine Incorporated

New Patient Intake Information

Please fill out the following information and check each box that applies to you:

Name:	Intake Start Date:
Address:	Intake Continuation Date:

City: State: Zip: Phone:

E-mail Address:

Occupation:

Relationship Status:

Date of Birth: Place of Birth: Age: Height: Weight:

Sex: Gender Identity:

In Case of Emergency Notify:

How did you hear of this office?

Have you ever tried acupuncture or Chinese herbal medicine before?

CHIEF COMPLAINT

List the main complaints for which you are seeking treatment:	Affect on your daily life: **1 - 10**	Your commitment to resolution: **1 - 10**
1.		
2.		
3.		
4.		
5.		
6.		

What is your desired outcome from treatment?

What other forms of treatment have you sought for your main complaints?

MEDICATIONS (include dosage and frequency)

List medications and nutritional supplements you are currently taking or **see attached list** ☐

LIFESTYLE (please indicate your current use and frequency of the following:)

☐ Coffee
☐ Black Tea
☐ Other Caffeinated Beverages
☐ Tobacco
☐ Alcohol
☐ Recreational Drugs
☐ Toxic Exposure
☐ Frequent Travel
☐ Stress at Work
☐ Stress at Home
☐ Weight Gain
☐ Weight Loss

☐ **Exercise** (please specify type and frequency)

☐ **Diet** goals and restrictions:

New Patient Intake Information

****Check any symptom you have experienced recently or in the past and circle matching choice:**

SLEEP, ENERGY, AND TEMPERATURE

☐Insomnia/Disturbed Sleep	☐Hot/Cold While Sleeping	☐Cold in the bones
☐Fatigue whole body	☐Sudden Energy Drops	☐Mental Fatigue
☐Trouble Falling Asleep	☐Sleep Walking/Talking	☐Hot Hands/Feet/Chest
☐Trouble Staying Asleep	☐Night Sweats	☐Heat in Afternoon
☐Restless Sleep	☐Sweat Easily/Spontaneously	☐Naps
☐Trouble Napping	☐Wakes tired/not refreshed	☐Other (please specify)

IMMUNE SYSTEM

☐Chills - Shivering	☐Fevers	☐Alternating Fever & Chills
☐Sudden Body Aches	☐Sore Throat	☐Nasal Discharge
☐Sensitive to Drafts	☐Catch Colds Easily	☐No Thirst/Strong Thirst
☐Lymph Node Swelling	☐Viral Outbreaks	☐Other (please specify)

SKIN, HAIR AND NAILS

☐**Rashes:** ☐Raised ☐Flat ☐Blanch with pressure ☐Itchy ☐Moist ☐Dry

☐Rashe Shape: ☐Rash Color:

☐Skin Itching	☐Dermatitis	☐Eczema	☐Psoriasis	
☐Ulcerations	☐Toe Fungus	☐Skin Infections	☐Ringworm	
☐Acne/Pimples	☐Skin Redness	☐Recent Moles	☐Warts	
☐Dry Skin	☐Damp Skin	☐Oily Skin	☐Thin Skin	☐Thick Skin
☐Hives	☐Nail Ridges	☐Soft/Brittle Nails	☐Spots/Streaks in Nails	
☐Dry Nails	☐Nail Fungus	☐Dandruff	☐Dry/Brittle Hair	
☐Premature Grey	☐Hair Loss	☐Hair Growth	☐Skin Cancer	

☐Other (please specify)

HEAD, EYES, EARS, NOSE, THROAT

☐Dizziness or Vertigo	☐Eye Pain	☐Blurred Vision	☐Cataracts
☐Floaters	☐Spots in Eyes	☐Night Blindness	☐Poor Vision
☐Tearing	☐Dry eys	☐Color Blindness	☐Gritty Eyes
☐Poor Hearing	☐Ringing in Ears	☐Earaches	☐Excessive Ear Wax
☐Nosebleeds	☐Poor Smell	☐Post nasal drip	☐Sinus Pressure
☐Sinus Problems	☐Facial Pain	☐Jaw Clicking	☐Teeth Grinding
☐Voice issues	☐Dry Mouth/Throat	☐Hard to Swallow	☐Recurrent Sore Throats
☐Migraines	☐Headaches	☐Light Headed	☐Heavy Head
☐Cancer	☐Other (please specify)		

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Irregular Heart Beat
- ☐ Chest Pain
- ☐ Stuffiness in Chest
- ☐ Bruise/Bleed Easily
- ☐ Cold Fingers/Toes
- ☐ Migrating Pains
- ☐ Heart Disease
- ☐ Hemangioma/petechii
- ☐ Low Blood Pressure
- ☐ Fainting
- ☐ Tightness in Chest
- ☐ Swelling of Hands/Feet
- ☐ Difficulty Breathing
- ☐ Hands Redder than Face
- ☐ Energy Rushing up sensation
- ☐ Edema: pitting in legs
- ☐ Phlebitis
- ☐ High Blood Pressure
- ☐ Cold Hands/Feet
- ☐ Weight on Chest
- ☐ Blood Clots
- ☐ Palpitations
- ☐ Face Redder than Hands
- ☐ Vericose Veins
- ☐ Spider Veins
- ☐ Other (please specify

RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Pain with Breathing
- ☐ Stuck Phlegm
- ☐ Frequent Sighing
- ☐ Edema
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Frequent Yawning
- ☐ Fatigue
- ☐ Coughing Phlegm
- ☐ Nasal Congestion
- ☐ Difficulty Breathing
- ☐ Inhalant Allergies
- ☐ Lung Cancer
- ☐ Other (please specify)

GASTROINTESTINAL, LIVER, GALL BLADDER and MOUTH

- ☐ Nausea
- ☐ Bloating
- ☐ Abdominal Pain/Cramps
- ☐ Heartburn/Reflux/Regurgitation
- ☐ Retention of Food in Stomach
- ☐ Irregular Stool
- ☐ Hemorrhoids
- ☐ Sensitive Abdomen
- ☐ Black Stools
- ☐ Food Allergies/Sensitivities
- ☐ No Thirst/Strong Thirst
- ☐ Bleeding Gums
- ☐ Mouth Sores
- ☐ Vomiting
- ☐ Gas/Belching/Hiccough
- ☐ Cold Abdomen
- ☐ Excessive Appetite
- ☐ Constipation
- ☐ Pain w/Bowel Movement
- ☐ Blood with Stool
- ☐ Bowel Incontinence
- ☐ Clay colored stool
- ☐ Eating Disorder
- ☐ Bad Breath
- ☐ Gum Disease
- ☐ Dry Mouth/Lips
- ☐ Difficulty Swallowing
- ☐ Abdomen Noises
- ☐ Hot Abdomen
- ☐ Lack of Appetite
- ☐ Diarrhea
- ☐ Rectal Pain
- ☐ Hiatal Hernia
- ☐ Chronic Laxative Use
- ☐ Stool color not brown
- ☐ Cravings
- ☐ Taste in Mouth
- ☐ Sores on Lips/Tongue
- ☐ Tongue Problems

GENITO-URINARY

☐Pain on Urination	☐Frequent Urination	☐Blood in Urine
☐Urgency to Urinate	☐Unable to Hold Urine	☐Urinary Tract Infection
☐Kidney Stones	☐Recent decrease in Urine Flow	☐Puss in Urine
☐Sores on Genitals	☐Sexually Transmitted Disease	☐Deformity
☐Sex Drive: low/high/normal	☐Urine color: dark/cloudy/clear	☐Prolapse
☐Waking at Night to Urinate	☐Urine output large/small	☐Trauma to area
☐Difficult start/stop urination	☐Cancer	☐Other (please specify)

REPRODUCTIVE/GYNECOLOGICAL INFORMATION

Female: Age of 1st Period: Age at menopause: Age at each pregnancy:

☐**CURRENTLY PREGNANT OR MAY BE PREGNANT**

Give number of each: Live Births_____, Premature Births _____, Miscarriages _____, Abortions _____

☐Pregnancy complications	☐Delivery problems	☐Post-partum complications

Days in cycle _____, Days of flow _____, Color of blood _____, Amount of flow _____

☐Clots (Color _____)	☐Irregular Menses	☐Painful Menses
☐Endometriosis	☐Premenstrual Symptoms	☐Breast Lumps/Swellings
☐Strong Menstrual Odor	☐Vaginal Discharge	☐Vaginal Odor
☐Vaginal Dryness	☐Vaginal itching	☐Vaginal swellings
☐Fibroids	☐Ovarian Cyst	☐Positive Mammogram/Pap
☐Hot Flashes, feeling of heat	☐Birth control medicine/IUD: type:	

Male: Age of onset of puberty:

☐Vasectomy	☐Erectile Dysfunction	☐Enlarged Prostate	☐Seminal leakage
☐Pain	☐Premature ejaculation	☐Breast Discharge/Lumps	☐Hot Flashes

****Check any symptom you have experienced recently or in the past and circle matching choice:**

NEUROLOGICAL-PSYCHOLOGICAL

☐Seizures	☐Loss of Balance	☐Paralysis
☐Areas of Numbness	☐Tremors	☐Aphasia
☐Lack of Coordination	☐Localized Weakness	☐Electrical sensations
☐Concussion	☐Depression	☐Anxiety
☐Bad Temper	☐Easily Stressed	☐Attempted Suicide
☐Treated for Emotional Problems	☐Poor Memory	☐Learning Disabilities
☐Brain Cancer	☐Other (please specify)	

MUSCULO-SKELETAL

☐ Head Pain	☐ Neck Pain	☐ Back Pain	☐ Hip Pain
☐ Muscle Pain	☐ Muscle Weakness	☐ Nerve Pain	☐ Joint Pain
☐ Foot Pain	☐ Ankle Pain	☐ Toe Pain	☐ Leg Pain
☐ Hand Pain	☐ Wrist Pain	☐ Finger Pain	☐ Arm Pain
☐ Knee Pain	☐ Shoulder Pain	☐ Elbow Pain	☐ Sciatica
☐ Cancer	☐ Past Accidents/Injuries	☐ Other Joint/Bone Problems (please specify)	

MEDICAL HISTORY: Check ☐ for your self and ( ) for a family member.

☐ ( ) Cancer	☐ ( ) High Blood Pressure	☐ ( ) Hepatitis	☐ ( ) Diabetes
☐ ( ) Heart Disease	☐ ( ) Rheumatic Fever	☐ ( ) Parasites	☐ ( ) Vaccinations
☐ ( ) Infectious Diseae	☐ ( ) Epidemic Diseases	☐ ( ) Tuberculosis	☐ ( ) Asthma
☐ ( ) Arthritis	☐ ( ) Seizures	☐ ( ) Aneurism	☐ ( ) Stroke
☐ ( ) Emotional Disorder	☐ ( ) Anomalies	☐ ( ) Osteoperosis	☐ ( ) High Cholesterol
☐ ( ) Chronic Fatigue	☐ ( ) AIDS/HIV	☐ ( ) Surgeries	☐ ( ) Edema
☐ ( ) Endocrine Disease	☐ ( ) Hematological Disease	☐ ( ) Thyroid Disease	☐ ( ) Addiction
☐ ( ) Birth Trauma	☐ ( ) Childhood Illnesses	☐ ( ) IBS/Chrone's	☐ ( ) PCOS
☐ ( ) Other (please specify)			