



Harmony Acupuncture and Wellness Center

Confidential New Patient Intake Form

Name _____ Date _____

Address _____ Home# _____

_____ Work# _____

Age _____ Date of Birth _____ Mobile# _____

Occupation _____ E-Mail _____

Referred by _____ Preferred contact method (Circle above)

Emergency contact information _____

Chief Complaint _____

Onset _____

Is your complaint related to an injury? _____

Do you have any other conditions that are causing you worry or discomfort?

Have you ever received acupuncture treatment? If yes, when? _____

When were you last seen by a medical doctor? _____

Name of physician _____ Reason for visit _____

Diagnosis _____

Please list any medications and/or supplements you are currently taking

<u>Medication</u>	<u>Reason</u>	<u>Dosage</u>	<u>Duration</u>

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Major Accidents, Illnesses, Surgeries	Age and/or Date

Please list any allergies _____

Have you or a blood relative had any of the following? Please check box(es).

	Self	Blood Relative
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>

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On a scale from 1 to 10 (Mark an X on the scale where appropriate), please rate the following about your current condition.

Pain Today	0	2	4	6	8	10
	No Pain			Unbearable Pain		
Pain Average	0	2	4	6	8	10
	No Pain			Unbearable Pain		
Pain at Worst this week	0	2	4	6	8	10
	No Pain			Unbearable Pain		
Energy Level	0	2	4	6	8	10
	Low			High		
Immune System	0	2	4	6	8	10
	Low			High		
Stress Level	0	2	4	6	8	10
	Low			High		
Current Health Condition	0	2	4	6	8	10
	Awful			Terrific		
Current Employment	0	2	4	6	8	10
	Awful			Terrific		
Current Social Life	0	2	4	6	8	10
	Awful			Terrific		
Current Love Life/Partner	0	2	4	6	8	10
	Awful			Terrific		

Please list any other factors in your life that may be affecting your health. Such as a change in living circumstance, job, friends, love relationship, quitting smoking, alcohol consumption, coffee/caffeine, or any addictive substance or behavior.

Please tell me your health goals and how you envision your health to be in five years time.
