Carlette Zottola Lac, MSTOM
Acupuncture New Patient Intake Form

Patient Information

Name:_____ Date of Birth:_____

Age:_____ Gender(please circle) M or F Occupation:_____

Address:_____ Home Phone:_____

City, State, Zip:_____ Cell Phone:_____

Email:_____ Work Phone:_____

Have you had acupuncture before?_____

How did you hear of us?_____

Emergency Contact Information

Emergency Contact:_____ Relationship to You:_____

Address:_____ Home Phone:_____

Cell Phone:_____ Work Phone:_____

Health History

What is the reason for your visit? (please list your main complaint)_____

_____

Is there anything that improves or aggravates your condition?_____

Please list other health concerns in order of importance?

1._____ Date of Onset:_____

2._____ Date of Onset:_____

3._____ Date of Onset:_____

4._____ Date of Onset:_____

5._____ Date of Onset:_____

Are you under a physician's care for any of your health concerns? (please describe)_____

_____

Date of Last Physical Exam:_____ Name of Physician:_____

Please list any hospitalizations and / or surgeries:

Reason	**Date**

Please check all that apply:

Condition	**Date diagnosed**	**Condition**	**Date diagnosed**
☐ Diabetes		☐ Autoimmune Disorder	
☐ High Blood Pressure		☐ Seizures	
☐ Heart Disease		☐ Allergies	
☐ High Cholesterol		☐ Arthritis	
☐ Cancer		☐ Anxiety / Depression	
☐ HIV		☐ Irritable Bowel Syndrome	
☐ Hepatitis		☐ Allergies	
☐ Asthma		☐ Acid Reflux	
☐ Anemia			

Please list below any over the counter or prescription drugs you are currently taking:

Name	**Dosage**	**For what purpose/condition**	**Date began**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please list below any vitamins, minerals, and supplements you are currently taking:

Name	**Dosage**	**For what Purpose/Condition**	**Date began**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Family Medical History

Please check if any of the following that applies to family members and specify relation:

Condition	Family Member	Condition	Family Member
☐ Asthma		☐ Heart Disease	
☐ Alcoholism		☐ High Blood Pressure	
☐ Allergies		☐ Mental Illness	
☐ Cancer		☐ Seizures	
☐ Diabetes		☐ Stroke	

Symptoms

Please check all that apply:

Skin and Hair

- ☐ Rashes
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Skin Cancer
- ☐ Acne
- ☐ Night Sweats
- ☐ Skin Dryness
- ☐ Bruise Easily
- ☐ Hair Loss

Head, Eyes, Ears, Nose, Throat

- ☐ Glasses
- ☐ Night Blindness
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Red Eyes
- ☐ Itchy Eyes
- ☐ Spots in Visions
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Nosebleeds
- ☐ Sinus Problems/Infections
- ☐ Heaviness of Head
- ☐ Ear Ringing
- ☐ Hearing Loss
- ☐ Ear Infections
- ☐ Headaches
- ☐ Dizziness
- ☐ Migraines
- ☐ Sore Throat
- ☐ Swollen Glands
- ☐ Teeth Grinding
- ☐ TMJ (Jaw pain)
- ☐ Gum Problems
- ☐ Lip Sores
- ☐ Mouth Sores
- ☐ Excessive Saliva
- ☐ Facial Pain
- ☐ Facial Numbness

Respiratory

- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Tight Chest
- ☐ Asthma
- ☐ Wheezing
- ☐ Headaches
- ☐ Bronchitis

Cardiovascular

- ☐ Hypertension (High Blood Pressure)
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Slow Heart Rate
- ☐ Blood Clots
- ☐ Rapid Heart Rate
- ☐ Edema (Swelling)
- ☐ Pacemaker
- ☐ Hypotension (Low Blood Pressure)
- ☐ Fainting
- ☐ Irregular Heart Rate

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Acid Regurgitation/Reflux
- ☐ Gas/Flatulence
- ☐ Hemorrhoids
- ☐ Rectal Pain/Itching
- ☐ Fissures
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hiccups
- ☐ Bloating
- ☐ Bad Breath
- ☐ Dark Colored Stool
- ☐ Light Colored Stool
- ☐ Mucus in Stools
- ☐ Blood in Stools
- ☐ Intestinal Pain
- ☐ Poor Appetite

Neurological

☐ Fainting/Syncope	☐ Dizziness	☐ Vertigo
☐ Drowsiness	☐ Loss of Balance	☐ Poor Memory
☐ Tremor	☐ Convulsions	☐ Paralysis
☐ Stroke/CVA/TIA	☐ Seizures	☐ Numbness

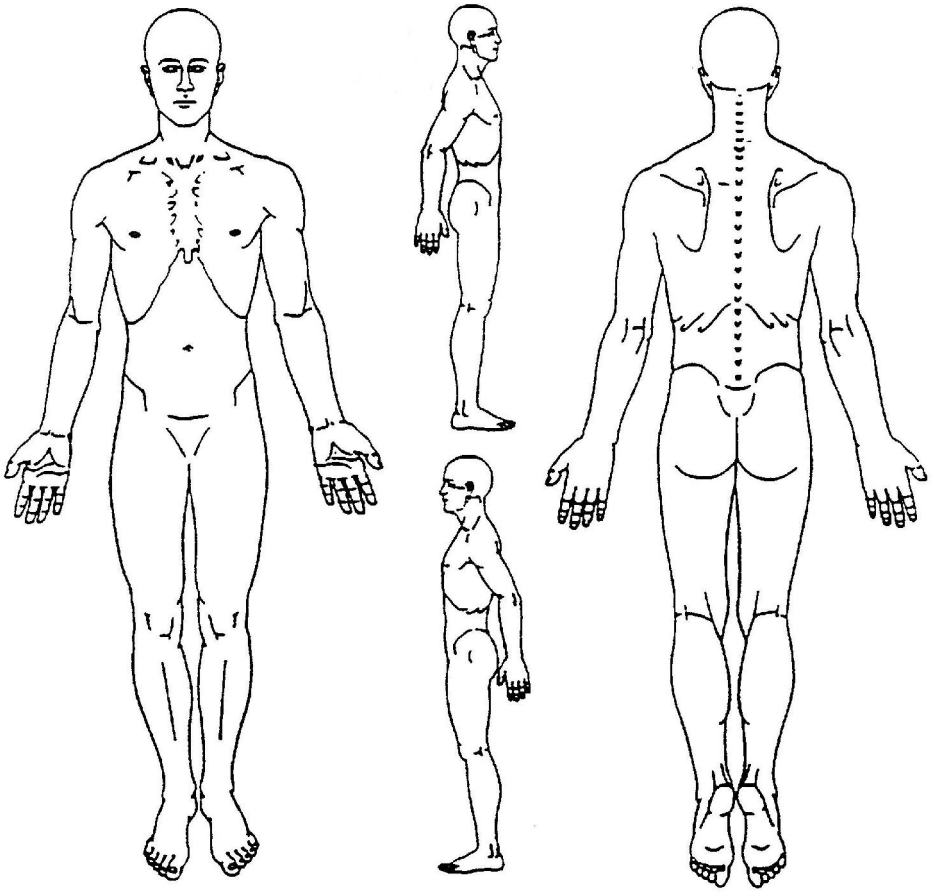
Neurophysiological

☐ Depression	☐ Easily Frustrated	☐ Frightened Easily
☐ Irritable	☐ Worry Easily – Anxious	☐ Numbness
☐ Easily Stressed	☐ Unresolved Grief	☐ Poor Memory

Musculo-Skeletal

☐ Muscle Weakness	☐ Injuries	☐ Limited Range of Motion
☐ Muscle Cramps	☐ Muscle Atrophy	☐ Arthritis
☐ Muscle Spasms	☐ Falls	☐ General Aches
☐ Joint Pain	☐ Chronic Pain (long-term pain)	
☐ Joint Instability	☐ Acute Pain (short-term pain)	

Please mark areas below where you experience pain:



For Women

Are you pregnant now? ☐ Yes ☐ No ☐ Unsure

Indicate number of occurrences:
Live Births _____
Pregnancies _____
Miscarriages _____
Abortions _____

Age of first period _____

Age of menopause (if applicable) _____

Date of last OB/Gyn Exam _____

Any history of abnormal pap smear? ☐ Yes ☐ No If so, when?_____

Is your menses cycle regular? ☐ Yes ☐ No

The flow is ☐ Normal ☐ Heavy ☐ Light

The color is ☐ Normal ☐ Dark ☐ Purple ☐ Lt Brown ☐ Brown

Average number of days of flow _____

Do you have the following menstruation related signs/symptoms?

☐ Difficulty with Orgasm ☐ Cramps ☐ PMS

☐ Pain with Intercourse ☐ Nausea ☐ Bleeding between Periods
☐ Blood Clots ☐ Breast Distention ☐ Vaginal Discharge

Is fertility an issue for you? (Please describe) _____

_____

_____

Please check all conditions that apply:

Gynecology

☐ Endometriosis ☐ Urinary tract infections ☐ Fibrocystic breasts
☐ Ovarian Cysts ☐ Pain/itching of genitalia ☐ Breast cancer
☐ Uterine fibroids ☐ Genital lesions/discharge ☐ Breast lumps
☐ Yeast infections ☐ Pelvic inflammatory disease ☐ Herpes
☐ HPV ☐ Other STDs ☐ Hysterectomy

Lifestyle History

- ☐ Currently use Tobacco, # packs per Day?_____
- ☐ Former Tobacco Use, Year Quit?_____
- ☐ Currently use alcohol, # drinks per week?_____
- ☐ Currently use recreational drugs?
- ☐ Coffee, tea, soft drinks, # drinks per day?_____
- ☐ Vegetarian/Vegan
- ☐ Eat a lot of Fried Foods
- ☐ Eat a lot of Sweets
- ☐ Exercise Regularly
- ☐ Healthy Diet
- ☐ Normal weight for Height
- ☐ Very Overweight
- ☐ Underweight
- ☐ Overweight
- ☐ Eat a lot of Dairy
- ☐ Eat a lot of Red Meat

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad
Significant other	☐	☐	☐	☐	☐
Family relations	☐	☐	☐	☐	☐
Friendships	☐	☐	☐	☐	☐
Living arrangements	☐	☐	☐	☐	☐
Self image	☐	☐	☐	☐	☐
Sex	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐
Vacations/time off	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
spirituality	☐	☐	☐	☐	☐

Any additional information about yourself?_____

_____

_____

_____

_____

_____