HealthMark

OnPoint Medical Group

New Patient Intake Form

Name________________________________ Date__________________

Address__________________________ City/State/Zip__________________

Date of Birth __________ Age ______ Gender _______ HT_____ WT________

Phone ______________ Email ______________________________________

Emergency Contact Name ____________________ Contact #________________

How did you hear about me ? ______________________________________

If Referral who can I thank? ______________________________________

Have you had acupuncture before ? ______________ If Yes please indicate:

Reason/ Date/ Practitioner Name:___________________________________

Primary Reason For Seeking Care: Please indicate the primary reasons for your visit today and how they are impacting your day-to-day activities. Reason#1 ______________________

how long you've had this condition? __________ **when it started ?**__________________

what have you tried to resolve it?____

	work		standing		sitting		
	walking		bending		stretching		
	sleep		relationship		mentally		
	sexually		emotionally		spiritually		

Reason#2______________________ **how long you've had this condition?**____________

when it started ?__________ **what have you tried to resolve it?**____________________

	work		standing		sexually		
	sleep		bending		relationship		
	walking		stretching		mentally		
	sitting		emotionally		spiritually		

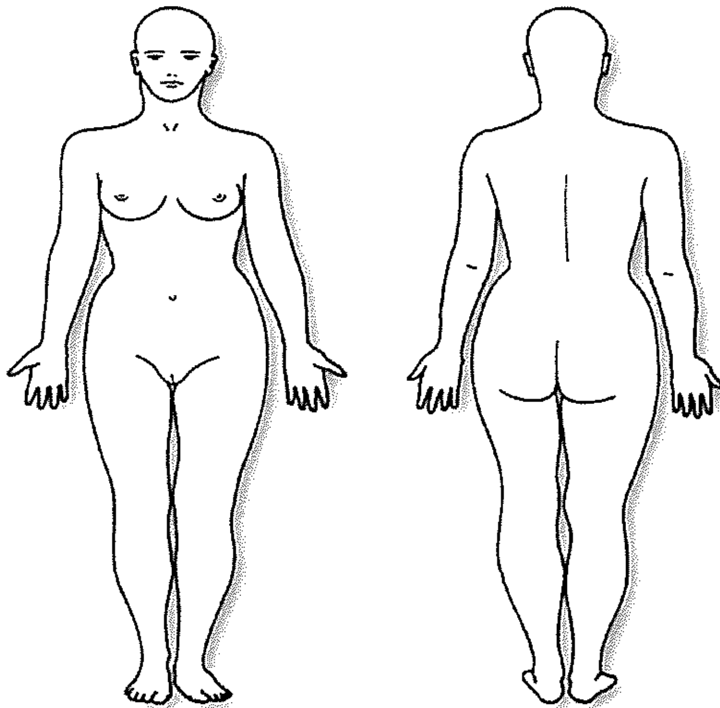
Name________________________________ Date____________________

Describe quality of pain;Please clearly mark areas of pain with an X and any scars with an O

	sharp		burning
	cramping		dull
	fixed		aching
	moving		on/off

What makes it feel better ? ____

What makes it Feel worse ? ____



MEDICAL HISTORY Please complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, however they can aid in your diagnosis and treatment. All information is STRICTLY CONFIDENTIAL.

How was your childhood health?____

List any surgeries & dates:____

____

List any traumatic events and date of occurence (auto accidents, falls, emotional or sexual abuse).____

____

Name________________________________ Date____________________

Personal Health History: Please circle any illnesses or conditions you currently have or have had in the past.

Do you have a ***Pacemaker*** **? Y / N**

AIDS/HIV	Bleed Easily	Heart Disease	Multiple Sclerosis	Shingles
Alcoholism	Cancer	Hepatitis	Night sweats	Stroke
Allergies	Chicken Pox	High Blood Pressure	Pertussis/ whooping cough	Thyroid Disease
Anemia	Diabetes	Jaundice	Pneumonia	Tuberculosis
Antibiotics	Epilepsy	Kidney Disease	Polio	Ulcers
Asthma	Glaucoma	Mental Disorder	Rheumatic fever	Vascular Disease

Other: ____

Family Health History: Circle illnesses that have occurred in any of your immediate blood relatives.

Alcoholism	Bleed easily	Diabetes	Heart Diseases	Kidney Disease	Obesity
Allergy	Cancer	Epilepsy	High Blood Pressure	Mental Illness	Stroke

Other: ____

List any allergies to Foods, Drugs or Environmental allergens :

____

____

Medications, Vitamins & Supplements

Date Started	Name	Reason for taking	Dosage	Quantity	Frequency

Lifestyle and Nutrition:

Circle which substances below you use and how much:

Caffeine ______________________

Alcohol ______________________

Tobacco ______________________

Marijuana ______________________

Sugar ______________________

Circle if your work or lifestyle expose you to these:

Stress

Insufficient Sleep

Very Long Work Hours

Long Commuting Times

Heavy Lifting or hazardous substances

Typical Daily intake:

Breakfast: ______________________

Lunch: ______________________

Dinner: ______________________

Snacks: ______________________

What do you **NOT** eat: ______________________

Exercise & Energy : What is your normal energy level ? high medium Low

What type of exercise do you do ? ______________________ How often?______________

Name____ Date________________________

Chinese Medical Diagnosis (continued)

For Men:

Libido: normal high low

swollen testes _____________testicular pain______________ impotence____________

premature ejaculation______________ feeling cold or numbness in genitalia _________

other ____

For Woman:

Menstrual cycle Y or N Age menses started _____ # Days of flow_____________

Date of last menstrual period ____________ Are you or could you be pregnant now ? Y/N

If you use contraceptives, which one(s)____

# of pregnancies __________ # of children _______ Age of children_________________

Age of menopause ____________ Are you experiencing hot flashes ? ________________

Night sweats ? _______________ Heart Palpitations ?______ Frequency? ______________

Do you experience any of the following premenstrual symptoms:

_____ Nausea _____food cravings _____depression _____vomiting ___Headaches/ migraines

_____irritability _____water retention ___anxiety ___breast swelling/ tenderness ___heightened sensitivity

Please fill in menstrual chart	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color- (bright red, pale, brown,dark red)							
Amount of flow (normal, heavy, light)							
Pain/cramps (dull, sharp, other)							
Clots (large, small,red,purple,black)							

Name ______________________________ Date ______________

Chinese Medical Diagnosis - **Please Check any frequent symptoms you are currently experiencing or place an X if you have experienced it the past year.**

Liver/Gallbladder
Wood
Prone to depression
Anxiety/stress
Headaches/migraines
Dizziness
Red/dry/itchy eyes
Blurred vision
Gallstones
Feeling lump in throat
Clenching teeth at night
Difficulty falling asleep at night
Vivid dreams/scary
Shingles
Herpes- oral/genital
PMS
Menstrual problems
Seizures/tremors
Muscle cramps/twitch
Neck/shoulder- pain / tightness
Heartburn
Bitter taste in mouth
Pain below rib cage
Brittle fingernails
Tendonitis
Eczema
Bitty stools
Anger easily
Crave sour foods

Heart/Small Intestine
Fire
Heart palpitations
Rapid /irregular heartbeat
High/low blood pressure
Chest pain
Insomnia
Nightmares
Waking too early unable to fall asleep
Prone to extreme restlessness
Prone to agitation,anxiety
Easily Startle
Gum problems
Lack vitality
Crave bitter foods

Spleen/Stomach
Earth
Muscles feel tired frequently
Tendency to gain weight
Feel sluggish
Hard to get up in the morning
Abdominal pain
Fatigue/low energy
Edema of hands/feet
varicose veins
Bruise easily
Bad breath
Sweetish taste in mouth
Lack of taste
Excessive hunger
Low appetite
Gas/belching
Bad breath
Excessive thirst
Lack of thirst
Nausea/vomiting
Gas/belching
Chronic loose stools
Hemorrhoids
Abdominal pain
Hypothyroidism
Mouth ulcers
Overthinking/worry
Crave sweets foods

Kidney/Bladder
Water
Osteoporosis
Dark circles under eyes
Thyroid problems
Poor memory
Impotence
Premature ejaculation
Low libido
Poor circulation
Weakness/Pain low back knees
Lack of bladder control
Frequent urination
Urgency/dribbling
Wake at night to urinate
Dark urine
Early morning loose stool
Loss of hearing
Ringing in ears
Cold hands/feet
Night sweats/hot flash
Vaginal dryness
Emotional instability
Feel fearful
Crave Salty

Lung/Large Intestine
Metal
Chronic cough
Dry cough
Cough with sputum
Bloody cough
Nasal discharge
Post nasal drip
Dryness mouth/nose/throat
Itchy/red/painful throat
Bronchitis
Allergies
Sinus infection/congestion
Asthma
Low immunity
Catch colds easily
Snoring
Dry skin
Black or Tarry stools
Constipation
Diarrhea
IBS
Colitis/spastic colon
Skin rashes / hives
Crave spicy foods

Dampness
Tired/ sluggish after meals
Cystic or pustular acne
Mental sluggish/brain fog
Urgent/ foul smelling stools
Joint achiness

Blood Deficiency
Dry flaky skin,
Chapped lips
Pale lips,tongue,inside lower eyelid
Diminished night vision