**Metsuyan Wellness** nikki@metsuyanwellness.com 301.828.8856

# New Patient Intake Form

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your information is confidential. Please print clearly in ink.

**IDENTIFICATION:**

Name: _____ Sex: ☐F ☐ M Date:_____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (Home)_____(Work)_____ (Cell)_____

Date of Birth: _____ Age: _____ Email:_____

Single: ☐ Married: ☐ Partnered: ☐ Separated: ☐ Divorced: ☐ Widowed: ☐

Height:_____ Weight:_____ Occupation:_____

Education: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Telephone:_____(Home) _____(Cell)

Name of Physician*: _____ Physician's Telephone:_____

Physician's Address:_____

Date of Last Physician Appointment:_____ Date of Last Gynecology Exam: _____ ☐ N/A

Have you ever been treated with acupuncture before? ☐ Yes ☐ No

*No contact will be made to the physician without your permission.

Reason why coming for Acupuncture: _____

_____

_____

_____

Current symptoms or problems:_____

_____

_____

_____

**FAMILY HISTORY**: Please complete for each family member, as best you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes:

| | Self (date) | Mother | Father | Sibling | Spouse / Partner | Children |
|---|---|---|---|---|---|---|
| Adopted | | | | | | |
| Good Health | | | | | | |
| Cancer or Tumors | | | | | | |
| Diabetes | | | | | | |
| Thyroid Disorders | | | | | | |
| Kidney Disorders | | | | | | |
| High Blood Pressure / Heart Disease/ | | | | | | |
| Stroke | | | | | | |
| Blood or bleeding disorders / Anemia | | | | | | |
| Seizures | | | | | | |
| Allergies | | | | | | |
| Alcohol or other drug use | | | | | | |
| Depression or mental illness | | | | | | |
| Hepatitis / Other liver disorder | | | | | | |
| Musculo-skeletal Disorder | | | | | | |
| Deceased (age) | N/A | | | | | |

**PERSONAL LIFESTYLE HABITS**: For each item, please indicate how much, how many or how often. Please note if this is current or the date that you quit

Cigarettes (Pack per day) _____ Coffee / Tea (cups per day) _____
Alcohol (drinks per week) _____ Soda (regular or diet) _____
Drug Use (recreational) _____ Exercise ☐ Yes ☐No How Often? _____
What Kind of Exercise? _____

**MEDICAL**: If you have been hospitalized or in the Emergency Room for a serious medical illness or operation, please list all of them below (do not include normal pregnancies)

| YEAR | OPERATION / ILLNESS |
|---|---|
| | |
| | |
| | |
| | |

**MEDICINES:** Please list all medications, vitamins, and / or food supplements you are currently taking:

Medications_____ Dosage_____ For what condition?_____
_____ _____ _____
_____ _____ _____
_____ _____ _____
Vitamins _____ Dosage_____ For what condition?_____
_____ _____ _____
_____ _____ _____
Food Supplements _____ For what condition? _____
_____ _____
_____ _____
_____ _____

**CURRENT AND PAST CONDITIONS / SYMPTOMS / TRAUMAS**

Please put a "**C**" if the condition is current or a "**P**" if you had it in the past

**General**

_____ Insomnia
_____ Dreams / nightmare
_____ Fatigue
_____ Poor Memory
_____ Strongly like cold drinks
_____ Strongly like hot drinks
_____ Recent weight loss/gain
_____ Cold hands & feet
_____ Chills
_____ Fever
_____ Bad Breath
_____ Other (Describe)
_____

**Head & Neck**

_____ Headaches
_____ Migraines
_____ Stiff Neck
_____ Dizziness
_____ Fainting
_____ Swollen Glands
_____ Other (Describe)
_____

**Ears**

_____ Ringing
_____ Hearing Loss
_____ Hearing aids
_____ Infections
_____ Earache
_____ Vertigo
_____ Other (Describe)
_____

**Eyes**

_____ Glasses / contact lenses
_____ Blurred Vision
_____Poor Night Vision
_____ Spots or floaters
_____ Eye inflammation
_____Double Vision
_____ Glaucoma
_____ Cataracts
_____ "Lazy" Eye
_____ Other (Describe)
_____
_____ How often checked?

**Nose, Throat & Mouth**

_____Sinus Infection
_____ Hay Fever / Allergies
_____ Frequent sore throat
_____ Difficulty swallowing
_____ Mouth & tongue ulcers
_____ Frequent colds
_____ Nosebleeds
_____ Dry nose
_____ Nasal congestion
_____ Loss of voice
_____ Thirst
_____ Excessive phlegm
_____ TMJ
_____ Facial pain
_____ Gum problems
_____ Dry mouth
_____ Other (Describe)
_____
_____ Dental problems? Last visit
_____

**Skin**

_____ Hives
_____ Rashes
_____ Eczema / psoriasis
_____ Night sweating
_____ Excess sweating
_____ Dry skin
_____ Easily bruised
_____ Changes in moles, lumps
_____ Itching
_____ Other (Describe)
_____

**Respiratory**

_____ Difficulty breathing
_____ Difficulty breathing when reclining
_____ Wheezing
_____ Asthma
_____ Chronic cough
_____ Wet cough
_____ Dry cough
_____Coughing up phlegm
_____Coughing up blood
_____ Shortness of breath
_____ Tight chest
_____ Pneumonia
_____ Other (Describe)

**Cardiovascular**

_____ High blood pressure
_____ Low blood pressure
_____ Chest pain or tightness
_____ Palpitations
_____ Rapid heart beat
_____ Irregular heart beat
_____ Poor circulation
_____ Swollen ankles
_____ Phlebitis
_____ Anemia
_____ History of heart disease
_____ Heart murmur
_____ Night sweats
_____ Tendency to be cold
_____ Tendency to be warm
_____ Other (Describe)
_____

**Gastrointestinal**

_____ Nausea
_____ Indigestion
_____ Stomach Pain
_____ Diarrhea
_____ Constipation
_____ Poor appetite
_____ Excessive hunger
_____ Vomiting
_____ Gas
_____ Hiccups
_____ Acid regurgitation
_____ Bloating
_____ Laxative use
_____ Bloody stool
_____ Other (Describe)
_____

**Musculoskeletal**

_____ Joint pain / swelling
_____ Sore muscles
_____ Weak muscles
_____ Difficulty walking
_____ Pain (describe)
_____
_____
_____
_____ Limited range of motion
_____ Other (Describe)

**Neurological**

_____ Seizures
_____ Tremors
_____ Numbness or tingling
_____ Pain (describe)
_____
_____
_____ Paralysis
_____ Poor coordination
_____ Other (Describe)
_____

**Mental / Emotional**

_____ Depression
_____ Mood swings
_____ Irritability
_____ Difficulty relaxing
_____ Loneliness
_____ Sensitive
_____ Shyness
_____ Frequent crying
_____ Worries frequently
_____ Compulsive behaviors
_____ Difficulty focusing
_____ Hopeless outlook
_____ Suicidal thoughts
_____ Lose temper
_____ Frustration
_____ Other (describe)
_____

**Urinary**

_____ Pain on urination
_____ Frequent urination
_____ Urgent urination
_____ Blood in urine
_____ Incontinence
_____ Incomplete urination
_____ Bedwetting
_____ Wake to urinate
_____ History of UTI
_____ Kidney (specify)
_____
_____
_____ Other (describe)
_____

**Male Genital**

_____ Impotence
_____ Premature Ejaculation
_____ Nocturnal emission
_____ Pain / itching of genitalia
_____ Lumps in testicles
_____ Increased libido
_____ Decreased libido
_____ Other (Describe)
_____

**Gynecology (Women Only)**

_____ Currently pregnant
_____ # of pregnancies
_____ # of Live births
_____ # of miscarriages
_____ # of abortions
_____ Menopause
_____ Hormone Replacement Therapy
_____ Irregular periods
_____ Menstrual cramps
_____ Excessive blood flow
_____ Menstrual blood clots
_____ Breast tenderness
_____ Abnormal pap smear
_____ Vaginal infections
_____ Vaginal pain / itching
_____ Uterine fibroids
_____ Endometriosis
_____ Breast lumps, cysts
_____ Increased libido
_____ Decreased libido
_____ Other (describe)
_____

**Infection Screening**
**(check self and/or partner)**

_____ HIV risks ☐ Self ☐ Partner
_____ TB ☐ Self ☐ Partner
_____ Hepatitis risk ☐ Self ☐ Partner
_____ History of sexually transmitted disease ☐ Self ☐ Partner
(specify)
_____
_____
_____ Other (describe)
_____

**Trauma** (List)

_____
_____
_____
_____

**Other Information**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Referred by:**_____

**Signature:**_____ **Date:**_____