

# NEW PATIENT INTAKE FORM



Acupuncture \* Herbs \* Nutrition  
Located inside of Yoga 360  
91 Bankview Drive Frankfort, IL 60423  
815-806-0360/www.yoga-360.com  
lkacupuncture.com  
lizkelchak@gmail.com

## How To Prepare for your First Acupuncture Appointment

- It is best to eat food within 4 hours of receiving your treatment. If you have not recently eaten a light snack is recommended.
- Please refrain from caffeine and alcohol before your treatment.
- Loose fitting clothing is recommended. If you forget or are coming from work, don't worry, we have towels you can use!
- Please provide any recent lab results that pertain to your condition.
- Please provide a list of any medications you are currently taking.
- Please complete the following New Patient Intake form and bring it with you to your first appointment.
- Questions before your appointment?  
Email Liz: lizkelchak@gmail.com

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**PLEASE READ:** Fill out this intake completely and include as much detail as possible. Some questions may seem irrelevant to your main complaint, however this information is significant in helping us make an accurate diagnosis and formulate the most appropriate treatment for you.

**All information is confidential.**

## PATIENT INFORMATION:

Patient Name (Mr., Mrs., Ms.): \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: F \_\_\_\_ M \_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_lbs

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Legal Guardian (if Under 18): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you find out about us? \_\_\_\_\_

MAJOR COMPLAINTS	WHEN DID THE CONDITION START?
1.	
2.	
3.	
4.	
5.	

How do these conditions affect your daily activity? \_\_\_\_\_

**PATIENT MEDICAL HISTORY** (Circle any of the following that you had/ or have)

Allergies  
Anemia  
Arthritis  
Asthma  
Blood transfusion  
Cancer-  
Type \_\_\_\_\_  
Chicken Pox  
Diabetes  
Epilepsy/Seizures  
Glaucoma  
Gonorrhea/Herpes

Gout  
Heart Attack  
Hepatitis  
High Blood Pressure  
High Cholesterol  
HIV/Aids  
Jaundice  
Kidney Stones  
Liver Illness  
Low Blood Pressure  
Measles  
Migraines

Mononucleosis  
Multiple Sclerosis  
Mumps  
Obesity  
Pacemaker  
Parasites  
Parkinson's  
Pneumonia  
Polio  
Syphilis  
Thyroid Disease  
Tuberculosis

Other:

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Hospital

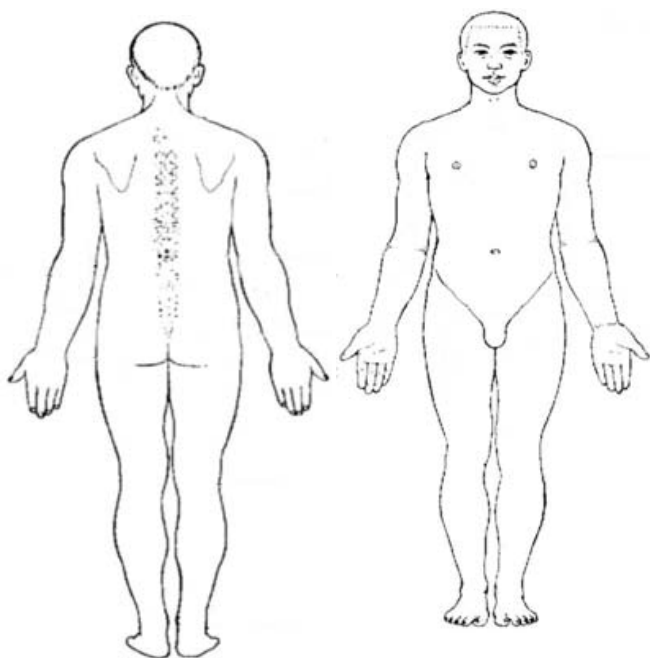
Stays/Surgeries: \_\_\_\_\_

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Recent Tests: (include type of test, test results, and date):

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**Please mark areas of pain:**



**PAIN QUALITY**

\_\_\_ Sharp    \_\_\_ Achy    \_\_\_ Burning

\_\_\_ Numb    \_\_\_ Tingling    \_\_\_ Throbbing

\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_

**WHAT MAKES THE PAIN BETTER?**

\_\_\_ Heat    \_\_\_ Cold    \_\_\_ Pressure

\_\_\_ Stretching    \_\_\_ Rest    \_\_\_ Movement

\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_

**WHAT MAKES THE PAIN WORSE?**

\_\_\_ Heat    \_\_\_ Cold    \_\_\_ Pressure

\_\_\_ Stretching    \_\_\_ Rest    \_\_\_ Movement

\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_

Please check the following that currently  
pertain to you:

**OVERALL:**

- ☐ Hot body temperature
- ☐ Cold body temperature
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in Hands, feet, chest
- ☐ Hot flashes any time of day
- ☐ Thirsty
- ☐ Perspire easy
- ☐ Lack of perspiration
- ☐ Low energy
- ☐ Dizziness
- ☐ Catch colds easily
- ☐ Shortness of breath
- ☐ Difficult keep eyes open during day
- ☐ Floaters in vision

**HEART:**

- ☐ Anxiety
- ☐ Palpitations
- ☐ Sores on tip of tongue
- ☐ Mental Confusion
- ☐ Frequent Dreams
- ☐ Tightness in chest
- ☐ Trouble Falling Asleep
- ☐ Trouble Staying Asleep

**LUNG:**

- ☐ Allergies—To what \_\_\_\_\_
- ☐ Asthma
- ☐ Sinus Congestion/Pressure
- ☐ Cough
- ☐ Headache—Location \_\_\_\_\_  
Frequency \_\_\_\_\_
- ☐ Dry Throat
- ☐ Dry Nose
- ☐ Dry Mouth
- ☐ Alternate chills & fever
- ☐ Smoke cigarettes—#/day \_\_\_\_\_
- ☐ Sadness
- ☐ Sore throat
- ☐ Stiff Neck
- ☐ Stiff Shoulders
- ☐ Difficulty breathing
- ☐ Snoring
- ☐ Chest Congestion

**SPLEEN, STOMACH, INTESTINES:**

- ☐ Low Appetite
- ☐ Large Appetite
- ☐ Abdominal Bloating
- ☐ Abrupt weight loss
- ☐ Abrupt weight gain
- ☐ Abdominal gas
- ☐ Bad breath
- ☐ Gurgling in the stomach
- ☐ Fatigue after eating
- ☐ Bruise easily
- ☐ Hemorrhoids
- ☐ Worry
- ☐ Over-thinking
- ☐ Prolapsed organs—Which \_\_\_\_\_
- ☐ Loose stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Incomplete
- ☐ Blood in stool
- ☐ Mucous in stool
- ☐ Undigested food in stool
- ☐ Burning sensation after eating
- ☐ Heartburn
- ☐ Acid Reflux/Regurgitation
- ☐ Ulcer
- ☐ Belching
- ☐ Hiccups
- ☐ Bleeding, swollen gums
- ☐ Stomach pain
- ☐ Vomiting

**DAMPNESS IN THE BODY:**

- ☐ Mental Heaviness
- ☐ Mental Fogginess
- ☐ Mental Sluggishness
- ☐ Sensation of heaviness in body
- ☐ Swollen Hands
- ☐ Swollen Feet
- ☐ Swollen Joints
- ☐ Nausea

Please check the following that currently  
pertain to you:

**LIVER, GALLBLADDER:**

- ☐ Alternating diarrhea & Constipation
- ☐ Tightness in chest
- ☐ Bitter taste in mouth
- ☐ Headache top of head
- ☐ Depression
- ☐ Frustration
- ☐ Anger Easily
- ☐ Irritability
- ☐ Numbness
- ☐ Muscle Twitching
- ☐ Muscle Spasms
- ☐ Muscle Cramping
- ☐ Tingling Sensation
- ☐ Seizures
- ☐ Lump in Throat
- ☐ Neck tension
- ☐ Shoulder tension
- ☐ Drink Alcohol
- ☐ Skin Rash
- ☐ High-Pitched ringing in ears
- ☐ Limited Range-of-Motion—Neck
- ☐ Limited Range of Motion---Shoulder
- ☐ Adapt to Stress Poorly
- ☐ Recreational drug use—  
Which? \_\_\_\_\_  
How often per week? \_\_\_\_\_

**EYES :**

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot sensation
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry Vision
- ☐ Decrease night vision
- ☐ Near-sighted
- ☐ Far-sighted

**KIDNEY, URINARY BLADDER:**

- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weakness of knees
- ☐ Cold sensation in knees
- ☐ Frequent Cavities
- ☐ Low Back pain
- ☐ Memory Problems
- ☐ Excessive hair loss
- ☐ Low-pitch ringing in ears
- ☐ Kidney stones
- ☐ Bladder infection
- ☐ Lack of Bladder control
- ☐ Wake during night to urinate  
# of times/night \_\_\_\_\_
- ☐ Startle easy
- ☐ Fear

**URINATION:**

- ☐ Normal Color
- ☐ Dark Yellow
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong Odor
- ☐ Burning
- ☐ Painful
- ☐ Difficult
- ☐ Urgent
- ☐ Frequent
- ☐ Weak Stream

**LIBIDO (Sex Drive):**

- ☐ Normal
- ☐ High
- ☐ Low

**MEN ONLY:**

- ☐ Swollen Testes
- ☐ Testicular Pain
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Coldness or Numbness in external genitalia
- ☐ Enlarged Prostate
- ☐ Prostate Cancer

## WOMEN ONLY:

Are you Pregnant? YES / NO                      Number of Children        \_\_\_\_\_                      # of Pregnancies \_\_\_\_\_

Age of first menstruation \_\_\_\_\_                      Regular Menstrual Cycles? YES / NO

Avg # of days of cycle \_\_\_\_\_                      Avg # of days bleeding \_\_\_\_\_                      Bleeding between periods—YES / NO

Age of Menopause \_\_\_\_\_                      Hysterectomy YES / NO

## PMS SYMPTOMS:

\_\_\_\_Breast Swelling                      \_\_\_\_Breast Tenderness                      \_\_\_\_Water Retention                      \_\_\_\_Migraines  
\_\_\_\_Headaches                      \_\_\_\_Anxiety                      \_\_\_\_Depression                      \_\_\_\_Irritability  
\_\_\_\_Nausea                      \_\_\_\_Vomiting                      \_\_\_\_Food Craving

\_\_\_\_Cramping/Pain—When? \_\_\_\_\_                      \_\_\_\_Spotting—When? \_\_\_\_\_

Please use the following choices to describe your menses flow every day during your period in the table below:

Color:                      black / brown    / purple / dark red / bright red / pink / pale

Amount:                      heavy / medium / light / spotting

Clots:                      many / few / none

Clot size:                      dime-size / nickel-size / quarter-size / larger

Consistency:                      thick / thin / watery / dilute

	Color	Amount	Clots	Clot size	Consistency
Day 1					
Day 2					
Day 3					
Day 4					
Day 5					
Day 6					
Day 7					

# MEDICATION LOG

*(Please include ALL prescriptions, OTC meds, Vitamins, & supplements)*

Any known Allergies? \_\_\_\_\_

Medication/Vit/Supplement	Reason taking	Dosage	Frequency	Date Started

## Diet

<b>Breakfast</b>	
<b>Lunch</b>	
<b>Dinner</b>	
<b>Snacks</b>	
<b>Other</b>	

Water intake per day? \_\_\_\_\_

Coffee per day?      0      1-2      3-4      5+

Soda/Pop per day?   0      1-2      3-4      5+      Diet or Regular

Energy Drinks? \_\_\_\_\_

Do you drink Milk?      Daily   3-5x/wk      1-2x/wk      Never

Alcohol? \_\_\_\_\_

Do you eat Organic food?      Never      Sometimes      Always

Do you use Artificial Sweeteners? Yes / No which one? \_\_\_\_\_