3712 MacArthur Blvd. Ste 208
New Orleans, LA 70114
(504) 362 - 8020
info@nolaacupuncture.com
www.nolaacupuncture.com

ACUPUNCTURE WELLNESS CENTER

5150 Highway 22, Suite A6
Mandeville, LA 70471
(985) 635 - 8846
info@mandevilleacupuncture.com
www.mandevilleacupuncture.com

New Patient Intake Form

This information is strictly confidential. If we do not sincerely believe that you will respond favorably to acupuncture, we will not accept your case, but will refer to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely. If you have any questions, don't hesitate to ask one of our staff members for help.

PATIENT INFORMATION

Today's Date: _____

Name _____ SSN _____ Age _____ Date of Birth _____

Height _____ Weight _____ Sex ❑ M ❑ F Marital Status ❑Single ❑Married ❑Divorced ❑Widowed ❑Partnered

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Occupation _____ Employer/School Name _____

Emergency Contact: Name _____ Relationship _____ Phone _____

Primary Physician /Referring Physician _____ Phone _____

Insurance Carrier _____ Policy Number _____

How did you hear about us? ❑Family/Friend ❑Health Professional ❑Internet ❑Other _____ Referred by _____

Have you received acupuncture before? ❑Yes ❑No If yes, when? _____ from who? _____ for what? _____

Have you used Chinese herbal medicine before? ❑Yes ❑No If yes, please list formula:_____

CHIEF COMPLAINT

Main complaint _____

Please rate your current pain/discomfort on a scale of 1-10: very slight ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 unbearable

How long have you had this problem? _____

What seems to cause this problem? _____

Have you been given a diagnosis? ❑Yes ❑No If yes, what? _____

by whom? Physician's Name _____ Phone _____

To what extent does this problem interfere with your daily activities (work, exercise, sleep, sex, etc.)? _____

_____

What kinds of treatment have you tried? How did your condition change? _____

_____

What makes it better? _____ Worse? _____

Is there anyone in your family with the same/similar problems? _____

Do you have a pacemaker? ❑Yes ❑No Do you bleed for a long time? ❑Yes ❑No

Do you have any of the following conditions currently? ❑Cold/ Flu ❑Infection/Inflammation ❑Menstruation ❑Pregnancy/Lactation

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MEDICAL HISTORY

Please check any of the following which have ever affected you and indicate date.

❑ Addiction _____	❑ Candida	❑ Fibromyalgia	❑ HIV positive	❑ Rheumatism
❑ AIDS	❑ Chicken pox	❑ Gall stones	❑ Kidney stones	❑ Scarlet fever
❑ Alcoholism	❑ Chronic fatigue	❑ Glaucoma	❑ Malaria	❑ Seizures
❑ Anemia	❑ Colitis/ Bowel disease	❑ Goiter	❑ Measles	❑ Stroke
❑ Appendicitis	❑ Diabetes	❑ Gout	❑ Meningitis	❑ STD _____
❑ Arteriosclerosis	❑ Digestive disorders	❑ Heart disease	❑ Mononucleosis	❑ Thyroid problems
❑ Arthritis	❑ Eating disorder	❑ Hernia	❑ Multiple sclerosis	❑ Tonsillitis
❑ Asthma	❑ Elevated liver enzymes	❑ Hepatitis	❑ Mumps	❑ Tuberculosis
❑ Breast lumps	❑ Emotional imbalance	❑ Herpes	❑ Nephritis	❑ Typhoid fever
❑ Breathing problems	❑ Emphysema	❑ High cholesterol	❑ Neuralgia	❑ Ulcers
❑ Bronchitis	❑ Epilepsy	❑ Hypertension	❑ Paralysis	❑ Urinary problems
❑ Bursitis	❑ Food, chemical, drug poisoning	❑ Hypotension	❑ Prostate problems	❑ Whooping cough
❑ Cancer _____		❑ Other _____		

Surgeries, Hospitalizations and Significant Trauma's (auto accidents, falls, loss of loved one, etc)

DATE	EVENT

Allergies and adverse reactions _____

Medications taken in last 3 months, including vitamins, supplements, over-the-counter medicines, herbal medicines.

MEDICATION	DOSAGE	REASON	HOW LONG	LAST CHECKUP DATE

List any other issues you would like to discuss today. _____