Acupuncture & Integrative Medicine Center

3201 N. 3rd Street – Phoenix, Arizona 85012
Phone: (602) 265-1774 Fax: (602) 265-1738

New Patient Intake

Name ______________________________________ Date ________________

Age _____ Date of Birth _____________ Sex: M F SS# ________________

Address: Street ____
City ______________________ State _____ Zip code ______________

Phone #: Home ______________________ Work/Other ______________________
E-mail: ______________________________ Occupation ______________________
Employer ___________________________ Hours per week ___________________
Insurance co ____

Are you: Married _____ Significant partnership _____ Single _____
Separated _____ Widowed _____ Divorced _____

Live with: Spouse _____ Partner _____ Relatives _____
Friends _____ Parents _____ Alone _____

In case of emergency, contact __________________________ Phone_____________
Relationship ____________________ Address _______________________________

Where did you last receive health care? ______________________________________
Approximate date ________ Reason _______________________________________
May we contact your previous physicians? Yes _____ No _____

What are your most important health problems or concerns? List as many as you can in order of importance. *(You may use additional space on the back of this sheet if needed)*

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

What are your health goals?

____
____
____
____
____

How did you learn about A.I.M. Center? ______________________________________
____

What natural therapies have you tried?

Acupuncture	_____	Herbs	_____	Homeopathy	_____
Nutrition/Diet mgmt.	_____	Vitamins	_____		
IV nutrition	_____	Counseling	_____		
IV chelation	_____	Yoga	_____		
Spinal Manipulation	_____	Massage	_____		

Other____

Are you coming here for any specific therapy? ________________________________
____

Family History

Check all that apply	Father	Mother	Brothers	Sisters	Spouse/ Partner	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health G=good P=poor	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Allergies Asthma, Hayfever	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

Personal Health History/Significant illness or injuries (diagnosis and treatments):
____
____
____
____

Surgeries/Hospitalizations (tonsils, gall bladder, appendix, uterus, ovaries…)
____
____
____
____

Known Allergies (medications, antibiotics, latex, foods, food additives/dyes): _______
____

Date of Last Physical Exam: ____

This survey will help us to evaluate you more completely. Please place a check mark next to those symptoms that You NOW experience Or have experienced in the PAST. Include all the complaints that are familiar to you. If there are one or more words in a line which describe your specific problem you may want to circle those words.

NOW	PAST	GENERAL SYMPTOMS
____	____	tired, weak, lack of energy
____	____	depression, melancholy, moodiness
____	____	worry, anxiety, nervousness, irritability
____	____	mental cloudiness or "foggy brain"
____	____	sleep too much
____	____	insomnia – difficulty falling asleep/staying asleep
____	____	don't sweat enough
____	____	sweat too much
____	____	night sweats
____	____	dizziness, fainting, convulsions
____	____	loss or gain of weight
____	____	frequent colds or other illness
____	____	headaches: tension and/or migraine
____	____	chronic pain
____	____	difficulty managing stress
____	____	other ____________________

NOW	PAST	SKIN AND HAIR
____	____	acne or pimples
____	____	skin rashes
____	____	hives
____	____	stretch marks
____	____	skin ulcers or sores
____	____	dry, rough or scaling skin – head, arms, legs, torso
____	____	hair loss or thinning
____	____	dry, coarse hair or split ends
____	____	bruise easily
____	____	nails weak, ridged or split easily
____	____	brown spots or bronzing on skin
____	____	moles, warts or skin tags
____	____	sunburn easily
____	____	cuts heal slowly
____	____	flush easily
____	____	hands or feet numb or tingling
____	____	feet burn
____	____	athlete's feet
____	____	other ____________________

NOW	PAST	EYES
____	____	corrective eyewear – nearsighted or farsighted
____	____	blurred vision
____	____	dry, burning or itching eyes
____	____	eyes water excessively
____	____	eyes sensitive to light
____	____	night blindness
____	____	bloodshot or puffy eyes
____	____	glaucoma
____	____	cataracts
____	____	other ____________________

NOW	PAST	EARS
____	____	lots of wax
____	____	earaches
____	____	noises or ringing
____	____	discharges
____	____	loss of hearing
____	____	other ____________________

NOW	PAST	NOSE, MOUTH & THROAT
____	____	hay fever, sinusitis, runny nose
____	____	dry mouth or nose
____	____	nosebleed
____	____	snoring
____	____	dry or chapped lips
____	____	sore throats or tonsillitis
____	____	clear throat often
____	____	sore, red or cracked tongue
____	____	cold sores or herpes
____	____	inability to smell or taste
____	____	lots of cavities
____	____	bleeding gums
____	____	hoarseness
____	____	bad breath
____	____	metallic or bitter taste in mouth
____	____	other ____________________

NOW	PAST	GASTROINTESTINAL
____	____	loss of appetite
____	____	increased appetite
____	____	food cravings
____	____	eating disorder–anorexia/bulim.
____	____	nausea or vomiting
____	____	difficulty swallowing
____	____	heartburn
____	____	indigestion
____	____	heaviness after eating
____	____	belching or gas
____	____	bloating
____	____	stomach/abdomen tenderness
____	____	symptoms better after eating
____	____	symptoms worse after eating
____	____	avoid/unable to eat certain foods
____	____	headache, dizzy or irritable if skip a meal
____	____	diarrhea or loose stools
____	____	constipation
____	____	change in bowel movements
____	____	irritable bowel
____	____	gray, yellow or greasy stool
____	____	dark stools or blood in stools
____	____	undigested food in stool
____	____	feeling incomplete bowel mvmt.
____	____	foul odor to stool or gas
____	____	hemorrhoids
____	____	other ____________________

NOW	PAST	RESPIRATORY
____	____	cough frequently
____	____	difficulty breathing
____	____	shortness of breath on exertion
____	____	asthma
____	____	bronchitis
____	____	frequent respiratory infections
____	____	chest pain
____	____	spitting up mucus or blood
____	____	other ____________________

NOW	PAST	**CARDIOVASCULAR**
____	____	heart beats fast
____	____	heart beats irregular
____	____	tightness in chest
____	____	dizzy or weak on standing
____	____	swollen feet, ankles or legs
____	____	hands, feet or fingernails turn blue
____	____	varicose veins
____	____	leg pain while walking
____	____	high blood pressure
____	____	low blood pressure
____	____	anemia
____	____	other ____________________

NOW	PAST	**URINARY**
____	____	difficulty urinating
____	____	urinate frequently at night
____	____	incontinence or bedwetting
____	____	incomplete urination, dribbling
____	____	pain on urination
____	____	bladder infections
____	____	kidney infections
____	____	urine – cloudy or foamy
____	____	urine color change: dark, light
____	____	kidney stones
____	____	low back pain
____	____	other ____________________

NOW	PAST	**MUSCULAR-SKELETAL-NEUROLOGIC**
____	____	muscle pain, stiffness, spasms
		where? ____________________
____	____	swollen, painful or stiff joints
____	____	back pain
____	____	painful feet, ankles or calves
____	____	tremors or twitches
____	____	numbness or tingling
____	____	bone pain
____	____	loss of strength or muscle wasting
____	____	broken or fractured bones
____	____	other ____________________

NOW	PAST	**GENITAL-SEXUAL**
____	____	not sexually active
____	____	sexually active with men
____	____	sexually active with women
____	____	diminished sexual desire
____	____	excessive sexual desire
____	____	pain/discomfort in genital area
____	____	genital itching, sores or lesions
____	____	physical and/or sexual abuse
____	____	questions/concerns about sex
____	____	concern about STDs
____	____	other ____________________

MALES ONLY

NOW	PAST	
____	____	prostate problems
____	____	difficult or unusual urination
____	____	inability to impregnate

NOW	PAST	
____	____	difficulty with erections
____	____	discharge from penis
____	____	other ____________________

Date of Last Testicular or Prostate Exam ___/___/___

Date of Last PSA blood test: ___/___/___

FEMALES ONLY

NOW	PAST	
____	____	irregular menstruation or no menses
____	____	pain prior to or with menses
____	____	heavy or scanty menstrual flow
____	____	clots with menses
____	____	headaches prior to or with menses
____	____	irritable or depressed around periods
____	____	water retention around periods
____	____	food cravings around menses
____	____	painful or swollen breasts
____	____	lumps in breasts
____	____	fibrocystic breasts
____	____	discharge from breasts
____	____	breast cancer
____	____	breast implants
____	____	abnormal mammogram
____	____	hysterectomy

NOW	PAST	
____	____	vaginal discharge or itching
____	____	vaginal infections / candida
____	____	vaginal dryness
____	____	vaginal pain
____	____	uterine fibroids
____	____	ovarian cysts
____	____	endometriosis
____	____	trying to get pregnant
____	____	hot flashes and/or night sweats
____	____	menopause
____	____	osteoporosis
____	____	birth control pills or shots
____	____	IUD, diaphragm, cervical cap
____	____	hormone replacement therapy
____	____	abnormal PAP smear
____	____	other ____________________

Age at onset of first menses _____ Pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Date of Last Menses ____/____/____ Length of Menses _____ days *(avg 1-5 days)* Length of Cycle _____ days *(avg 21-28 days)*

□ Pads □ Tampons — How Many on Heaviest Day? _______ Yearly Gynecological Exams? Y N Date of last Pap_______

Additional Information: ____

Please list food supplements, vitamins, minerals, homeopathics, and herbs you currently take:

____
____
____
____
____

Please list prescription and non-prescription medicines you currently take:

____
____
____
____
____

Check the diet that most closely matches yours:

- ◻ meat, potatoes, vegetables, breads
- ◻ vegetarian (no cheese or dairy)
- ◻ vegetarian (eat cheese or dairy)
- ◻ high protein, low carbohydrate
- ◻ low fat
- ◻ fast food
- ◻ kosher
- ◻ other: ____

Do you use any of the following?:

◻ Cigarettes	______ packs per day for ______ years
◻ Alcohol	______ drinks per ____ day ____ month type _________________
◻ Marijuana or other drugs	______ times per month
◻ Coffee or black tea	______ cups per day
◻ Caffeinated drinks/sodas	______ drinks per day

Subjective Stress Assessment

Directions: Place an "X" on the position of the line that corresponds most closely to how you rate yourself on the scale below.

For example: ***Relaxed*** /------------*X*------------/---------------------------/ ***Tense***

Relaxed	|---------------------------|---------------------------|	**Tense**
Calm	|---------------------------|---------------------------|	**Anxious**
Worry Free	|---------------------------|---------------------------|	**Worry Excessively**
Happy	|---------------------------|---------------------------|	**Depressed**
High Energy	|---------------------------|---------------------------|	**Low Energy**
Sleep Good	|---------------------------|---------------------------|	**Sleep Poor**
Unhurried	|---------------------------|---------------------------|	**Hurried/Pressured**
Carefree	|---------------------------|---------------------------|	**Overcommitted**
Daily Relaxation	|---------------------------|---------------------------|	**No Daily Relaxation**
Take Time for Recreation/Hobbies	|---------------------------|---------------------------|	**No Time for Recreation/Hobbies**
Enjoy Occupation	|---------------------------|---------------------------|	**Detest Job**
Satisfying Life	|---------------------------|---------------------------|	**Not Fulfilled/Feel Frustrated**
Achieve Personal Goals	|---------------------------|---------------------------|	**Not Achieving Goals**
Feel Loved	|---------------------------|---------------------------|	**Don't Feel Loved**
Feel Loving	|---------------------------|---------------------------|	**Angry or Resentful**
Live in Quiet Surroundings	|---------------------------|---------------------------|	**Live in Noisy Environment**
Ordered Surroundings	|---------------------------|---------------------------|	**Chaotic Surroundings**