LaDue Acupuncture, LLC

NEW PATIENT INTAKE

Name _____ **Date** _____

Natural healthcare is possible only when the practitioner completely understands the patient's physical, mental and emotional conditions. The information you provide helps your practitioner understand your needs and how to help you reach your health goals. Please answer each question completely. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Address _____
(Note: Insurances will not use a PO Box as an address. Please provide a street address for all insurance billing.)

City _____ **State** _____ **Zip** _____

Phone (H) _____ **Phone (C)** _____ **Phone (W)** _____

Email _____

Date of Birth _____ **Age** _____ **Sex** ☐ Female ☐ Male

Weight _____ **Height** _____ **Are you Pregnant?** ☐ No ☐ Yes, # of weeks? _____

Emergency Contact Name _____

Emergency Contact Phone _____

How were you referred? _____

Marital Status ☐ Single ☐ Married ☐ Partnered

☐ Separated ☐ Divorced ☐ Widowed

Partner/ Spouse Name _____

Number and ages of Children _____

Who is your Primary Care Doctor? _____ **Phone** _____

Date of last visit? _____ **Reason for visit?** _____

MEDICAL QUESTIONNAIRE

HEALTH CONCERNS YOU WOULD LIKE ADDRESSED WITH CHINESE MEDICINE

(In order of importance)

1. _____

2. _____

3. _____

4. _____

CURRENT PRESCRIPTION MEDICATION *(Attach additional sheet if necessary.)*

Name	Dose	How Often	Reason
1.			
2.			
3.			
4.			

CURRENT SUPPLEMENTS – *Nutritional, Vitamins, Herbs, OTC. (Attach additional sheet if necessary.)*

Name	Dose	How Often	Reason
1.			
2.			
3.			
4.			

ALLERGIES

Medication/ Food/ Environment	What effect?
1.	
2.	
3.	
4.	

PAST MEDICAL HISTORY

Major Illnesses (Including childhood illnesses):

1. _____

2. _____

3. _____

4. _____

Major Injuries (Please give location of any scars):

1. _____

2. _____

3. _____

4. _____

Hospitalizations and Surgeries (Please give month/year if possible):

1. _____

2. _____

3. _____

4. _____

Contagious Diseases

1. _____

2. _____

3. _____

Emotional Trauma

1. _____

2. _____

3. _____

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health (G=Good P=Poor)						
Age (at death)						
Cause of Death						

Check and note all that apply to each family member

Cancer (type)						
Diabetes (type)						
Stroke						
Mental Illness						
Asthma						
Hay Fever/ Hives						
Kidney Disease						
Obesity						
Heart Disease						
High Blood Pressure						

OCCUPATIONAL HISTORY

	Position Held	Type of Work	# of Years
Present			

Do you enjoy your work? ☐ Yes ☐ No

Previous _____

HEALTHCARE MAINTENANCE

Test	Date	Result	Test	Date	Result
Physical Exam			Breast Exam (Doctor)		
Rectal Exam			Mammogram		
Stool for Blood			Pap Smear/ Pelvic		
Colonoscopy			Prostate/ Testicle		
Sigmoidoscopy			PSA Blood Test		
Eye exam/ Vision			MRI		
Hearing Test			X-Ray		
Dental Exam			Other		

HEALTH SYSTEMS

Y = a condition you have now **P** = a condition in the past

GENERAL

Fatigue	Y	P
Insomnia	Y	P

SKIN

Dry Skin	Y	P
Rash	Y	P
Hives	Y	P
Acne	Y	P

HEAD

Headache	Y	P
Head Injury	Y	P

EYES

Impaired Vision	Y	P
Eye Pain	Y	P
Dryness	Y	P
Double Vision	Y	P
Glaucoma	Y	P
Cataracts	Y	P

NOSE & SINUS

Frequent Colds	Y	P
Nose Bleeds	Y	P
Stuffiness	Y	P
Hay Fever	Y	P
Sinus Problems	Y	P

MOUTH & THROAT

Freq Sore Throats	Y	P
Sore Tongue	Y	P
Gum Problems	Y	P
Hoarseness	Y	P
Dental Cavities	Y	P

NECK

Lumps	Y	P
Swollen Glands	Y	P
Goiter	Y	P
Pain or Stiffness	Y	P

RESPIRATORY

Cough	Y	P
Sputum	Y	P
Spitting up blood	Y	P
Wheezing	Y	P
Asthma	Y	P
Bronchitis	Y	P
Pneumonia	Y	P
Pleurisy	Y	P
Emphysema	Y	P
Pain on breathing	Y	P
Tuberculosis	Y	P
Shortness of breath	Y	P

BLOOD

Anemia	Y	P
Bleed/Bruise Easily	Y	P

EARS

Impaired Hearing	Y	P
Ringing	Y	P
Earache	Y	P
Dizziness	Y	P
Vertigo	Y	P

GASTROINTESTINAL

Appetite Change	Y	P
Heartburn	Y	P
Thirst Change	Y	P
Nausea	Y	P
Vomiting	Y	P
Loose stool	Y	P
Diarrhea	Y	P
Blood in Stool	Y	P
Gas/Bloating	Y	P
Constipation	Y	P

MUSCULOSKELETAL

Joint Pain	Y	P
Joint Stiffness	Y	P
Arthritis	Y	P
Broken Bones	Y	P
Muscle Spasms	Y	P
Weakness	Y	P

PERIPHERAL VASCULAR

Deep Leg Pain	Y	P
Cold Hands/Feet	Y	P
Varicose Veins	Y	P

EMOTIONAL

Depression	Y	P
Mood Swings	Y	P
Anxiety	Y	P
Suicidal	Y	P

NEUROLOGIC

Fainting	Y	P
Seizures	Y	P
Paralysis	Y	P
Muscle Weakness	Y	P
Numbness/ Tingling	Y	P
Concentration Prob	Y	P
Loss of Memory	Y	P

URINARY

Pain on urination	Y	P
Increased frequency	Y	P
Frequency at night	Y	P
Inability to hold urine	Y	P
Frequent infections	Y	P

ENDOCRINE

Hypothyroid	Y	P
Heat/Cold Intolerance	Y	P
Excessive Thirst	Y	P
Excessive Hunger	Y	P
Hypoglycemia	Y	P
Low Blood Pressure	Y	P
Sugar Cravings	Y	P

Weight Gain

_____ lbs over _____ yrs/mos

Weight Loss

_____ lbs over _____ yrs/mos

CARDIOVASCULAR

Heart Disease	Y	P
Angina	Y	P
High Blood Pressure	Y	P
Heart Murmur	Y	P
Rheumatic Fever	Y	P
Chest Pain	Y	P
Swelling in ankles	Y	P
Palpitations	Y	P

MALE REPRODUCTIVE

Hernias	Y	P
Testicular mass	Y	P
Testicular pain	Y	P
Sexually active	Y	P
Sexual difficulties	Y	P
Prostate disease	Y	P
STDs	Y	P
Discharge	Y	P
Sores	Y	P
Diminished sex drive	Y	P
Erectile dysfunction	Y	P

FEMALE REPRODUCTIVE

Age Menses Began	_____	
Average # of days	_____	
Length of cycle	_____	
Spotting	Y	P
Painful Intercourse	Y	P
Painful Menses	Y	P
Excessive Flow	Y	P
Birth Control	Y	P
What type?	_____	
# of Pregnancies	_____	
# of Live Births	_____	
# of Miscarriages	_____	
# of Abortions	_____	
Difficulty Conceiving	Y	P
Sexually Active	Y	P
Diminished Sex drive	Y	P
Sexual Difficulties	Y	P
STDs	Y	P
PMS	Y	P
Irregular Periods	Y	P

Menopausal Y P

When did menses stop?

_____

Decreased Vaginal Lubrication Y P

Day/Night Sweats Y P

Hot Flashes Y P

Nipple Discharge __ One breast

__ Two breasts

Have you ever had a

Hysterectomy Y

When? _____

Ovaries removed Y

When? _____

Tubal Ligation Y

When? _____

TYPICAL DIET

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Dietary Restrictions: _____

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Signed: _____ Date: _____