

# PHYSICAL THERAPY SPECIALISTS

## ACUPUNCTURE NEW PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Marital Status: (*circle one*) Single Married Divorced Widowed  
Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Referred By: \_\_\_\_\_

**What is the reason for today's visit?** \_\_\_\_\_  
How long have you had this condition? \_\_\_\_\_  
What seemed to be the initial cause? \_\_\_\_\_  
What seems to make it better? \_\_\_\_\_  
What seems to make it worse? \_\_\_\_\_  
Are you currently under the care of a physician? \_\_\_\_ No \_\_\_\_ Yes (if so, for what?) \_\_\_\_\_  
Physician's name and phone number: \_\_\_\_\_  
Other concurrent therapies: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Family Medical History

- Allergies    Arteriosclerosis    Asthma    Alcoholism    Cancer    Diabetes    Heart Disease    Stroke  
 Seizures    High Blood Pressure

### Your Past Medical History

- AIDS/HIV    Birth Trauma    Hepatitis    Allergies    Arteriosclerosis    Asthma    Alcoholism    Cancer    Diabetes  
 Heart Disease    High Blood Pressure    Seizures    Stroke    Surgery (list) \_\_\_\_\_

**Your Lifestyle**  Alcohol    Tobacco    Recreational Drugs    Stress    Occupational Hazards

### Other

Are you pregnant?  No    Yes   Have you ever been pregnant?  No    Yes

Have you ever had Acupuncture before?  No    Yes   If yes, for what? \_\_\_\_\_

Are there any things you feel you should mention beyond what was covered above? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_