

ANNIE STURMAN, A.P.

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NEW PATIENT INTAKE FORM

Name: _____ Date: _____ SS#: ____/____/____
Date of Birth: ____/____/____ Age: ____ Height: _____ Weight: _____ M: ____ F: ____
Address: _____ Zip code: _____
Home phone: _____ Work phone: _____ Occupation: _____
Cell phone: _____ Email address: _____
Emergency contact name & phone: _____
Referred by: _____ Have you had acupuncture before? Yes No
Reason for visit today: _____ When did symptoms first appear? _____
Are symptoms related to an accident, birth defect or heredity? Please explain: _____
Severity of symptoms: Slight Moderate Severe Does it bother your: Sleep Work Other
Have you had these symptoms in the past? Yes No Are symptoms: Better Worse Constant
 Comes & Goes? What makes it better? _____ What makes it worse? _____
Are you under the care of a physician now? Yes No If yes, for what? _____
Physician's name: _____ Phone: _____
Other concurrent therapies: _____
Medications, drugs, herbs, supplements you are currently taking and for what conditions (Attach separate sheet if necessary): _____
Surgeries and dates: _____
Date of last physical exam: _____ By whom: _____

MEDICAL HISTORY: (Do you have or have you ever had any of the following conditions?)

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Polio	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Allergies	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney/Bladder Trouble	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Measles	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Mumps	<input type="checkbox"/> Sudden Weight Gain	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Sudden Weight Loss	<input type="checkbox"/> Metal plate or steel in body
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Thyroid Disorders	_____
<input type="checkbox"/> Major Trauma (Auto, fall, etc.)	_____	_____	_____	_____

FAMILY MEDICAL HISTORY: Has any member of your family had any of the above? Yes No

If yes, which member and what did they have? _____

ENERGY LEVEL:	<input type="checkbox"/> Night sweat	SKIN:	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> From 0-10	<input type="checkbox"/> Spontaneous daytime sweating	<input type="checkbox"/> Normal	<input type="checkbox"/> Changing moles
<input type="checkbox"/> High time of day	<input type="checkbox"/> Rarely sweat	<input type="checkbox"/> Dry	<input type="checkbox"/> Changing lumps
<input type="checkbox"/> Low time of day	<input type="checkbox"/> Spontaneous daytime sweat	<input type="checkbox"/> Itchy	<input type="checkbox"/> Bruise easily
STRESS LEVEL:	<input type="checkbox"/> Excess sweat	<input type="checkbox"/> Moist/clammy	<input type="checkbox"/> Dry scalp
<input type="checkbox"/> None	CIRCULATION:	<input type="checkbox"/> Burning	<input type="checkbox"/> Thinning hair
<input type="checkbox"/> Moderate	<input type="checkbox"/> Normal	<input type="checkbox"/> Boils	_____
<input type="checkbox"/> Caused by _____	<input type="checkbox"/> Feeling of cold	<input type="checkbox"/> Hives	_____
PERSPIRATION:	What area? _____	<input type="checkbox"/> Acne	_____
<input type="checkbox"/> Normal	Bleed easily? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Eczema	_____

SCARS: List scars from accidents or surgeries _____

SLEEP:

- Normal
- Trouble falling asleep
- Trouble staying asleep
- Excessive dreaming
- Hours sleep at night

HEAD:

- Headaches-describe location _____
- Memory loss
- Loss of balance
- Other _____

EYES:

- Pain
- Dryness
- Blurred vision
- Darkness under eyes
- Other _____

EARS:

- Hearing loss
- Earaches
- Ear discharge/infections
- Ringing/buzzing
- Other _____

NOSE:

- Frequent nose bleeds
- Sinus problems
- Nasal drip
- Other _____

THROAT:

- Soreness
- Hoarseness
- Difficulty swallowing
- Jaw problems
- Teeth/gum problems
- Swollen/sore tongue
- Other _____

CHEST:

- Difficulty breathing
- Shortness of breath
- Wheezing
- Trouble breathing at night
- Persistent cough
- Pain/pressure in chest
- Palpitations
- Cough with blood
- Cough with phlegm:
Color _____
- Consistency _____
- Other _____

BLOOD PRESSURE:

- Normal
- High
- Low
- Don't know

BOWELS:

- Diarrhea
- Constipation
- Bloody stools
- Black stools
- Mucus in stools
- Hemorrhoids
- Lower bowel gas
- Foul smelling stools
- Colon disease
- # of bowel movements/day

URINE:

- Color _____
- Amount _____

- Frequent? Day Night
- Strong smell
- Difficult to urinate
- Pain/burning w/urination
- Blood in urine
- Frequent infections
- Dribbling urine
- Water retention

MUSCULOSKELETAL PAIN:

- Neck
- Shoulders
- Arms
- Hands
- Hip
- Knees
- Joints
- Fingers
- Big toe
- Upper back
- Mid back
- Lower back
- Loss of grip
- Swollen knees/elbows
- Nighttime leg cramps
- Weakness in legs
- Weak ankles
- Stiff all over
- Tingling in feet
- Muscle spasms/cramps
- Loss of feeling in hands/feet
- Other _____

NEUROLOGICAL:

- Nervousness
- Depression
- Easily angered/irritated
- Frequent crying
- Worry/anxiety
- Mood swings
- Confusion
- Poor concentration
- Tremors
- Numbness/tingling in limbs
- Poor coordination
- Muscle weakness
- Feel weak/shaky
- Seizures
- Neuralgia (nerve pain)
- Shingles
- Other _____

FEMALES:

- Pregnant
- Date last monthly period _____
- Date last PAP test _____
- Age started menstrual cycle: _____
- Age stopped: _____
- Irregular cycle
- Menstrual pain
- Low backache
- Clotting
- Heavy bleeding
- Light scanty bleeding
- Color of menstrual blood: _____
- Mood changes
- Low or no sex drive
- Painful breasts
- Hot flashes
- Food cravings
- Other _____
- Discharges:
 - Yellow
 - White
 - Thick
 - Clear
 - Odor
 - Itching
 - Other _____
- No. of pregnancies
- No. Of miscarriages
- No. Of abortions
- No. Of Cesareans
- Other _____

FEMALES: Continued

Surgeries:

Cervix

Uterus

Ovaries

Other

MALES:

Low sex drive

Impotence

Pain with ejaculation

Enlarged prostate

Prostate infection

Other

APPETITE:

Excessive

Poor

Constantly changing

Feel tired/weak if meal missed

Excessive thirst

Never thirsty

Thirsty, no desire to drink

Food cravings: _____

DIGESTION:

Stomach gas

Lower bowel gas

Heartburn

Belching

Stomach pain/cramps

Nausea

Vomiting

Bad breath

Mouth sores

Weight gain

Weight loss

Bitter/sour taste in mouth

Abdominal bloating

How long after eating? _____

Food allergies

If yes, to which foods? _____

NUTRITION:

Skip breakfast

Eat a hearty breakfast

No. Of meals per day

Biggest meal _____

Eat when worried/rushed

How often? _____

No. Glasses water per day

Coffee

Sodas

Artificial sweetener

Sugar

Salty food

LIFESTYLE:

Alcohol

Tobacco

Marijuana

Drugs

Stress

Occupational hazards

Regular exercise

Type & frequency _____

TEENS:

Sexually active

Use protection

Use drugs/alcohol

Depressed

Able to speak with parent

Friends

Extracurricular activities/sports

Physician's comments: _____

CANCELLATION POLICY

Appointments must be cancelled 24 hours in advance. If an appointment is cancelled less than 24 hours in advance and we are unable to fill the appointment time, or the appointment is forgotten (patient does not come or call), there will be no charge for the first time. After that, the normal fee will be charged.

Patient's signature: _____

Date: _____