Dr Patricia Vegas Acupuncture Date:

New Patient Intake Form

Note: The information provided on this form is confidential. It is very important to obtain complete and accurate information to properly assist you in your healing process. Skip what doesn't apply; add lines if needed.

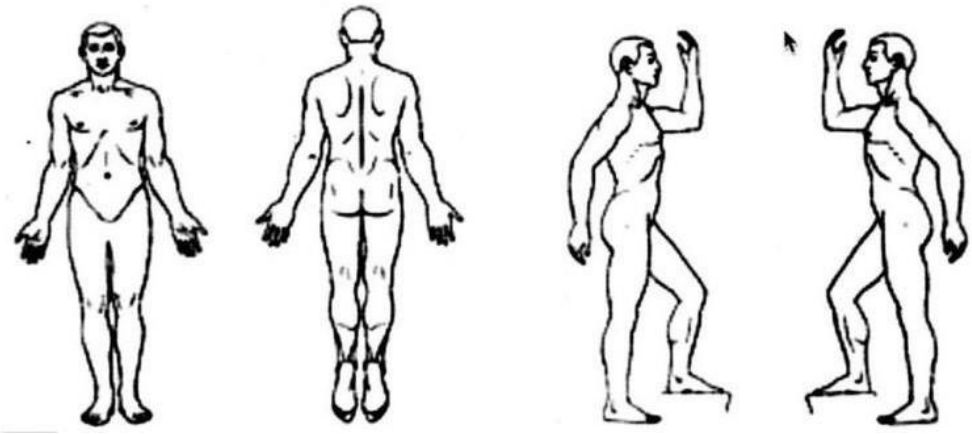
Personal information											
Name											
Date of Birth		Age		Place of Birth							
Gender											
Cell Phone				Office Phone							
Email											
Address											
Marital status	single		married		partnered		divorced		widowed		
Any Children? Age? Gender?											
Date of First Visit											
Source of Referral											

Doctor information (MD)	
Date of last physical exam:	
Name of Primary doctor:	
Address	
Phone number:	

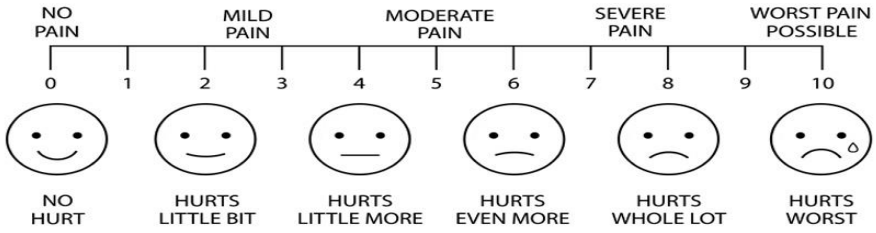
Emergency Contact	
Name:	
Relationship:	
Cell Phone:	
Email address:	

Insurance Information	
Providers name:	
Member ID	
Type	
Email address:	

Chief Complaint	**(Please be as detailed as possible)**
Your primary goal for this visit?	
Where is the discomfort?	
When did it start?	
What did induce the problem?	
When does it bother you the most?	
Nature of the discomfort:	
Severity (0-10, 10 being most severe)	
What does make it worse?	
What does make it better?	
First time you suffered from this?	
Did you go to see a MD for this?	
Did you get a diagnosis from the MD?	
Test result, X-ray. MRI, cat scans report?	
Other:	



Pain Please, mark and describe the location and quality (dull, sharp, deep, constant) i.e. Right knee throbbing pain.
1
2.
3.
4.
5.



Vital Signs	Weight:1kg=2.2 lbs	
	Height:1ft=30.48cm 1 inch+2.54cm	
	Blood pressure:	
	Pulse per minute:	
	Respiratory rate per minute:	
	Temperature:	
Last (CBC)Blood Count		

Allergies		
	Please list	What happens?
Medications		
Food		
Environment		
Other:		

Any Current or Past Medical Diagnoses	**Date**
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Hospitalizations, Injuries, Surgeries, Chemical Exposure, Bone fractures		
Type of operation or illness:	Date	Name of hospital

Infection Screening							
HIV risks-self		TB-self		Herpes-oral/genital		Genital warts	
Gonorrhea		Chlamydia		Syphilis		Hepatitis C	
Hepatitis A		Hepatitis B					

Prescription Medications you are taking		
Name of medication	Dosage/day	Reason for taking? Taking since?

Supplements you are taking		
Name of supplement:	Dosage/day:	Reason for taking? Taking since?

Over the counter	**Frequency of use**
Antacids	
Diet pills	
Ibuprofen/ Aspirin	
Cold tablets	
Herbs	
Oral contraceptives	
Hay fever tablets	
Laxatives	
Sleeping pills	
Tranquilizers	
Other	

Family medical history	self	Paternal grandma	Paternal grandma	Maternal grandpa	Maternal grandma	mother	father	brother	sister	Spouse partner	child
Allergy											
Blood disorder/anemia											
High blood pressure											
Heart disease											
Stroke											
Seizures											
Diabetes											
Thyroid disorder											
Musculoskeletal disorder											
Kidney or bladder disease											
Stomach or intestinal disease											
Substance abuse											
Skin disease											
Mental illness											
Tuberculosis											
Herpes oral/genital											
HIV											
Hepatitis											
Alzheimer's / Parkinson’s											
Cancer or tumor											
Age if living:											
Age of death:											

Personal health history							
Cardiovascular and Circulatory							
High Blood Pressure		High Cholesterol		Tachycardia		Arrhythmia	
Palpitations		Chest pain		Rapid heartbeat		Irregular heartbeat	
Poor circulation		Swelling ankles		Phlebitis		Varicose veins	
Strokes		Blood Cots		Aneurism		Thrombosis	
Bleed or bruise easily:							

Respiratory							
Chronic cough		Cough up blood		Cough up phlegm		Wheezing/asthma	
Difficulty breathing		Difficulty breathing on exertion				Difficulty breathing at rest	
Smoke		Covid		Frequent colds		Other	

Neurological							
Seizures		Tremors		Neuropathies		Paralysis	
Parkinson		Alzheimer		Multiple Sclerosis		Concussion	
Muscular weakness		Other:					

Muscles and joints							
Herniated disk		Sore muscles		Weak muscles		Difficulty walking	
Scoliosis		Back pain		Neck pain		Arthritis	
Joint disorder		Knee pain		Fibromyalgia			

Autoimmune disorders					
Rheumatoid Arthritis		Polymyalgia Rheumatica		Lupus	
Sjogren's syndrome		Multiple Sclerosis		Arthritis	
Ankylosing Spondylitis		Alopecia areata		Myasthenia gravis	
Other:					

Skin							
Hives		Rashes		Eczema		Night sweating	
Excess sweating		Dryness		Bruise easily		Moles or Lumps	
Acne		Hives		Hair loss		Premature graying	
Psoriasis		Other					

Head and Neck							
Dizziness		Fainting		Neck pain		Lymph nodes	
Headaches		Migraines				Other	

Ears							
Infection		Ringing		Hearing loss		Clogged/popped	
Pain		Other:					

Eyes							
Blurred vision		Visual changes		Poor night vision		Spots, floaters	
Eye pain		Red eyes		Eye inflammation		Cataracts	
Other:							

Nose, throat and mouth							
Bleeding		Sinus infection		Hay fever		Sore throat	
Hoarseness		Swallowing difficulty		Changes in taste		Changes in smell	
Oral ulcers		Dry mouth		Cold sores		Other:	

Denhtal condition							
Denture		Dental filling		Cavities		Gum bleeding	
Toothache		Other:					

Digestive system							
Nausea		Vomiting		Stomach pain		Diarrhea	
Constipation		Poor appetite		Excessive hunger		Vomiting blood	
Blood in stools		Hemorrhoids		Gallbladder issues		Body weight change	
Celiac disease		Heart burns		Bloating		Hernia	

Eating Habits			
Breakfast		Time:	
Lunch		Time:	

Dinner								Time:	
Fasting habits?		Hours?			Frequency?				
Any special diet?									
Any eating disorder									
Sweet cravings?		Chocolate cravings?		Other Food cravings					
Daily Water intake?		Usually thirsty?		Coffee?					

Alcohol	Hard liquor	Amount	Frequency	Ever been a problem for you
Beer	Tequila			
Wine	Vodka			
Champagne	Whisky			
Other				

Bowel movement													
How many times a day?		Regular fixed time?		When?									
Is it easy for you to go		Hard and difficult to expel		Incontinence?									
Bowel Quality	Well formed		watery		pasty		Food particle		blood		pain		
Need laxatives, since when?													
What will keep you from going?													
Do you have hemorrhoid?													
Anal itching/burning problem?													
Pattern changes, When? Why?													
Other:													

Urinary System			
How frequent do you urinate a day?		Urine color:	
Do you have the urgency to go?			
Can you void completely (dribbling)?			
Trouble starting stream?			
Dribbling with sneezing?			
Do you tend to hold your urination?			
Nocturia? Urge to urinate at night?			
Urinary Tract Infections (UTI)	Burning when you go?	Blood in your urine?	
Cloudy, greasy or debris in urine?			
Urinary or Kidney stones? When?			

Perspiration													
Do you sweat easily?													
When do you sweat?													
Sweat more on	top		Front		above shoulder		armpit		Hand and feet		all over		
Changes in sweating pattern? when?													
Others													

Energy level	
How is your energy?	

Do you fatigue easily?	
When is your energy the highest?	
When is your energy the lowest?	
Other:	

Sleep Patterns						
How many hours do you sleep night?						
Usually when do you go to bed						
Usually when do you wake up						
I have difficulty with	Falling asleep		Staying asleep		Dream-disturbed sleep	
How many times do you wake up per night?			Since when?		Around what time	
Insomnia		Can you fall back to sleep easily?				
Do you use sleeping pills?		How frequent do you use sleep aid?				
Any change in sleep pattern? Why?						
Do you Snore?		Sleep apnea?				

Occupation	
What do you do for living:	
How long have you been working on this job?	
Retired? Since when?	
Do you have any hobbies?	

Emotional State		**Describe if possible**
Happy		
Even tempered		
Angry		
Anxious		
Irritable		
Depressed/sad		
Mood swing		
Obsessive/compulsive		
Thinking too much		
What causes affect your emotions		
How do you de-stress or relax?		

Any Psychotherapy or Psychiatric treatment	
When, frequency, and for how long?	
For what? By whom?	
Do the treatments help?	

Temperature Preference	
Do you feel cold or hot more?	
Are your hands and/or feet cold?	
Do you have hot flashes?	
You prefer warm or cool temperatures	
Which season do you like the most?	

Exercise Routine				
Type of exercise	Cardiovascular	Stretching	Frequency	Duration

Female

Menstruation									
Age at first menstruation		Cycle Length		Regular		Irregular			
Days of bleeding		Painful?		Flow Color?		Amount?			
Is there any clots		Bleeding in between cycle?							
Premenstrual symptoms? (PMS)									
Vaginal infection? Lesion? discharge?		Pain		Itching					
Do you need pain killer for menstrual pain?									
Any menstrual pattern changes? since when:									
Contraception:									
Age at menopause, any symptoms?		Hotflashes		Fatigue					
Are you presently trying to get pregnant?									
Are you breast feeding currently?									
Any Breast Lumps		Abnormal Bleeding							

Reproductive System						
Last Pap Smear Checkup:		**Last Mammogram:**				
Pelvic Inflammatory disease (PID)		Currently pregnant?				
Total pregnancies:	Live births:	Ectopic:	Miscarriages:	Abortions:		
Year	Length	Labor hours	Delivery type	Male/female	Weight	Name
1.						
Complications:						
2.						
Complications:						
3.						

Male

Last prostates checkup:							
Genitals pain/itching		Erectile dysfunction		Weak urinary stream		Lumps in testicles	
Prostatitis		**Other**					

Alternative Medicine Treatments		
Acupuncture		
When, frequency and for how long		
For what, By Who? Does it help?		
Chinese Herbs or Formulas		
	For what?	**When?**

Massage Treatment	

Chiropractic	

Physical Therapy	

Homeopathic treatment	

Ayurveda treatment	
When, frequency, and for how long?	
For what? By whom?	
Do the treatments help?	

Plant base Medicine								
Cannabis		Psilocybin		Ayahuasca		Other drugs for recreational use		
Any other alternative Treatment								

Signature: