Beaumont

Acupuncture New Patient Form

Name: _____ **Date of Birth:** _____ **MRN:** _____

What sex were you assigned at birth? _____ **How would you like to be addressed?** _____

What is your current gender identity? _____ **Preferred Pronoun?** _____

Referred by: _____ **Date of Appointment:** _____

Email Address: _____

Would you like to be added to Integrative Medicine's electronic newsletter email list? Yes: ☐ No: ☐

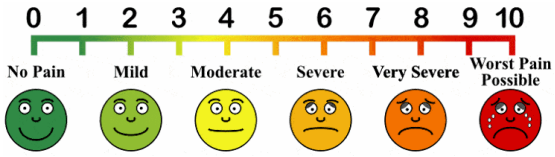
Current list of health concerns:

Priority 1: _____ Priority 3: _____

Priority 2: _____ Priority 4: _____

If experiencing pain today:

Circle Your Pain Level on Scale Below



Location: _____

Onset: _____

Duration: Constant Intermittent

Describe pain: Achy Burning Dull Throbbing Sharp Stabbing Moves Around

Decreases with: Movement Pressure Heat Cold Other: _____

Increases with: Movement Pressure Heat Cold Other: _____

Is pain:

Worse in the morning and decreases as the day goes on? Yes: ☐ No: ☐

Better in the morning and increases as the day goes on? Yes: ☐ No: ☐

Stays the same all day? Yes: ☐ No: ☐

Varies throughout the day? Yes: ☐ No: ☐

Any associated numbness and/or tingling? Yes: ☐ No: ☐

Any diagnostic tests completed? X-rays ☐ CT Scan ☐ Ultrasound ☐ MRI ☐

Any previous treatment for the pain?

Type: _____ When: _____ Did it help? _____

Type: _____ When: _____ Did it help? _____

List current medications along with dose, frequency and duration of use.

Medication	*Dose*	*Frequency*	*Duration*

Name: _____ **Date of Birth:** _____

List current supplements along with dose, frequency and duration of use.

Supplement	*Dose*	*Frequency*	*Duration*

Diet – What do you typically eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Are you on a special diet? Yes: ☐ No: ☐ Describe diet? _____

List food sensitivities or allergies: _____

Sensitivity or allergic reaction: _____

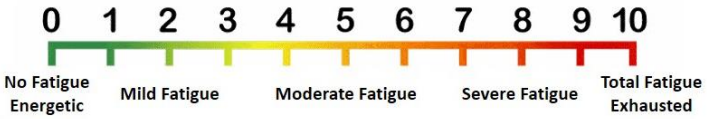
Sleep

Number of hours per night? _____ What time do you usually fall asleep? _____

Refreshed upon waking? Yes: ☐ No: ☐

Energy Level

Circle Your Energy Level on Scale Below



Exercise

Do you exercise regularly? Yes: ☐ No: ☐

Type of exercise: _____ Frequency: _____

Type of exercise: _____ Frequency: _____

Stress/Distress Level

Circle Your Stress Level on Scale Below

How do you manage stress? _____

What brings you joy? _____

Body Temperature Do you tend to feel? Warm Normal Cold

Name: _____ **Date of Birth:** _____

Medical History

Surgeries Location: _____ When: _____

Location: _____ When: _____

Use the back of this page if more room is needed: ☐

Diagnosis of cancer N/A: ☐ Type: _____ Stage: _____ Date: _____

Treatments received? Chemotherapy Radiation Surgery Other: _____

Still receiving treatments? Yes: ☐ No: ☐

Lymph nodes removed? Yes: ☐ No: ☐

Heart condition

Do you have a pacemaker? Yes: ☐ No: ☐

Do you have any swelling in your: Legs? Yes: ☐ No: ☐ Feet? Yes: ☐ No: ☐

Social History

Alcohol Consumption How many? _____ Frequency: _____

Tobacco Use

Do you use tobacco? Cigarettes Cigars Smokeless Spitless Waterpipe Vape

How many/much? _____ Frequency: _____

Age when started? _____ If you quit, when? _____

Recreational Drug Use What? _____ Frequency: _____

Age when started? _____ If you quit, when? _____

Acupuncture Experience

Have you previously received acupuncture? Yes: ☐ No: ☐

If so, for what condition? _____

Miscellaneous

Are there any other issues or concerns that you would like to discuss? _____

Are you in a supportive relationship? Yes: ☐ No: ☐ Are you in a relationship you would like to change? Yes: ☐ No: ☐

Do you have someone that you can confide in? Yes: ☐ No: ☐ Do you feel unsafe in your home? Yes: ☐ No: ☐

Have you ever been physically, emotionally, or sexually abused? Yes: ☐ No: ☐

If you are experiencing physical, emotional, or sexual harm from someone, please talk to me so that I can help.

Name: _____ **Date of Birth:** _____

Men's Health

Date of most recent prostate check-up? _____ PSA results? _____

Please check the box next to all that apply:

☐ Back Pain	☐ Testicular Pain	☐ Groin Pain	☐ BPH/Prostate	☐ Premature Ejaculation
☐ Dribbling	☐ Incontinence	☐ Delayed Stream	☐ Retention of Urine	☐ Decreased Force of Stream
☐ Impotence	☐ Decreased Libido	☐ Increased Libido	☐ Weak Erection (ED)	☐ Rectal Dysfunction

Are you and your spouse/partner currently trying to get pregnant? Yes: ☐ No: ☐

If you have been unable to conceive, have you had medical testing for this issue? Yes: ☐ No: ☐

If yes, what were the results: _____

Women's Health

Age at first menstrual period: _____ Age at menopause: _____ Number of days between periods: _____

Number of days of flow: _____ Color of flow: _____ Clots? Yes: ☐ No: ☐

What is your average flow: Light: ☐ Medium: ☐ Heavy: ☐

Have you been diagnosed with: ☐ Cysts ☐ Fibrocystic Breasts ☐ Fibroids ☐ Endometriosis ☐ PCOS

Please check box next to all that apply and circle as follows: Before (B), During (D) or After (A) menses.

PAIN: ☐ Aching B D A	☐ Burning B D A	☐ Cramping B D A
☐ Dull B D A	☐ Sharp B D A	☐ Stabbing B D A
☐ Intermittent B D A	☐ Constant B D A	
☐ Vaginal Dryness B D A	☐ Discharge: B D A & Color:	☐ Odor B D A
☐ Constipation B D A	☐ Diarrhea B D A	☐ Headache B D A
☐ Swollen Breasts B D A	☐ Bloating B D A	☐ Nausea B D A
☐ Night Sweats B D A	☐ Insomnia B D A	☐ Hot Flashes B D A
☐ Mood Swings B D A	☐ Decreased Appetite B D A	☐ Increased Appetite B D A
☐ Increased Libido B D A	☐ Decreased Libido B D A	☐ Cravings B D A

*****Only complete if the reason for your visit is related to fertility support*****

Are you currently pregnant? Yes: ☐ No: ☐ Due Date: _____

# of Pregnancies: _____ # of Live Births: _____ How long have you been trying to conceive? _____

If you have been unable to conceive, have you had medical testing for this issue? Yes: ☐ No: ☐

If yes, what were the results: _____

Has your spouse/partner had medical testing for this issue? Yes: ☐ No: ☐

If yes, what were the results: _____