



The Ridge Acupuncture
Acupuncture & Massage

NEW PATIENT FORM

Last Name: _____

Today's Date: ____/____/____

Information provided on this form is confidential. Please print legibly.

Name: _____

Sex: Male Female Date of Birth: ____/____/____ Age: ____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Email address: _____

Telephone: Cell: _____ Home: _____ Work: _____

How did you hear about us?: _____

Main problem(s) you would like us to help you with: _____

How long have you had this condition? _____ The onset was: sudden gradual

Date of last physical exam: ____/____/____ Physician: _____

Medical diagnosis, if any? _____

What treatments have you tried? _____

Medicines/Supplements: Please check any of the following that you are now taking:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Aspirin or Ibuprofen | <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Antacids | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Diet Pills | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Sleeping Pills | <input type="checkbox"/> Allergy Medication |
| <input type="checkbox"/> Cold / Flu Medication | <input type="checkbox"/> Vitamins | <input type="checkbox"/> Herbs | <input type="checkbox"/> Other |

LAST NAME: _____

NEW PATIENT INTAKE FORM

List all Vitamins and Medications currently using:

Past Medical History: Please check any or all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Seizures | <input type="checkbox"/> Allergies | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Musculo-skeletal disorder | <input type="checkbox"/> Lymph nodes removal | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Organ Transplant |

Other/Comments: _____

Describe any significant injuries, surgeries, or major illnesses: _____

Emotions and Sleep: CHECK current symptoms. CIRCLE symptoms that have affected you in the past:

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fearfulness | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent sighing | <input type="checkbox"/> Anger, irritability, frustration | <input type="checkbox"/> Obsessive thoughts |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Panic attacks | | | |

Other: How do you feel emotionally?: _____

- | | | | |
|--|---------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Married/Stable Relationship | <input type="checkbox"/> Single | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |
|--|---------------------------------|-----------------------------------|----------------------------------|

How do you feel about your relationship? _____

NEW PATIENT INTAKE FORM

Urinary & Genital:

I urinate approximately? _____ times per day. Color: pale yellow dark yellow/brown/orange

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past:

- Trouble starting stream
- Dribbling when sneezing / coughing
- Frequent urination
- Incontinence
- Frequent urinary tract infections
- Blood in urine
- Painful urination
- Kidney stones
- Other: _____

How is your sexual energy? _____

What kind of birth control do you use? _____

Do you have (check all that apply):

- Infertility
- Pain during sexual relations
- Other: _____

WOMEN:

Are you *currently* pregnant? Yes No Are you *presently* trying to get pregnant? Yes No

At what age did you start menstruating? _____

Number of pregnancies? _____ Number of deliveries? _____ Abortions / Miscarriage(s)? _____

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past

- High Blood Pressure
- Low Blood Pressure
- Chest Pain
- Phlebitis
- Varicose veins
- Poor circulation
- Palpitations
- Irregular heartbeat

NEW PATIENT INTAKE FORM

Skin and Hair:

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past.

- Dry skin Hives Bruise easily Skin rashes
- Psoriasis Premature graying Itching Eczema
- Hair loss Acne Night sweating Excess sweating
- Changes in moles/lumps Other: _____

Muscles, Joints and Bones:

Do you have pain or tightness? _____ Where? _____

What is the current level of pain, from 1-10? ____ The pain feels worse with: _____

The pain feels better with: _____

The pain is: please check all that apply:

- Sharp Dull Superficial Deep
- Tingling Numb Burning Aching
- Fixed Moves around Other: _____

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past

- Swollen joints Tendonitis Arthritis/joint pain Rheumatism
- Bone pain Muscle cramps/pain Repetitive strain Weak muscles
- Spinal curvature Other: _____
injury

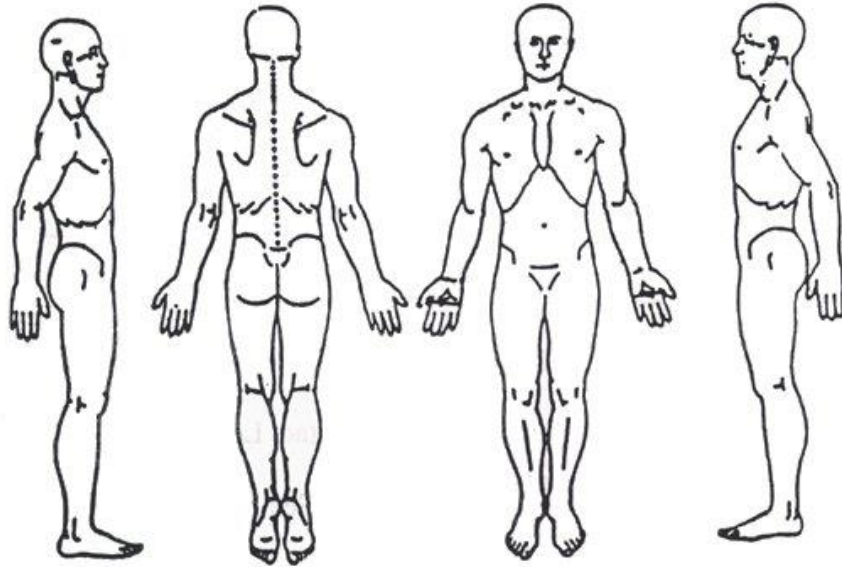
On the following diagram, please SHADE in the areas that you would like to be addressed.

LAST NAME: _____

NEW PATIENT INTAKE FORM

KEY: USE LETTERS TO INDICATE TYPE AND LOCATION OF DISCOMFORT

- A = ACHE
- B = BURNING
- P = PINS & NEEDLES
- S = STABBING
- N = NUMBING
- O = OTHER



Patient or Guardian Signature

Date