Hilltop Eastern Medicine
New Patient Intake Paperwork

Name: _____ Today is: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Biological Sex: M / F

Gender Identity / Pronouns: _____ Marital status: S M / P D W

Address: _____

_____

Phone: (cell) _____ (work) _____

(home) _____ Email: _____

Are you covered by insurance? Y / N Which company? _____

Please provide your insurance information to be copied for billing reference.

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you for your patience!

1. **When and where did you last receive health care?**

_____

For what reason?

_____

2. **Please identify the health concerns that have brought you to Hill Top Integrative Health Center for acupuncture treatment, in order of importance, below:**

Condition	**Past Treatment**
a. _____	_____

How does this condition affect you?

_____

Condition **Past Treatment**

b. _____ _____

How does this condition affect you?

_____

c. _____ _____

How does this condition affect you?

_____

d. _____ _____

How does this condition affect you?

_____

3. **If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):**

_____

_____

4. **Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are *currently* taking (please include dosage, if known):**

_____

_____

_____

5. **Do you have any reason to believe you may be pregnant?** Y N

If so, how far along are you?

_____

6. **Do you have any infectious diseases?** Y N

If yes, please identify: _____

7. **Family History:**

Do you share any symptoms, ailments, or diseases (even if not those that have brought you in for treatment today) with any of your biological family? Y N

If yes, please explain:_____

_____

_____

8. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____

When? _____

9. **Blood Pressure:** When was your last reading taken? _____ What were the values? _____/_____

10. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles

German Measles Chicken Pox

11. **Immunizations** (please circle any that you have had):

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

12. **Hospitalizations and Surgeries:**

Reason	When
_____	_____
_____	_____
_____	_____
_____	_____

13. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When
_____	_____
_____	_____
_____	_____

The following section contains lists of symptoms per region of the body. Please CIRCLE any that you currently experience and UNDERLINE any that you have had in the past. Thank you.

14. **Emotional**

Mood Swings Nervousness Mental Tension

15. **Energy and Immunity**

Fatigue Slow Wound Healing Chronic Infections

Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat**

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts

Tearing/Dryness Impaired Hearing Ear Ringing Earaches Headaches

Sinus Problems Nose Bleeds Frequent Sore Throats Teeth Grinding

TMJ/Jaw Problems Hay Fever

17. **Respiratory**

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma

Tuberculosis Shortness of Breath

Other Respiratory Problems: _____

18. **Cardiovascular**

Heart Disease Chest Pain Swelling of Ankles High/Low Blood Pressure

Palpitations/Flutter Stroke Heart Murmurs Rheumatic Fever Varicose Veins

Do you have a pace maker? Y N

19. **Gastrointestinal**

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C

Hemorrhoids Abdominal Pain

20. **Genito-Urinary Tract**

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

21. **Female Reproductive/Breasts**

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

22. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____

2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____

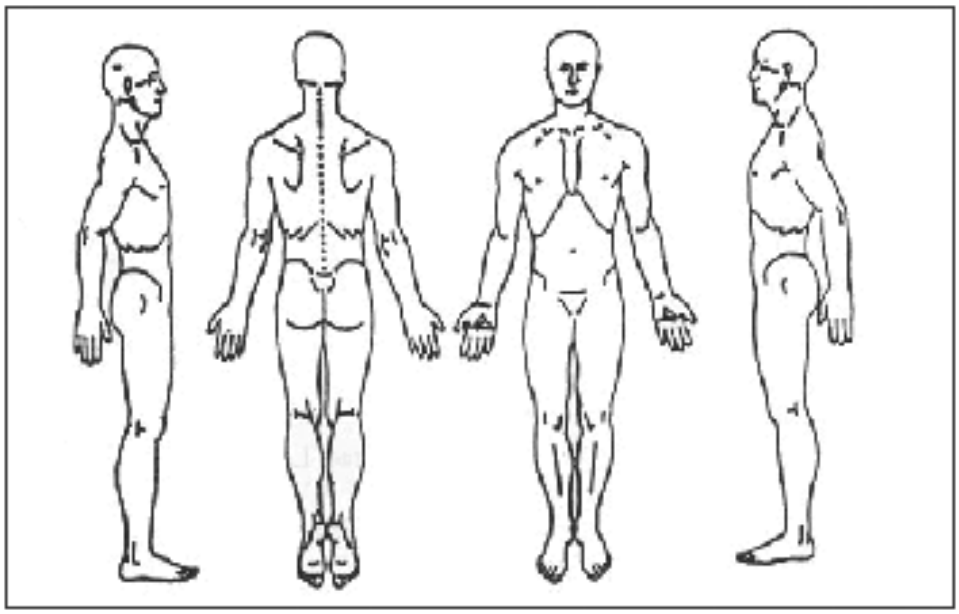
3. Length of Cycle: _____ 6. # of Miscarriages: _____

23. **Male Reproductive**

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

24. **Musculoskeletal**

(Please use the following diagram to indicate regions of distress, using the key at the right.)



Key

X = pain (if it radiates, please indicate the direction with a →)

N = numbness

B = burning

O = tension

* = stiffness (joints)

25. **Neurologic**

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

26. **Endocrine**

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats

Feeling Hot or Cold

27. **Other**

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know?

_____

_____

28. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y / N If no, how many? _____

b. Exercise routine:

_____

c. How many hours per night do you sleep? _____ Do you wake rested? Y N

d. Occupation: _____ Stress: Physical / Psychological

e. Nicotine/Alcohol/Caffeine Use:

_____

f. Have you experienced any major traumas? Y N

Explain:_____

_____

g. How many 8 oz. glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Are there any other comments or questions you would like to write?

How did you hear about us?