Professional Acupuncture & Physical Therapy
Heidi LaBore Smith, NRT, L.Ac., PT
1118 East Superior Street
Duluth, MN 55802
Phone (218) 724-3400
www.proacup.com heidi@proacup.com

New Patient Introduction Form

Patient Name: **Date:**

1. **Chief Concerns:**

2. **Medications and/or Nutritional Supplements currently on:**

3. **Dietary Intake for 2 days before appointment:**

Breakfast:	**Breakfast:**
Snacks:	**Snacks:**
Lunch:	**Lunch:**
Snacks:	**Snacks:**
Dinner:	**Dinner:**
Snacks:	**Snacks:**

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NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address _____

_____

Home Phone (____) ____-_____ Cell Phone (____) ____-_____

Work Phone (____) ____-_____

e-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

Previous treatments for this complaint _____

_____

Other complaints or problems: (use separate sheet if needed) _____

_____

Current medications/drugs being taken: (use separate sheet if needed) _____

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

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Office Use Only:

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NEW PATIENT INFORMATION FORM

Name:_____ Date _____

HISTORY:

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date: _____

NewClient 7/01

_____

Past Accidents or injuries: _____

_____

Any scars from injuries, surgeries, piercings, tattoos, childbirth? Yes____ No____

(if yes, please note their location on diagram - see separate page)

Type of diet: Varied____; Vegan/vegetarian____; Paleo/ketogenic____

Type of water you drink?_____

Any known allergies?_____

Any recent vaccines?_____

Marital Status: S M D W Name of Spouse_____

Describe health of spouse:_____ Number of children if any ___

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

Any family members or close associates with recent vaccines?_____

_____

Any household pets or other animals you or family members are in close contact with:

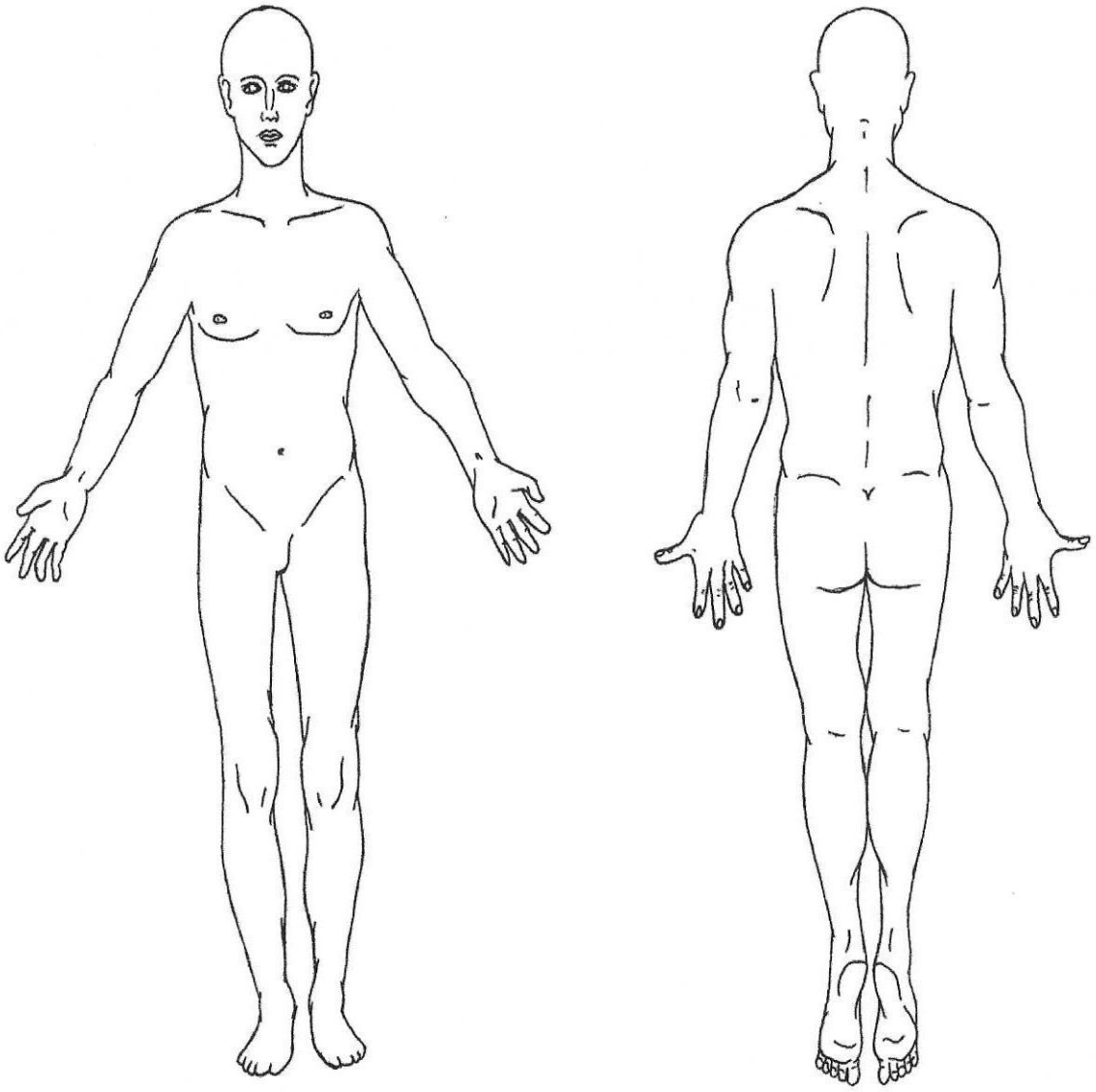
_____

What can we do to make you happier? _____

_____

SIGNED: _____ DATE_____

Please mark all scars below, including surgeries, injuries, piercings, tattoos, and childbirth (episiotomy, caesarian) scars.



Notes:

SYMPTOM SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ☐ Female ☐

Pulse: Recumbent _____ Standing _____ Vegetarian: Yes ☐ No ☐

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ☐

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurred once or twice last 6 months).
○ ● ○ MODERATE symptoms (occurred once or twice last month).
○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	
				GROUP 1
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Cut heals slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold, clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Fever easily raised
18	○	○	○	Neuralgia-like pains
19	○	○	○	Staring, blinks little
20	○	○	○	Sour stomach often
				GROUP 2
21	○	○	○	Joint stiffness on arising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen, puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; feels "lightheaded" often
29	○	○	○	Digestion rapid
30	○	○	○	Vomiting frequent
31	○	○	○	Hoarseness frequent
32	○	○	○	Breathing irregular
33	○	○	○	Pulse slow; feels "irregular"
34	○	○	○	Gagging reflex slow
35	○	○	○	Difficulty swallowing
36	○	○	○	Constipation, diarrhea alternating
37	○	○	○	"Slow starter"
38	○	○	○	Get "chilled" infrequently
39	○	○	○	Perspire easily
40	○	○	○	Circulation poor, sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				GROUP 3
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetite
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Fatigue, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Overeating sweets upsets
	1	2	3	
52	○	○	○	Awaken after few hours sleep - hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression - "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				GROUP 4
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	High altitude discomfort
60	○	○	○	Opens windows in closed rooms
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon "yawner"
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles, worse at night
65	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily, "black and blue" spots
69	○	○	○	Tendency to anemia
70	○	○	○	"Nose bleeds" frequent
71	○	○	○	Noises in head, or "ringing in ears"
72	○	○	○	Tension under the breastbone, or feeling of "tightness", worse on exertion
				GROUP 5
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter, metallic taste in mouth in mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Worrier, feels insecure
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upset
85	○	○	○	Stools light colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Use laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmare type bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				GROUP 6
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul-smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucous colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

	1	2	3	
				GROUP 7A
107	O	O	O	Insomnia
108	O	O	O	Nervousness
109	O	O	O	Can't gain weight
110	O	O	O	Intolerance to heat
111	O	O	O	Highly emotional
112	O	O	O	Flush easily
113	O	O	O	Night sweats
114	O	O	O	Thin, moist skin
115	O	O	O	Inward trembling
116	O	O	O	Heart palpitates
117	O	O	O	Increased appetite without weight gain
118	O	O	O	Pulse fast at rest
119	O	O	O	Eyelids and face twitch
120	O	O	O	Irritable and restless
121	O	O	O	Can't work under pressure
				GROUP 7B
122	O	O	O	Increase in weight
123	O	O	O	Decrease in appetite
124	O	O	O	Fatigue easily
125	O	O	O	Ringing in ears
126	O	O	O	Sleepy during day
127	O	O	O	Sensitive to cold
128	O	O	O	Dry or scaly skin
129	O	O	O	Constipation
130	O	O	O	Mental sluggishness
131	O	O	O	Hair coarse, falls out
132	O	O	O	Headaches upon arising, wear off during day
133	O	O	O	Slow pulse, below 65
134	O	O	O	Frequency of urination
135	O	O	O	Impaired hearing
136	O	O	O	Reduced initiative
				GROUP 7C
137	O	O	O	Failing memory
138	O	O	O	Low blood pressure
139	O	O	O	Increased sex drive
140	O	O	O	Headaches, "splitting or rending" type
141	O	O	O	Decreased sugar tolerance
				GROUP 7D
142	O	O	O	Abnormal thirst
143	O	O	O	Bloating of abdomen
144	O	O	O	Weight gain around hips or waist
145	O	O	O	Sex drive reduced or lacking
146	O	O	O	Tendency to ulcers, colitis
147	O	O	O	Increased sugar tolerance
148	O	O	O	Women: menstrual disorders
149	O	O	O	Young girls: lack of menstrual function
				GROUP 7E
150	O	O	O	Dizziness
151	O	O	O	Headaches
152	O	O	O	Hot flashes
153	O	O	O	Increased blood pressure
154	O	O	O	Hair growth on face or body (female)
155	O	O	O	Sugar in urine (not diabetes)
156	O	O	O	Masculine tendencies (female)
				GROUP 7F
157	O	O	O	Weakness, dizziness
158	O	O	O	Chronic fatigue
159	O	O	O	Low blood pressure
160	O	O	O	Nails weak, ridged
161	O	O	O	Tendency to hives
162	O	O	O	Arthritic tendencies
163	O	O	O	Perspiration increase
164	O	O	O	Bowel disorders
165	O	O	O	Poor circulation
166	O	O	O	Swollen ankles
167	O	O	O	Crave salt
168	O	O	O	Brown spots or bronzing of skin
169	O	O	O	Allergies - tendency to asthma

	1	2	3	
170	O	O	O	Weakness after colds, influenza
171	O	O	O	Exhaustion - muscular and nervous
172	O	O	O	Respiratory disorders
				GROUP 8
173	O	O	O	Apprehension
174	O	O	O	Irritability
175	O	O	O	Morbid fears
176	O	O	O	Never seems to get well
177	O	O	O	Forgetfulness
178	O	O	O	Indigestion
179	O	O	O	Poor appetite
180	O	O	O	Craving for sweets
181	O	O	O	Muscular soreness
182	O	O	O	Depression; feelings of dread
183	O	O	O	Noise sensitivity
184	O	O	O	Acoustic hallucinations
185	O	O	O	Tendency to cry without reason
186	O	O	O	Hair is coarse and/or thinning
187	O	O	O	Weakness
188	O	O	O	Fatigue
189	O	O	O	Skin sensitive to touch
190	O	O	O	Tendency toward hives
191	O	O	O	Nervousness
192	O	O	O	Headache
193	O	O	O	Insomnia
194	O	O	O	Anxiety
195	O	O	O	Anorexia
196	O	O	O	Inability to concentrate; confusion
197	O	O	O	Frequent stuffy nose; sinus infections
198	O	O	O	Allergy to some foods
199	O	O	O	Loose joints
				FEMALE ONLY
200	O	O	O	Very easily fatigued
201	O	O	O	Premenstrual tension
202	O	O	O	Painful menses
203	O	O	O	Depressed feelings before menstruation
204	O	O	O	Menstruation excessive and prolonged
205	O	O	O	Painful breasts
206	O	O	O	Menstruate too frequently
207	O	O	O	Vaginal discharge
208			O	Hysterectomy / ovaries removed
209	O	O	O	Menopausal hot flashes
210	O	O	O	Menses scanty or missed
211	O	O	O	Acne, worse at menses
212	O	O	O	Depression of long standing
				MALE ONLY
213	O	O	O	Prostate trouble
214	O	O	O	Urination difficult or dribbling
215	O	O	O	Night urination frequent
216	O	O	O	Depression
217	O	O	O	Pain on inside of legs or heels
218	O	O	O	Feeling of incomplete bowel evacuation
219	O	O	O	Lack of energy
220	O	O	O	Migrating aches and pains
221	O	O	O	Tire too easily
222	O	O	O	Avoids activity
223	O	O	O	Leg nervousness at night
224	O	O	O	Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____